



Hospital

GHA

Handbook

the current state of hospital finance and policy in Georgia



24 Hours a Day

7 Days a Week

365 Days a Year



**Caring for all patients
regardless of ability to pay,
hospitals are vital to the
communities they serve.**

Table of Contents

Hospital Quick Facts	2
The Unique Role of a Hospital	3
Types of Hospitals	4
Economic Impact	6
Community Benefit	8
Social Determinants of Health	10
Understanding Your Hospital Bill	13
Who Pays Your Bill	21
Who Governs Your Health Plans	37
Hospital Provider Payment Programs	43
Indigent Care Trust Fund	46
Rural Health	48
Emergency and Trauma Care	51
Health Care Workforce	55
Health Information	58
Quality and Patient Safety	60
State Regulatory Requirements	65
State and Federal Oversight of Hospital Billing and Payments	65
Glossary	68
Endnotes	75

Inside the H

We see them frequently, but maybe we don't give them much thought. Whether driving down the road and passing the blue-and-white "H" symbol or driving by the brick-and-mortar hospital building, both are signs that hospitals are integrated into their communities. Unfortunately, many do not fully appreciate hospitals until we need the services behind the H.

This publication explains the complicated health care industry, and our hope is that it will provide a better understanding of hospitals and health care.

Our Publication Vision

Throughout this book, you will see an 'Inside the H' sidebar in which key points are highlighted.

Hospital Quick Facts

Number of Georgia Hospitals (January 2023):

General Acute Care Hospitals/Campuses	102
Critical Access Hospitals	30
Psychiatric/Behavioral Health Hospitals	22
Specialty Hospitals	25
Veterans Affairs Hospitals	3

182 *Total Hospitals*

* 104 of 159 Georgia Counties have a hospital

Patient Utilization (FY 2022):

Inpatient Admissions	1.1 million
Outpatient Visits	11.3 million
Total	12.4 million

Patient Utilization by Insurance Status (FY 2022):

Employer/Private Insurance	3.7 million
Medicare	4.1 million
Medicaid	2.1 million
Uninsured	1.5 million
Other	1 million
Total Visits & Discharges	12.4 million

Hospital Employment (2019):

Number of Full-Time Hospital Jobs	162,135
Salaries and Benefits	\$12.7 billion

During 2020-2021, 2,800 volunteers volunteered a total of 153,000 hours at their hospitals and contributed funds totaling almost \$1 million. Volunteers gave over \$130,000 to their communities.

Hospital Uncompensated Care (2021):

Indigent, Charity and Free Care	\$1.7 billion
Bad Debt	\$0.83 billion
Total	\$2.5 billion

Average Margins (2021):

Patient Care Margin	6.1%
Total Margin	12.4%

Percent of Hospitals with Operating Losses (2021) considering:

Patient Care Revenue Only	42%
All Revenues	29%

Hospital Closures (since 2013)

Calhoun Memorial Hospital
 Stewart-Webster Hospital
 Charlton Memorial Hospital
 Lower Oconee Community Hospital
 Emory-Adventist Hospital
 North Georgia Medical Center
 Lake Bridge Behavioral Health
 Southwest Georgia Regional Medical Center
 Kindred Hospital Rome

Northridge Medical Center
 Select Specialty Hospital – Northeast Atlanta
 Chestatee Regional Hospital
 Southern Crescent Hospital for Specialty Care
 Crescent Pines Hospital
 Coliseum Center for Behavioral Health
 Wellstar Atlanta Medical Center
 Wellstar Atlanta Medical Center South

The Unique Role of a Hospital

America's hospitals are vital to meeting the health care needs of the communities they serve by providing a wide range of acute care and diagnostic services, supporting public health needs, and offering a myriad of other services to promote the health and well-being of the community.

Other types of health care providers may also deliver some of these services; however, three things make the role of the hospital unique:

- **24/7 ACCESS TO CARE:** The provision of health care services, including specialized resources, 24 hours a day, seven days a week (24/7), 365 days a year;
- **THE SAFETY-NET ROLE:** Caring for all patients who seek emergency care, regardless of ability to pay; and
- **DISASTER READINESS AND RESPONSE:** Ensuring that staff and facilities are prepared to care for victims of large-scale accidents, natural disasters, epidemics and terrorist actions.

These critical roles, collectively known as the “standby” role, represent an essential component of our nation's health and public safety infrastructure.¹ The standby role of hospitals is not explicitly funded; instead, the funding is built into a hospital's overall cost structure and supported by certain revenues received from providing direct patient care.

HOSPITAL

Types of Hospitals

Georgia law defines health care institutions, including hospitals, under O.C.G.A. § 31-7-1(4) (A); however, the classification of a health care institution as a hospital is determined by rules promulgated by the Georgia Department of Community Health.

Hospital Classifications

An **acute care hospital** provides treatment for a brief but severe injury, episode of illness, conditions that result from disease or trauma, or during recovery from surgery. Acute care is generally provided by a variety of clinical staff. There are 104 general acute care hospitals in Georgia.²

A **not-for-profit hospital** is an organization that can demonstrate that no part of its net earnings is given to a shareholder or individual. This type of hospital is exempt from most federal and state taxes due to its charitable status but is not exempt from employment taxes (e.g., Social Security and Medicare taxes). The term “non-profit” does not mean that the hospital does not make a profit. Instead, profits are utilized for the benefit of the hospital community.

Some hospitals are affiliated with a hospital authority. This is a local governmental entity and statutorily created public corporation that is authorized to create and operate a hospital in a county or municipality. Many hospital authorities use a not-for-profit management company to handle daily operations.

For **investor-owned (for-profit) hospitals**, the profit or loss of the hospital is a direct profit or loss for the shareholders (owners) of the hospital. In 2021, 41 Georgia hospitals reported being for-profit. In Georgia, these facilities may be publicly traded or privately owned and pay taxes on hospital property and purchases.

Established under the federal *Balanced Budget Act of 1997*, Critical Access Hospitals (CAH) are limited-service, acute-care hospitals located in rural areas. There are 30 critical access hospitals in Georgia compared with 34 only a few years ago.

Specialty hospitals are acute care hospitals that provide a limited service for one of the following types of care: children’s medical; long-term acute care; psychiatric; or rehabilitative.

A **hospital system** is a collection of hospitals previously described, such as for-profit, not-for-profit, acute medical surgical, specialty or critical access, that are all operating under a single corporate entity. Additionally, a hospital system may own or operate other lines of business, like a skilled nursing facility, pharmacy, or physicians’ practice.

Teaching hospitals are facilities that have been approved to participate in residency training by the Accreditation Council for Graduate Medical Education³ and/or have a residency or internship program(s) approved by the American Osteopathic Association and/or are members of the Council of Teaching Hospitals.



Inside the H

- There are 182 hospitals in Georgia.
- There are 102 general acute care hospitals in Georgia.
- There are 41 for-profit hospitals in Georgia.
- Critical Access Hospital is a special Medicare designation for payment that is limited to hospitals with no more than 25 beds and an average length of stay fewer than four days.
- There are 30 critical access hospitals in Georgia.
- The term “non-profit” does not mean that the hospital does not make a profit. Instead, profits of the hospital are returned to the control of the hospital for operations rather than to shareholders.

Economic Impact

The Health Care Industry in Georgia

In 2020, the health care and social assistance industry was the third-largest employment sector in Georgia.⁴ It is a major economic engine for Georgia and is considered key to the state's efforts to recruit and retain new and expanding businesses. The health care industry:

- Directly contributed \$40 billion, or 6.4 percent, to Georgia's Gross State Product (GSP);⁵ and
- Provided 9.5 percent, or 581,000, of the state's jobs.⁶

Economic Impact of Georgia Hospitals

In 2020, Georgia's hospitals:

- Spent \$30.9 billion to operate;
- Directly provided approximately 157,200 full-time jobs; and
- Paid salaries and wages of \$15.2 billion.⁷

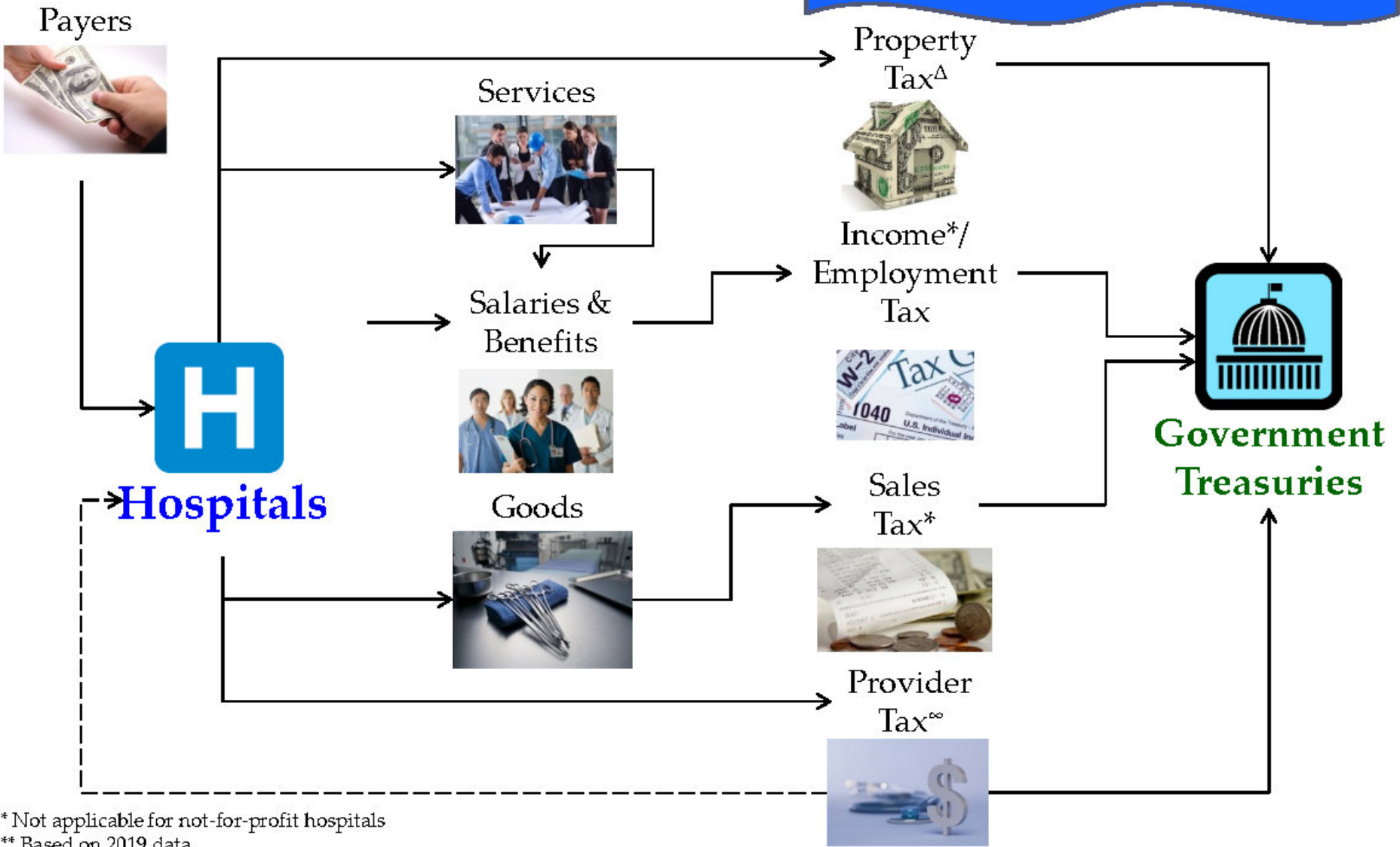
Hospitals are major drivers of economic activity in the communities they serve and a significant force that contributes to the economic stability and growth across the state. The most recent data used to provide hospitals' annual economic impact is from an unprecedented time when hospitals battled a pandemic while facing staff and supply shortages, not to mention extreme financial pressures. Because of the unique strategies employed by each hospital, we as well as timing and overall infection rates of each service area, it is difficult to aggregate the economic impact of hospitals. Indeed, doing so may be (at best) slightly misleading or (at worst) distort some hospitals' data. Several factors may have influenced any hospital's economic impact numbers, such as fiscal year end date, the timing of the pandemic and its effects on the hospital; total expenditure and the potentially high cost of basic supplies due to shortages; and payroll and contract labor efforts in which hospitals had to use innovative ways to ensure they were adequately staffed in times of high census.

GHA uses data from the U.S. Department of Commerce's Bureau of Economic Analysis to calculate a multiplier effect, which measures the change in output for a given change in demand. An increase in demand for health care services will elicit increases that support health care as well as ancillary industries. However, in the context of the pandemic, the Bureau of Economic Analysis has stated that their multiplier is not designed to estimate the impact of supply shocks to the economy. It is important to consider the impact of changing procurement patterns on hospital supplies; the widespread nature of temporary business closures in 2020 and the ability to spend money locally; and the impact of a COVID wave on staffing and hospital full-time employee counts, which are only a snapshot in time.

Since a majority of revenue received by hospitals is spent on wages and salaries as well as goods and services necessary to operate a hospital, these funds are distributed throughout the local community and are subject to various state and local taxes, which in turn support governmental treasuries. *See Figure 1 on page 7 for a diagram of this flow of funds.*

Figure 1

Hospital Economic Impact on the Local and State Economy in Georgia



* Not applicable for not-for-profit hospitals

** Based on 2019 data

^Δ Not-for-profit hospitals pay property taxes on locations where a medical service is not being offered.

[∞] Does not apply to state owned/operated facilities, critical access hospitals or free-standing psychiatric facilities

Community Benefit

In addition to treating patients inside their walls, Georgia hospitals address community health needs through community benefits such as health screenings, clinical services, support groups, research, subsidized health services, in-kind contributions, and the provision of indigent and charity care. Hospitals work to be an essential part of short-term and long-term health improvement by promoting healthy living and quality of life. They also work to expand access and coverage. In 2019, Georgia not-for-profit hospitals provided more than \$1.2 billion in community benefit.⁸

Indigent, Charity and Free Care

In FY 2021, hospitals cumulatively provided \$1.7 billion in financial assistance through indigent, charity and free care.⁹ This number is calculated based on the actual cost to provide that care, which is provided to patients who typically do not have insurance and have family incomes that qualify for a hospital's indigent or charity care policies. In some cases, the hospital covers the entire amount of the patient's bill. In other cases, the hospital will subsidize the cost of the bill and require the patient to pay some amount based on his or her income and a pre-established sliding scale.

Not-For-Profit Hospital Requirements

In exchange for their tax-exempt status, not-for-profit hospitals are expected to provide additional health benefits to their communities above and beyond indigent and charity care. Not-for-profit hospitals are federally required to report the value of these benefits annually on Schedule H of the IRS Form 990.

Generally, the IRS categorizes community benefits for not-for-profit hospitals as follows:

- Community health improvement services
- Health professions education
- Subsidized health services
- Research
- Cash and in-kind contributions to community groups

Schedule H separately captures community-building activities that a hospital engages in to protect or improve the community's health or safety (e.g., leadership development and training for community members or coalition building). Some community building activities may also meet the definition of community benefit but can only be reported as one or the other.

While there are no federally mandated or state-mandated requirements related to the amount of community benefit provided by hospitals, these amounts are watched closely by the IRS and other taxpayer advocacy groups to ensure not-for-profit hospitals are accountable for their tax-exempt status.

As reported on the 2019 Schedule H, Georgia's not-for-profit hospitals provided more than \$1.2 billion in community benefit and \$3.8 million in community building activities, which are not eligible as community benefits, but still play an important role in enhancing community wellness.¹⁰ This is in addition to amounts provided by these same hospitals in financial assistance for indigent and charity care.

To track compliance with these community benefit requirements, in 2011, the Internal Revenue Service significantly expanded the annual reporting requirements for tax-exempt hospitals on Schedule H.



Inside the H

The federal *Patient Protection and Affordable Care Act of 2010 (ACA)* placed additional community benefit mandates on not-for-profit hospitals. These hospitals must:

- Conduct a community health needs assessment at least once every three years and adopt an implementation strategy for all community needs identified in the assessment;
- Adopt and publicize a financial assistance policy;¹¹
- Limit amounts charged to uninsured individuals eligible for financial assistance to no more than they generally bill to patients who have insurance; and
- Forego extraordinary collection actions before the hospital has made reasonable efforts to determine whether the individual is eligible for financial assistance.

Social Determinants of Health

Social determinants of health, as defined by the federal government, are “the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”¹² GHA partners with Alliant Health Solutions to support the federally funded Hospital Quality Improvement Contract (HQIC), of which addressing the social determinants of health is a top priority. In the HQIC, we are addressing equity, diversity, and inclusion in health care. Health inequities contribute to health disparities, a well-documented factor in both the cost of care and quality outcomes. HQIC is moving forward with addressing health disparities and social determinants of health through a cohort for readmissions and health equity. Health equity means that every person has an opportunity to have optimal health regardless of race, ethnicity, level of education, gender identity, sexual orientation, employment status and/or disability. GHA works with and encourages all hospitals to engage in efforts to promote health equity.



Social determinants of health have a major impact on people's health, well-being, and quality of life.

Understanding Your Hospital Bill

Payer Types

It can be very confusing when trying to compare charges for service at different facilities. That's because there is a lot more that goes into determining what patients will pay for any given service. First, we must understand how payer types impact what patients will actually pay for services. Hospitals are required by federal law to charge the same amount for any service, regardless of whether the patient is insured or the type of insurance the patient has (private, government such as Medicare or Medicaid, uninsured, etc.). However, these factors do impact the price that the patient ends up paying for a service.

Private Insurance

Patients with private insurance will likely see an adjustment reflecting the difference in the hospital's charges and the amount the insurance company is covering. The amount the insurance company pays has been negotiated with the hospital through contracts.

Government Payers

Medicare and Medicaid pay the lowest rates and usually do not cover the cost of rendering the service. Medicare rates are pre-determined and non-negotiable. Medicaid is operated at the state level and is jointly funded by federal and state governments. Georgia's Medicaid program is administered by the Georgia Department of Community Health (DCH) and pays a predetermined fixed amount for inpatient services based on patients' diagnoses and treatments. Payments are not guaranteed to cover current costs (what the patient owes). Payments to critical access hospitals and state hospitals are paid at 100% of cost. All other hospitals are paid at 85.6% of cost, meaning that these hospitals are guaranteed by policy to lose 14.4% of their costs on Medicaid patients treated in outpatient settings.

Inside the H

Hospitals charge the same prices to all patients as a requirement of Medicare participation.

While charges are the same regardless of the patient being served, the hospital receives different payment amounts depending on the payer source.

Hospitals negotiate actual payments with some payers and receive predetermined amounts from programs like Medicare and Medicaid.

Figure 2 on page 12 reflects the distribution of patients by payer types.

Indigent, Charity, and Free Care

Uninsured and underinsured patients do not pay hospitals an amount that covers the cost of care. Indigent, charity, and free care is provided to patients who typically do not have insurance and have family incomes that qualify for a hospital's indigent or charity care policies. Hospitals may either cover the entire amount of the patient's bill or will subsidize the cost of the bill and require the patient to pay some amount based on income and a pre-established sliding scale.

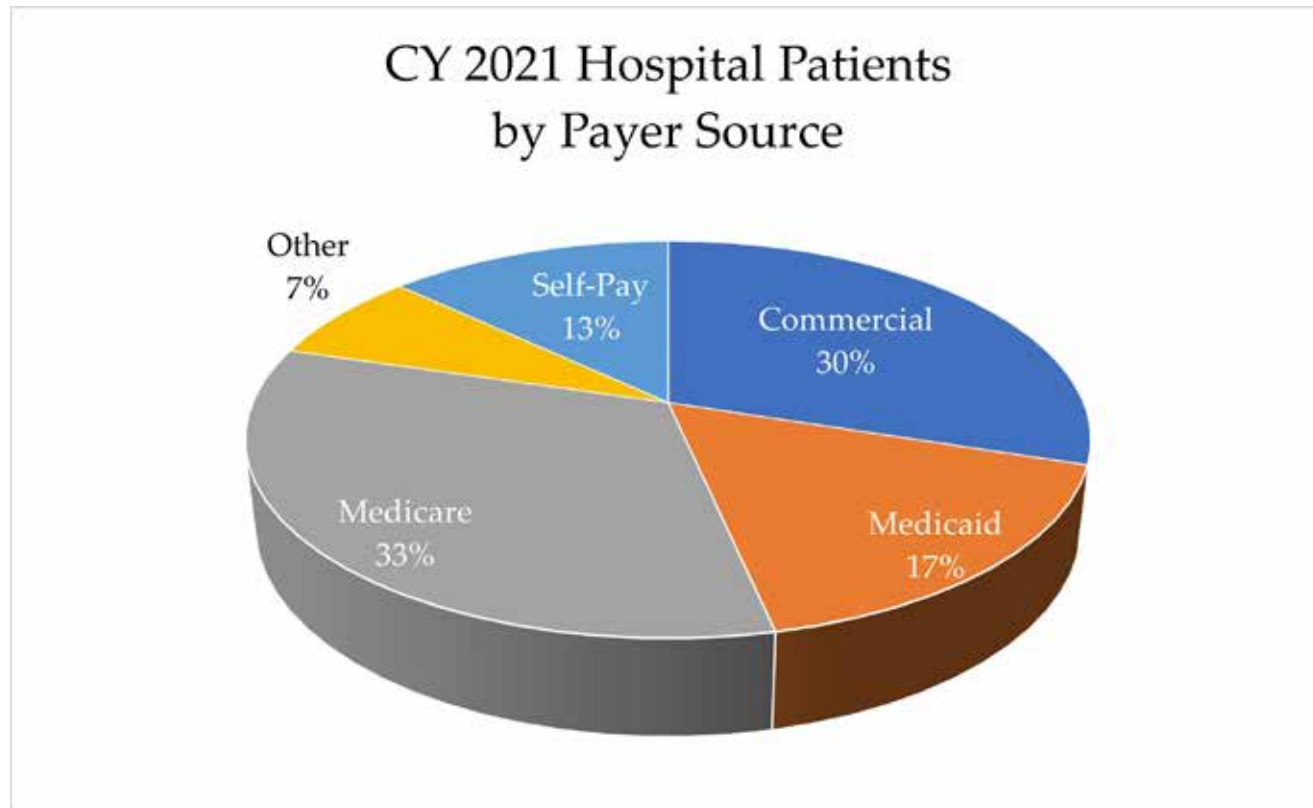
Bad Debt

Hospitals incur bad debt when a patient does not pay and does not qualify for indigent or charity care programs. Hospitals must cover bad debt losses from positive margins gained from other payers.

Other Sources of Payment

Hospitals may also receive payments from other sources, such as automobile insurance policies for patients injured in an accident. In summary, negotiated payments from insurers and public programs do not always reflect the actual cost of providing care. Medicare and Medicaid pay less than cost, the uninsured pay little or nothing, and others must make up the difference.

Figure 2



Patient Billing

The format of a hospital bill may vary by hospital; however, the elements of the bill are universal. A hospital bill will begin with the amounts the hospital charges for the services that were rendered. Hospitals are required to charge the same amount for any service regardless of the patient's payment source. Patients with insurance that has made a payment on the claim will likely see an adjustment reflecting the difference in the hospital's charges and the amount the insurance company has negotiated for the services rendered. This is known as a contractual adjustment and is the base amount used to determine the patient's cost sharing. Patients who qualify for the hospital's indigent or charity care programs would see similar adjustments showing the value of the financial aid being provided. Any residual amount left after considering these adjustments would typically be the amount owed by the patient. These amounts may comprise a combination of deductible, coinsurance, copayments and non-covered charges due as determined by the insurance plan.

Bad Debt Cost Analysis

According to the 2021 Georgia Department of Community Health's Hospital Financial Survey, Georgia hospitals reported \$831 million in bad debt cost, or about 2.9% of their total expenditures. Average bad debt decreased 4.5% from 2020 to 2021.

Subsidizing Uncompensated Care

To make up for deficits from Medicare, Medicaid and the uninsured, hospitals must make positive margins from other payers. Together, Medicare, Medicaid and uninsured patients account for 64% of all Georgia's hospital encounters.¹³

*As shown in Figure 3 on page 14, PPS hospitals need to make a 22% profit on the remaining encounters from other payers to offset their uncompensated care.*¹⁴

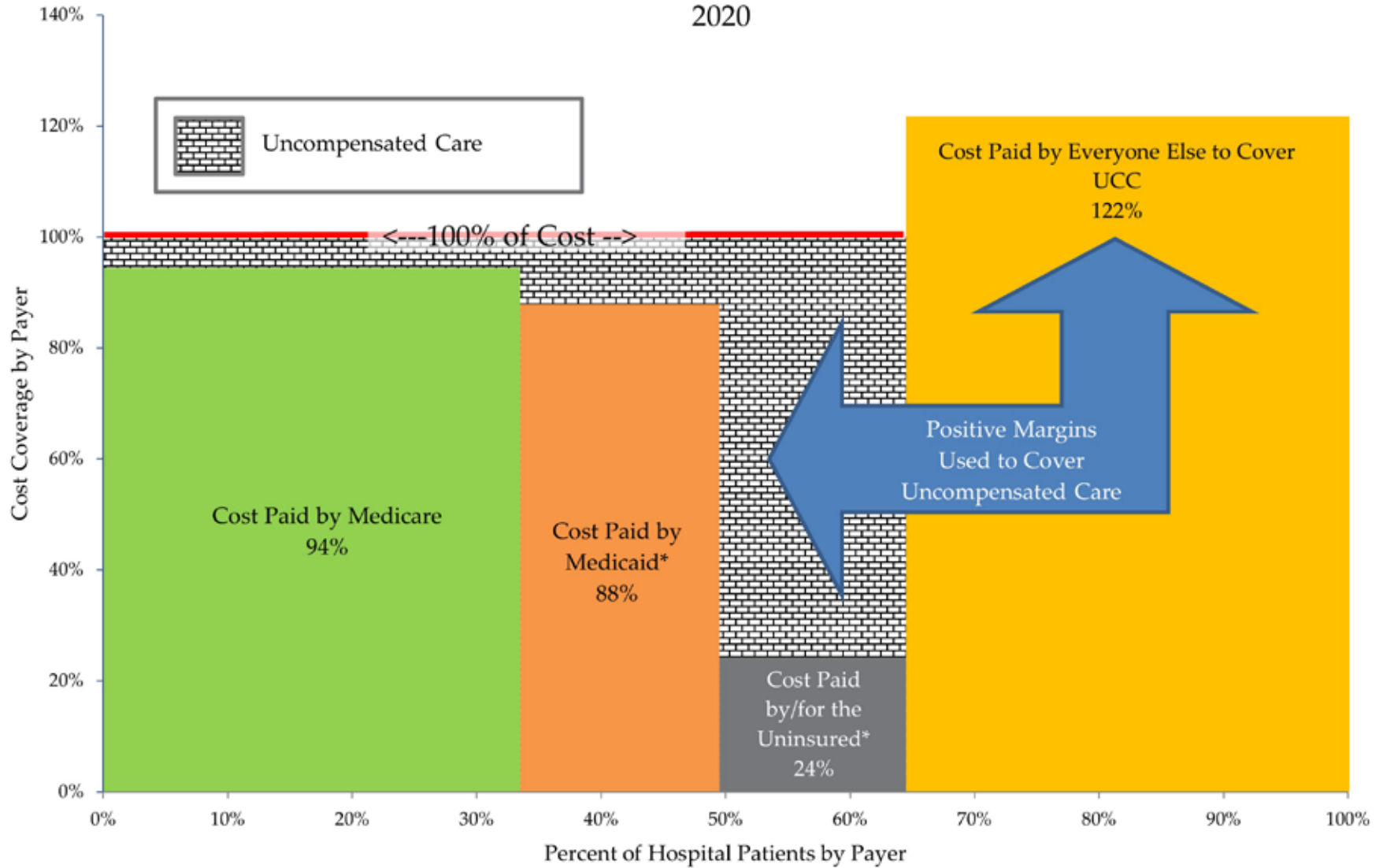
One way the state helps protect hospitals from the financial burdens of uncompensated care is through the Certificate of Need (CON) program. GHA supports CON as an important component of Georgia's health planning process because it discourages unfair competition from facilities that serve few, if any, patients with payer sources that don't cover cost. Discussed in more detail on page 65 of this publication, CON helps control costs by requiring all applicants wanting to build new health care facilities to demonstrate the need for additional health care capacity, thus preventing overutilization and unnecessary duplication of services.

Hospital Expense

In 2019, 49% of Georgia hospitals' expenses covered payroll and employee benefit payments for 157,000 full-time employees.¹⁵ The average cost of a 2022 hospital inpatient admission in Georgia was around \$17,400; however, costs varied widely depending on the services provided during the admission.¹⁶

Figure 3

Subsidizing Uncompensated Care from
Government Payers and Self-Pay
2020



* considers DSH and Medicaid supplemental payments

Hospital Fiscal Health

As discussed in other sections of this publication, hospitals incur costs in providing some health care services but don't get paid as a result. This can occur for various reasons; some are out of the hospital's control (e.g., fixed reimbursement by governmental payers that is less than cost, emergency care for the uninsured). Regardless of the cause, these situations can present a challenge to a hospital's fiscal health.

At the most fundamental level, hospitals measure their fiscal health by their ability to remain in business to provide services to patients in their communities. A more accounting-based measure is the use of the operating margin, which is the difference between net operating revenue divided by total operating revenue. The goal is for a facility to have a positive operating margin.

Hospitals with positive operating margins are able to enhance their community benefit and charitable care programs as well as invest in technology upgrades and capital improvements. Positive margins also allow them to weather future economic downturns through the use of reserve funds, much like the state does with its Shortfall Reserve Fund.

While Georgia's hospital industry is, on average, achieving modest margins, almost one-third or 29% of Georgia's hospitals lost money in 2021.¹⁸ This situation is significantly worse for rural hospitals, as 44% had negative total margins. Hospitals can cope with negative operating margins in the short term by carefully controlling cash flow, utilizing revenue from other lines of business the hospital may own (e.g., a nursing home), delaying capital improvements and, of course, reducing expenses. These are only short-term solutions, and hospitals that are unable to realize and maintain positive operating margins will likely face closure sooner or later. Unfortunately, this was the case for 16 Georgia hospitals since 2013.

*(See Figure 4 on page 16 for more details on trends in hospital margins.)
Hospitals must rely on other sources of revenue to achieve modest margins.*

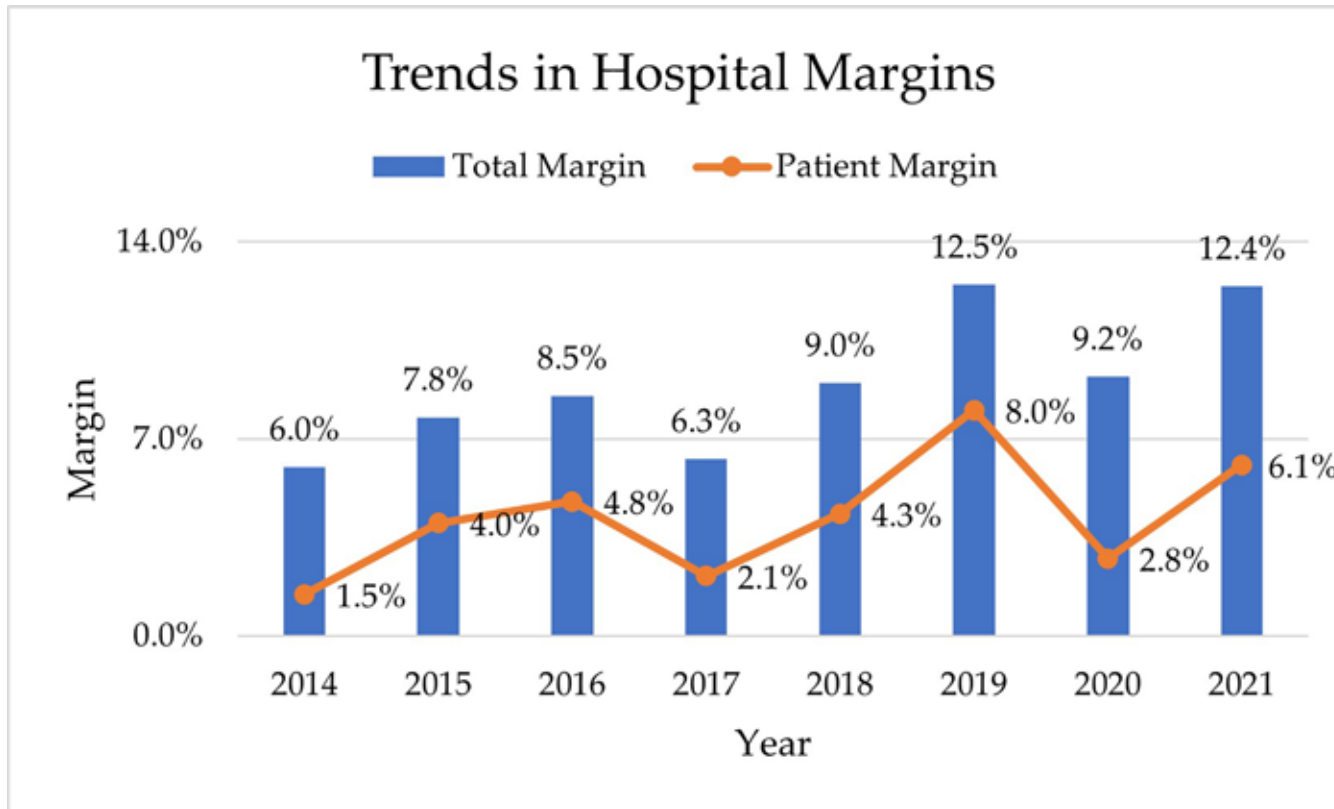
Inside the H

GHA annually calculates operating margins for patient care (i.e., revenue and expenses only from patient care) as well as total margins (i.e., revenue and expenses from all sources of the hospital's operations.)

In 2021, the patient care margin for all hospitals in Georgia was 6.1%, with 42% of them losing money based on the payments they received for taking care of patients. Revenue from supplemental governmental payments, investment income and other non-patient sources added 6.3% to the average margin in 2021.¹⁷

GHA predicts margins will continue to be negatively impacted, primarily due to accelerating reductions in payments from governmental programs like Medicare and the Medicaid Disproportionate Share Hospital (DSH) Program.

Figure 4



In 2021, 29% of Georgia's hospitals lost money; 44% of rural hospitals had negative total margins.

Reserves

Hospitals must maintain financial reserves in order to ensure their long-term financial viability. Reserves are required by financial institutions as a condition to lending hospitals money to pay for capital improvements that support an adequate infrastructure, replace old buildings and purchase the latest medical technologies. Bond covenants often include a requirement to maintain reserves and a violation of this requirement could result in the lender demanding immediate repayment.

In addition, the amount of reserves a hospital maintains directly impacts the costs of borrowing money. The healthier the hospital is financially, the lower the interest rates the hospital can obtain. Finally, many Georgia hospitals rely on investment income to stay in the black. In times of economic downturns and extreme market fluctuations like those in recent years, financial reserves are critical in enabling some hospitals to meet their everyday financial obligations, fund their employee pensions and continue their charitable missions.

Captives

A captive is, quite simply, an insurance company or a formalized risk financing plan. Hospitals, like all businesses, purchase insurance to protect themselves when things go wrong or mistakes are made. Health care facilities face many risks and purchase insurance for financial protection. Insurance coverage is available in the commercial marketplace; however, health care facilities can choose to provide their own insurance program or self-insured risk financing plan by creating a captive. Captives can provide savings on insurance costs and allow hospitals to invest those savings back into providing affordable, high-quality health care services to their patients and communities. Furthermore, captives provide broader risk coverage that may not be insured by traditional commercial insurance carriers. Hospitals that make sound business decisions are better positioned to provide excellent health care, employ a growing workforce, offer preventive services that benefit the community and provide a huge economic boost to the community and state.

A captive insurance company is a licensed insurance company. There are approximately 5,000 captive companies worldwide, of which almost 70% are owned by U.S. entities and 17% were formed by health care organizations. Captives can be a "pure captive," meaning it insures the risk of its parent; a "group captive" that shares risk with its participants or owners; or a "rent a captive" that offers a segregated cell to another entity. These companies are commonly known as segregated portfolio companies (SPCs).

Many industries utilize insurance captives because underwriting profit and investment income can be retained by the owner instead of an insurance company under an insured program. Additional benefits include:

- Flexibility and freedom to utilize the company's own strategy and select its own counsel;
- Stabilization and insulation from pricing swings;
- Broader coverage terms to cover risks not traditionally insured by commercial insurers;
- Ability to write third-party business, such as non-employed physicians and allied health care providers;
- Reinforce Senior Management engagement and support Risk Management and Risk Mitigation initiatives; and
- Ability to access worldwide reinsurance companies.

Captive domiciles exist in numerous U.S. states, along with the established offshore domiciles of the Cayman Islands and Bermuda. Georgia has its own captive law. The selection of the most appropriate domicile would be undertaken as part of the initial captive feasibility study. Generally accepted accounting principles require the captive's financial statements be consolidated with the hospital's financial statement and the offshore regulator requires that all captives have an independent audit of their own financial statements.

Captives are flexible in program design and can provide coverage for several insurance product lines, such as:

- Professional Liability
- General Liability
- Employed Physicians Liability
- Directors & Officers Liability
- Employment Practices Liability
- Auto Physical Damages/Liability
- Medical Stop Loss
- Third Party Liability such as non-employed physicians
- Cyber Risk

Executive Compensation

Hospital CEOs are responsible for ensuring the mission of a hospital is achieved. Activities that support the delivery of quality care to patients include day-to-day operations as well as long-term strategic planning. CEOs must also cultivate and maintain good relationships with physician groups, primary care clinics, nursing homes, home health agencies and other health care providers that provide the continuum of care needed by patients and the community.

CEOs are accountable for the quality of care provided to the patients being treated in their hospitals. They are also accountable to the hospital's Board of Directors for the financial well-being of the hospital so it can continue to support the health care and economic needs of the community. CEOs must also ensure their hospitals are compliant with the requirements of accreditation organizations and both state and federal regulatory agencies.

As a result of this expansive scope of responsibilities, hospitals compete with other industries to attract the best and brightest executives. Volunteer boards composed of community leaders determine executive compensation of hospital leaders and, in the case of not-for-profit hospitals, the IRS requires reasonable executive compensation. Failure to do so can result in "excess benefit penalties" or even the revocation of tax-exempt status.

Who Pays Your Bill?

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.¹⁹

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 1.34 million Georgians were enrolled in Medicare coverage in 2021.²⁰

Medicare pays predetermined, non-negotiable fixed amounts for hospital services based on the patient's diagnosis and treatment. Medicare payments vary among geographic regions to reflect local wage rates. 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 1.3 million Georgians were enrolled in Medicare coverage in 2021.²⁰

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.

Medicare

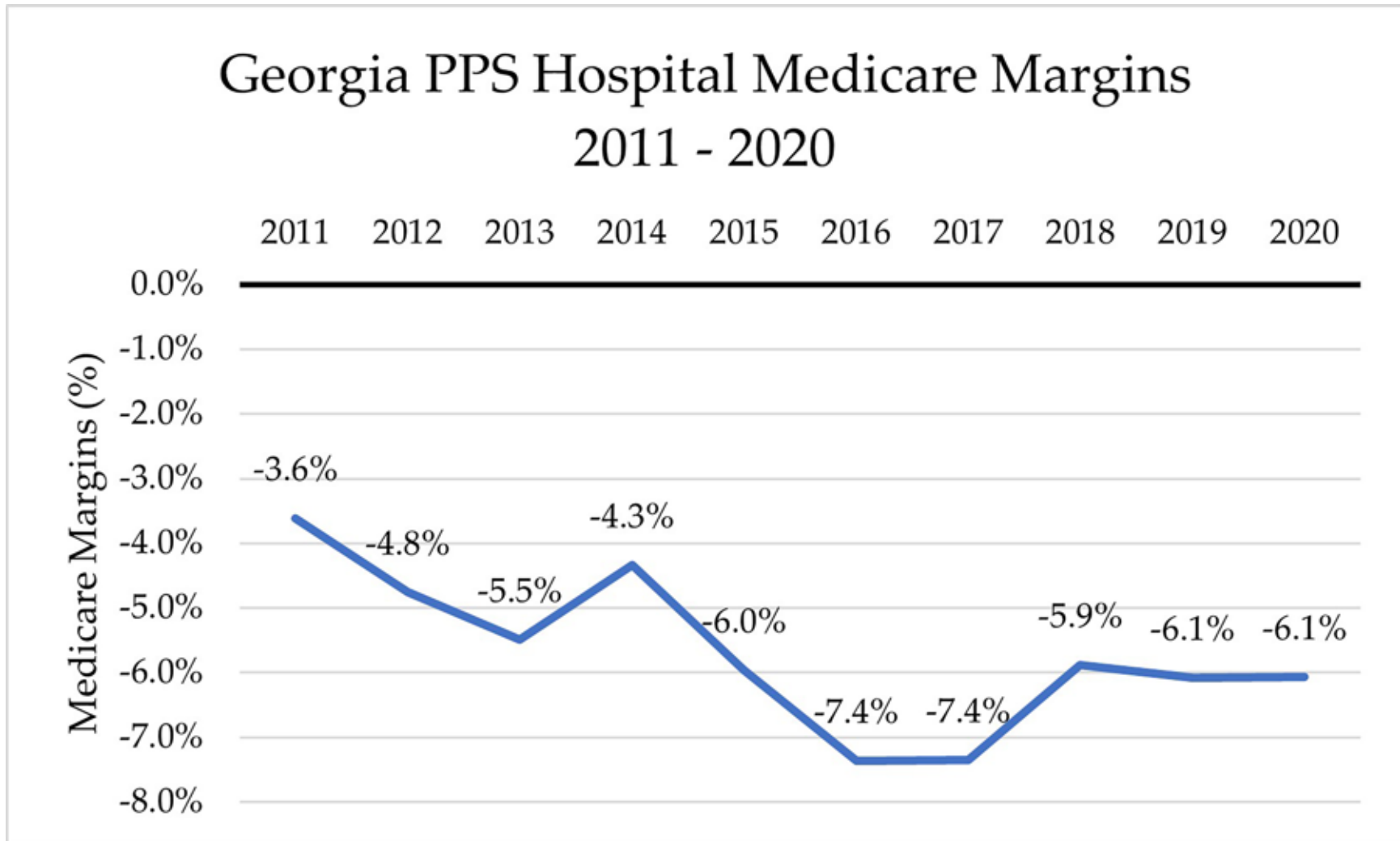
Serves most people age 65 or older regardless of income.

Medicaid

Serves the low income and disabled.

Overall, Medicare pays less than cost to most hospitals. In FY 2020, Medicare paid 94% of cost to PPS hospitals for inpatient and outpatient services.²¹

Figure 5



Several pieces of legislation over the past several years have reduced Medicare reimbursement to Georgia's hospitals and these reductions are expected to continue. A list of the federal legislative and regulatory action items can be seen on page 22 in Figure 6.

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 & Medicaid Services (CMS). Georgia's Medicaid program is administered by the Georgia Department of Community Health.



Inside the H

Who is Eligible for Medicaid?

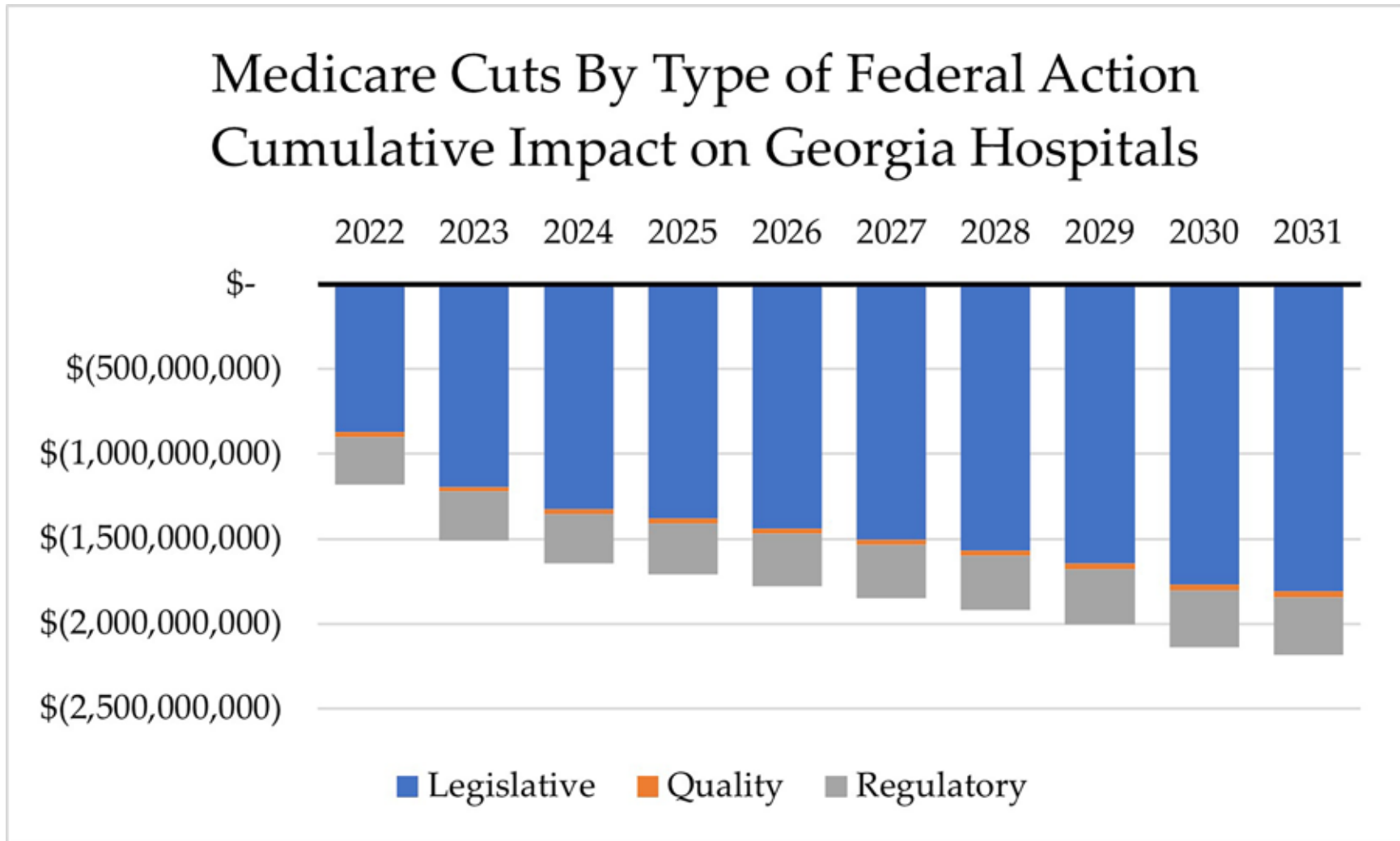
Contrary to popular belief, Medicaid does not provide coverage to all low-income people.

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;²² and
- State residency requirements.

Georgia Medicaid covered an average of 2.25 million beneficiaries each month during FY 2021.²³

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.*

Georgia is the third-highest ranked state for its percentage of uninsured residents, at 12.8%. Many who fall into this category also fall into the Medicaid coverage gap: They cannot afford private insurance yet make too much to qualify for Medicaid. As of late 2022, Georgia had 269,000 adults in the coverage gap.²⁴ Compared to other states, Georgia historically ranks low in terms of the percentage of state spending that is allocated to Medicaid. Only 31% of Georgia's state spending goes to Medicaid, ranking it 40th in the nation. The most recent data shows that Georgia spent about \$5,037 per full benefit enrollee compared to the United States average of \$7,106.²⁵ Although Georgia has not yet expanded Medicaid, in 2022, it did expand post-partum coverage for Medicaid beneficiaries to one year. In 2023, Georgia plans to implement a limited Medicaid expansion for adults up to 100% of the federal poverty level who meet certain work activities.



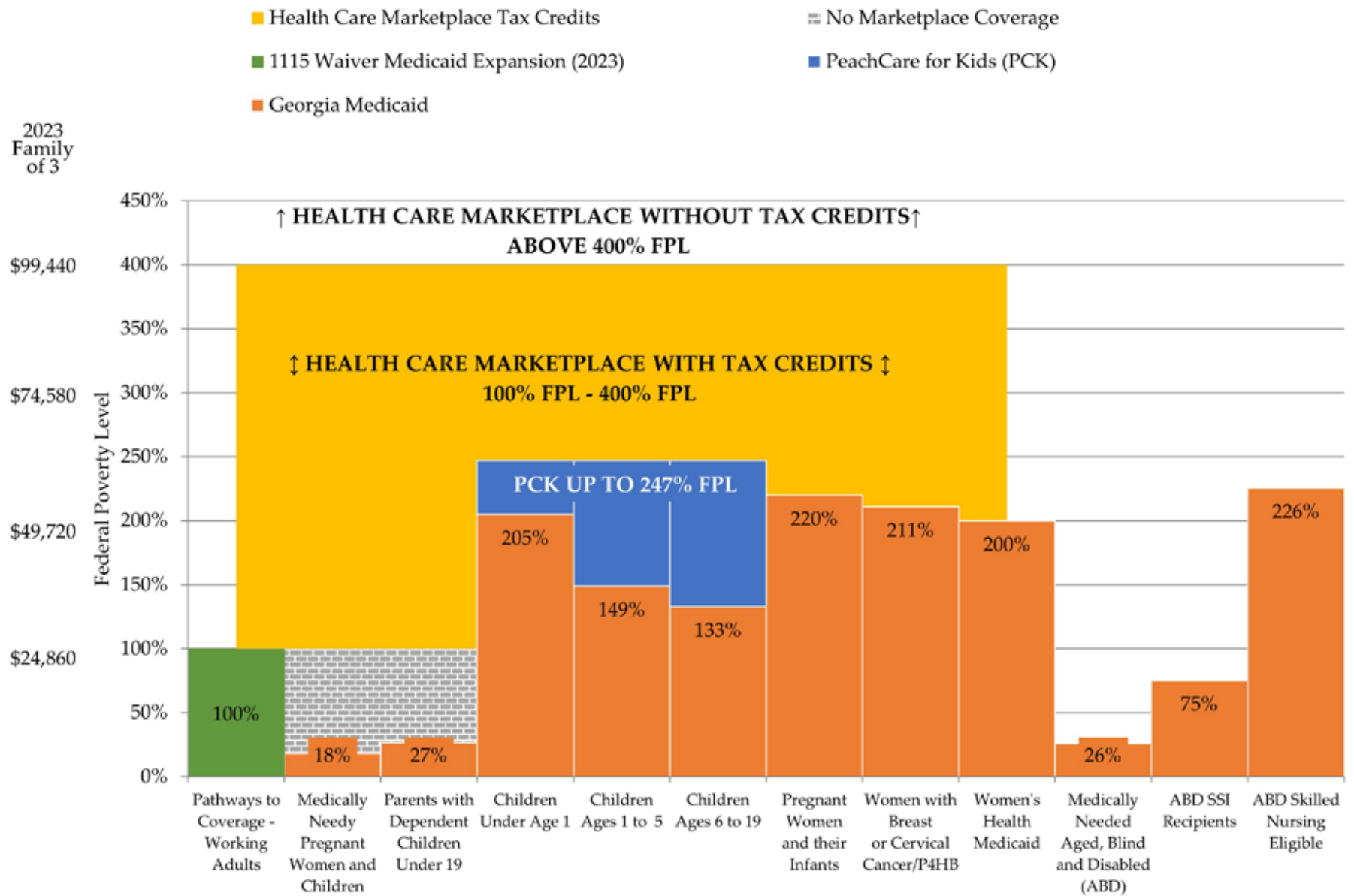
Inside the H

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 2016.²⁶
- **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% of cost, while all other hospitals are currently paid at 85.6% of cost. This means that hospitals paid at 85.6% of cost are guaranteed by policy to lose 14.4% 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% of the fee-for-service Medicaid rate for emergency services. However, non-emergency services may be covered at 90% 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 8A

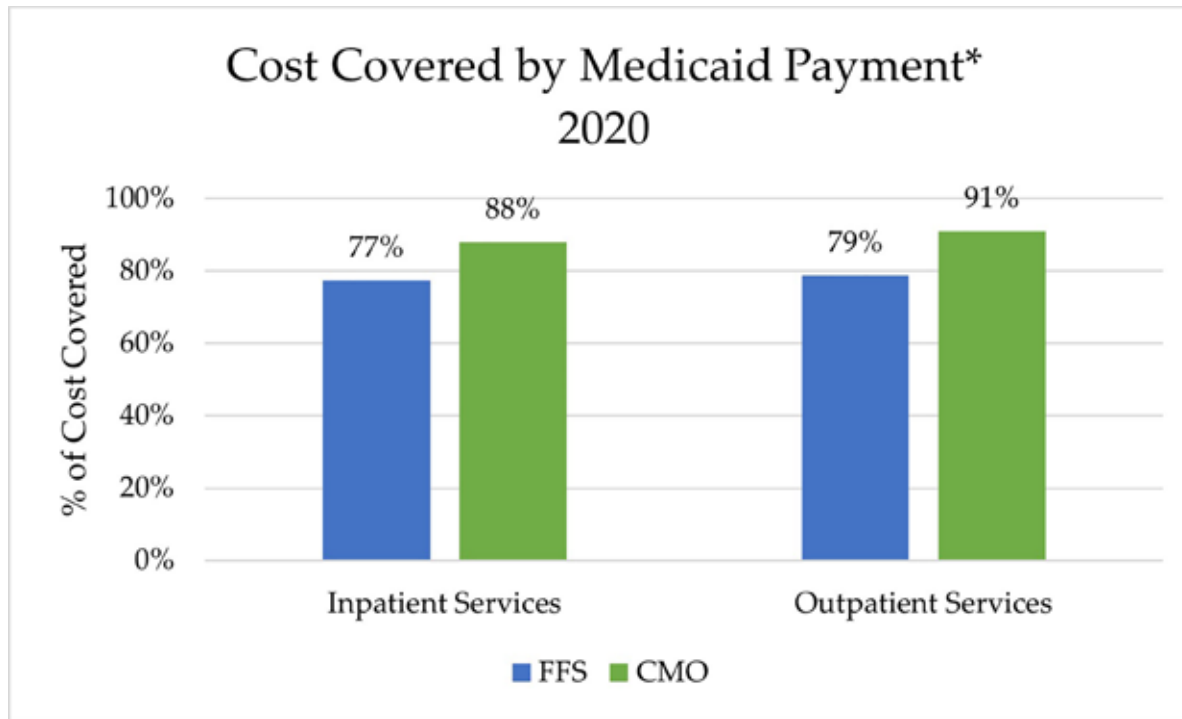
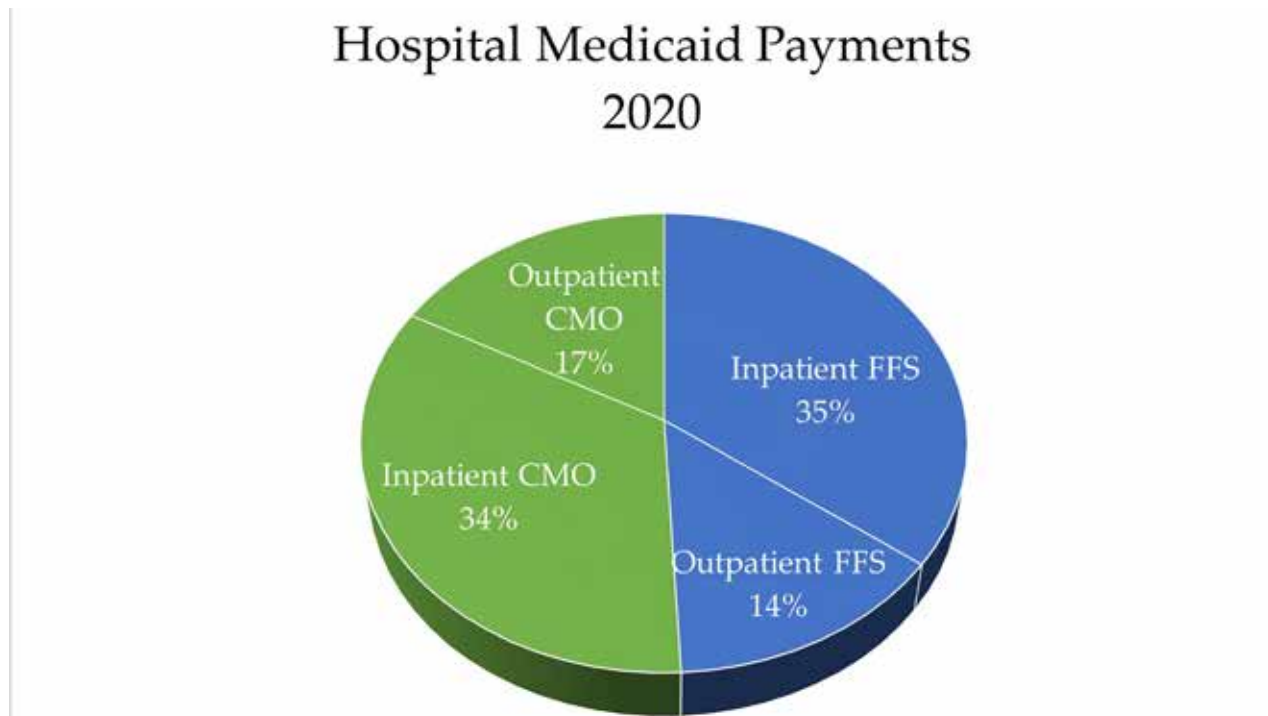


Figure 8B



Because CMOs negotiate with each hospital, payment methods 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 2020, Georgia Medicaid, under both payment arrangements, paid 17% less than cost for Medicaid inpatient and outpatient hospital services.²⁷ *See Figure 8A and 8B for more details.*

How is Medicaid Funded?

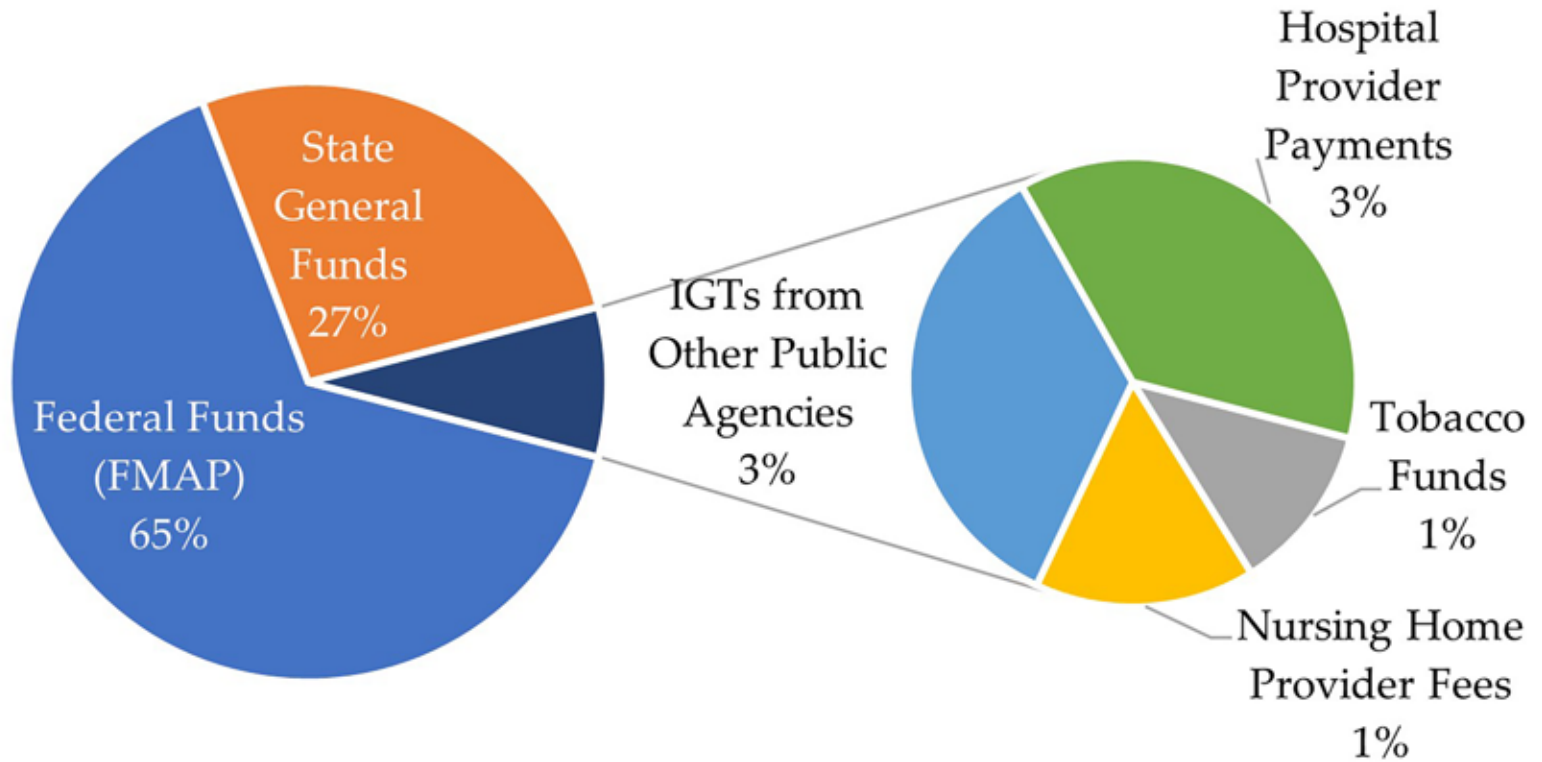
Medicaid is jointly funded by the federal and state governments. Generally, for each dollar paid to providers serving Medicaid patients, the federal government provides funding for about two-thirds of the payment while the State of Georgia pays the remaining one-third.

*Figure 9 details the sources of Medicaid funding.*²⁸



Figure 9

FY 2023 Appropriated Fund Sources for Medicaid = \$12.7 Billion



3. Special Supplemental Payments

There are three types of supplemental payments. One is the Disproportionate Share Hospital (DSH) program, which is a federal program that provides hospitals payment toward the cost of care for the uninsured and any remaining uncompensated Medicaid costs. The other two programs, the Medicaid Upper Payment Limit (UPL) program and the Directed Payment Program (DPP), and help subsidize regular Medicaid payments that are less than cost, are paid in addition to regular Medicaid payments. Payments from these programs help qualifying hospitals offset the cost of serving Medicaid and uninsured patients. *Figure 10 provides more detail about the components of these programs.* In 2021, almost one-third of Georgians were either uninsured (12.7%) or enrolled in Medicaid (18%).²⁹

Medicaid Disproportionate Share Hospital Program

To qualify for a DSH payment in Georgia, a hospital must meet the federal criteria of having at least a 1% Medicaid utilization rate (meaning at least 1% of their total inpatient days are attributable to patients who are eligible for Medicaid) and have an ongoing capability to do non-emergent delivery of newborns. 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.

Federal legislation delayed planned DSH cuts until May 2020 and extended them through 2025.³¹ The cuts will occur regardless of a state's decision to expand Medicaid. Nationally, available DSH funds will decrease by 58% beginning in FFY 2024. Georgia's annual federal DSH allotment is projected to be reduced by 48%, going from \$339 million to \$176 million.³²

Inside the H

The Uninsured in Georgia

- 1 in 8 Georgians, or 13% (1,333,100), is uninsured.
- Georgia ranks third-highest in the nation for the percentage of its citizens uninsured.
- 1 in 15 children in Georgia, or 6.6% (173,100) is uninsured.

SOURCE: Kaiser Commission on Medicaid and the Uninsured, 2021

After considering all payment sources for Medicaid and the uninsured, hospitals were paid 88% of cost for Medicaid and 24% of costs for the uninsured in FY 2020.³⁰ To offset these remaining cost deficits, hospitals need to receive payments from other payers in excess of cost to break even.

Figure 10

	Medicaid Disproportionate Share Hospital Program	Upper Payment Limit Program (UPL)	UPL - Medicaid Financing Program (Tier 2)	Directed Payment Program
Effective Date	1981	April 2000	July 2013	July 2022
Participating Hospitals	Hospitals Meeting Federal Criteria (OB Services, Medicaid Utilization)	Public PPS Hospitals and Critical Access Hospitals	Private PPS and LTAC Hospitals	PPS Hospitals
Payment Basis	Up to Uncompensated Cost for Medicaid and Uninsured Patients	Inpatient – Medicare Equivalent Outpatient – Cost		Teaching (Commercial Equiv.) Non-Teaching (Medicare Equiv.)
Applies To		Fee-for-Service Claims		Managed Care Claims
Financing Mechanism	Intergovernmental Transfers (IGTs) State Funds (Private)	Intergovernmental Transfers (Public PPS) State Funds (CAH)	Medicaid Hospital Financing Program	IGTs (Public) and Hospital Directed Payment Program

Medicaid Upper Payment Limit Payments

The maximum UPL that Medicaid can pay is either cost or what Medicare would have paid for a service provided to a Medicaid patient. UPL payments are capped and limited, so the state categorizes hospitals into two groups. Priority is given to regional perinatal centers, hospitals with poison control centers, teaching hospitals, critical access hospitals, and hospitals with sickle cell treatment centers. After payments have been made to these facilities, the state pays any residual funds to public and certain private hospitals.

Directed Payment Program Payments

In 2021, the Department of Community Health implemented a new supplemental payment program designed to increase payments for hospital services provided to Medicaid managed care patients. Referred to as a directed payment program, the state required Medicaid managed care plans to pay public PPS hospitals up to the Medicare equivalent. In 2022, the department expanded the program to private PPS hospitals and created two new directed payment programs that will pay teaching hospitals up to the equivalent of the average commercial insurance payment for hospital services. These directed payments fund investments in hospital initiatives designed to improve health outcomes and experiences for the Medicaid population as well as strengthen Georgia's health care workforce.

In state fiscal year 2023, the directed payment program is expected to increase net payments to participating hospitals by \$1 billion dollars. *While these new payments are an unprecedented and welcome increase in funding for the hospital industry, they do not eliminate the annual amount of uncompensated care provided to the Medicaid and uninsured patients, as shown in Figure 11.*

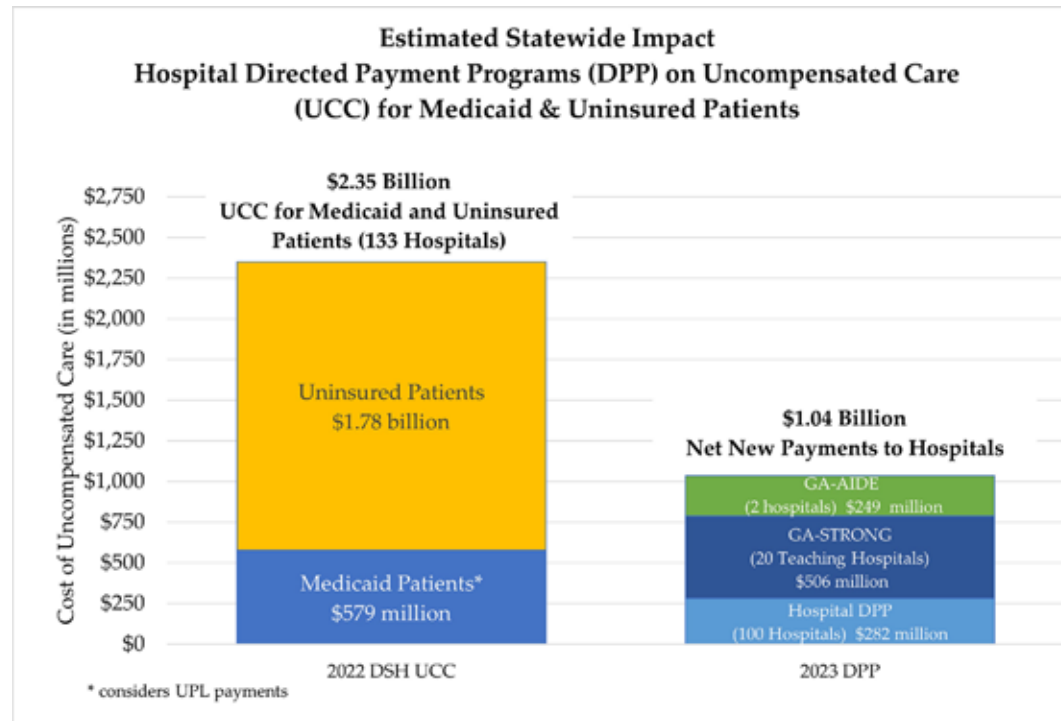
Inside the H

In FY 2022, Upper Payment Limit payments to all hospitals totaled \$311 million, with \$109 million made for targeted payments and \$202 million made in residual payments to public and certain private hospitals.³³

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.

Figure 11



4. PeachCare for Kids

PeachCare for Kids 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.

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% of the federal poverty level (about \$61,416 for a family of three in 2023.³⁴) In FY 2021, Georgia covered an average of almost 141,000 children each month.³⁵ 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 2023, premiums range from a maximum of \$36 for one child up to a maximum of \$72 per family.³⁶

Historically, Georgia’s enhanced FMAP for CHIP has been around 75%; 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% for most program expenditures. For FY 2023, Georgia’s FMAP is now at 80.55%.³⁷

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 2021, the State Health Benefit Plan provided coverage for a monthly average of 669,000 members statewide at a cost of nearly \$5.7 billion.³⁸ 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:³⁹

- **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.⁴⁰
- **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% 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.⁴¹ 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.

Who Governs Your Health Plans?

1. Fully Insured Accident and Health Insurance Plans

Accident and health insurance plans are regulated by state and federal law. The Patient Protection and Affordable Care Act of 2010 (ACA) made sweeping changes to the health insurance industry and imposed a number of requirements intended to control cost and expand the availability and quality of health insurance to consumers.

An insurance company in the United States must be licensed by the state in which it issues coverage. It is possible for an insurer to issue coverage in one state that covers members that live in another. The Georgia Office of the Commissioners of Insurance and Fire Safety (OCI) is responsible for the licensing of companies to transact business in Georgia and for ensuring that those companies remain solvent and comply with all the requirements of Georgia laws and regulations. There are separate licensure requirements for certain types of health insurance, such as Health Maintenance Organizations (HMO), including Medicaid managed care plans, and Provider Sponsored Health Care Plans (PSHCP). Self-insured plans, Medicare managed care plans, and the plans for veterans and their dependents are subject to federal law and are not under the authority of the OCI. Similarly, plans that are licensed by a different state are under the authority of that state's law, not Georgia law, even when the patient resides in Georgia. This can be confusing to hospitals as they attempt to determine which set of laws apply to a particular type of coverage for a patient.

Most health insurance offered in the United States today is considered "managed care." This term generally means a system for financing and, sometimes, delivery, of health care that is intended to control cost, utilization and quality of care. For plans licensed in Georgia, there are a number of state regulations that address the way they can do business, including the time within which the plan must pay claims, late payment interest and rules related to authorizations for services and appeals.

In recent years, the trend has been toward significantly increasing patient cost share amounts for both in- and out-of-network care to the point that the financial responsibility has become unaffordable for many patients and contributes to higher hospital bad debt. That trend has resulted in federal transparency requirements for hospitals to publish their charges and contract rates in a way that is accessible to consumers. There have also been regulatory efforts to reduce consumer debt related to health care, including surprise billing legislation and limitations on collections and credit reporting of medical debt.

Types of Plans

There are a variety of types of health plans although the distinction is not as clear as it was five or ten years ago. The major differences between the most common types of plans are:

- Health Maintenance Organizations (HMO) are separately licensed and generally have higher financial reserve requirements than other health insurance plans. HMOs often have closed provider networks which means that, except for emergency care, services are covered only when rendered by providers within the HMO network. HMOs may also require that a covered person have a primary care provider coordinate his or her care.
- Point of Service (POS) Plans are typically very similar to HMOs except they will cover care for providers that are not in the plan's network. Many POS plans fall under an HMO license, although they may also be offered by non-HMO health insurers.
- Preferred Provider Organization (PPO) plans do not require separate licenses in most states, although the insurers that use PPOs for their benefit plans must meet licensure requirements. Typically, plan rules are not as stringent for PPOs as they are for HMO & POS plans and out-of-network care is usually, but not always, covered.
- High Deductible Health Plans (HDP or HDHP) combine a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) with medical coverage that has higher deductibles than traditional insurance plans. The HSA or HRA may be funded by either employer or employee contributions, or both, and are designed to encourage patients to be better consumers of care.

Plan Billing and Payment

Billing and payment of claims for members of health plans can be very confusing to providers and patients and is determined by contract terms and benefit plan design as well as federal and state law. The degree to which hospitals and other providers can negotiate rates in a managed care contract varies considerably. Efforts to find new ways to reduce medical costs have led insurers to sometimes use "narrow networks," which have a limited choice of

Inside the H

There are many types of managed care plans, although the distinction between types has become more and more blurred over the past few years. All tend to share common characteristics to varying degrees, including:

- Networks of contracted providers that agree to accept reduced rates for services in exchange for an expected higher volume of patients or the ability to have coverage for patients in some plans;
- Requirements for authorization of many services;
- Tiered cost-share amounts for prescription drugs;
- Scrutiny of medical necessity of care;
- Payment policies that may dictate the setting or other prerequisites for coverage of some services; and
- Variability in the patient's share of cost for health care services.
 - Some plans may have no benefits for providers not in the network;
 - When covered, cost share amounts are typically higher for lower-tier or out-of-network providers.
 - Regardless of network participation, state and federal law require that emergency care be covered.
 - The ACA requires that specified preventive care be covered in full when provided by in-network providers.

providers that are considered in-network, even though other providers have contracts with the same insurance company. A provider must be diligent in verifying eligibility and benefits before rendering non-emergent services to a patient in order to ensure that full insurance benefits will be available.

For providers in a contracted provider network, the patient can be billed only for the patient cost share amount (copayments, coinsurance and deductibles) and for services not covered by the plan, regardless of the “allowed amount” determined by the insurer (which should be consistent with the provider’s contract rate). Even then, the provider is often required to obtain the patient’s consent prior to rendering non-covered services in order to bill for them.

When a provider is not in the plan’s network, there is no contract to dictate the amount that the plan must pay or the amount that can be billed to the patient. However, both aspects of the claim may be addressed by federal or state law. Many insurers will set the allowed amount at what they consider to be a reasonable fee for the service and then pay a portion of that at the lower out-of-network percentage. It is called “balance billing” when an in-network provider bills the patient for the discount he or she has agreed to in his or her contract or when an out-of-network provider bills the patient for the difference between the allowed amount and the provider’s charges. In some cases, patients are unaware of the network status of hospitals and providers and balance billing comes as a surprise to them, often referred to as surprise billing. The latter situation has received a great deal of attention in the media and among legislators recently as the financial burden for patients has increased.

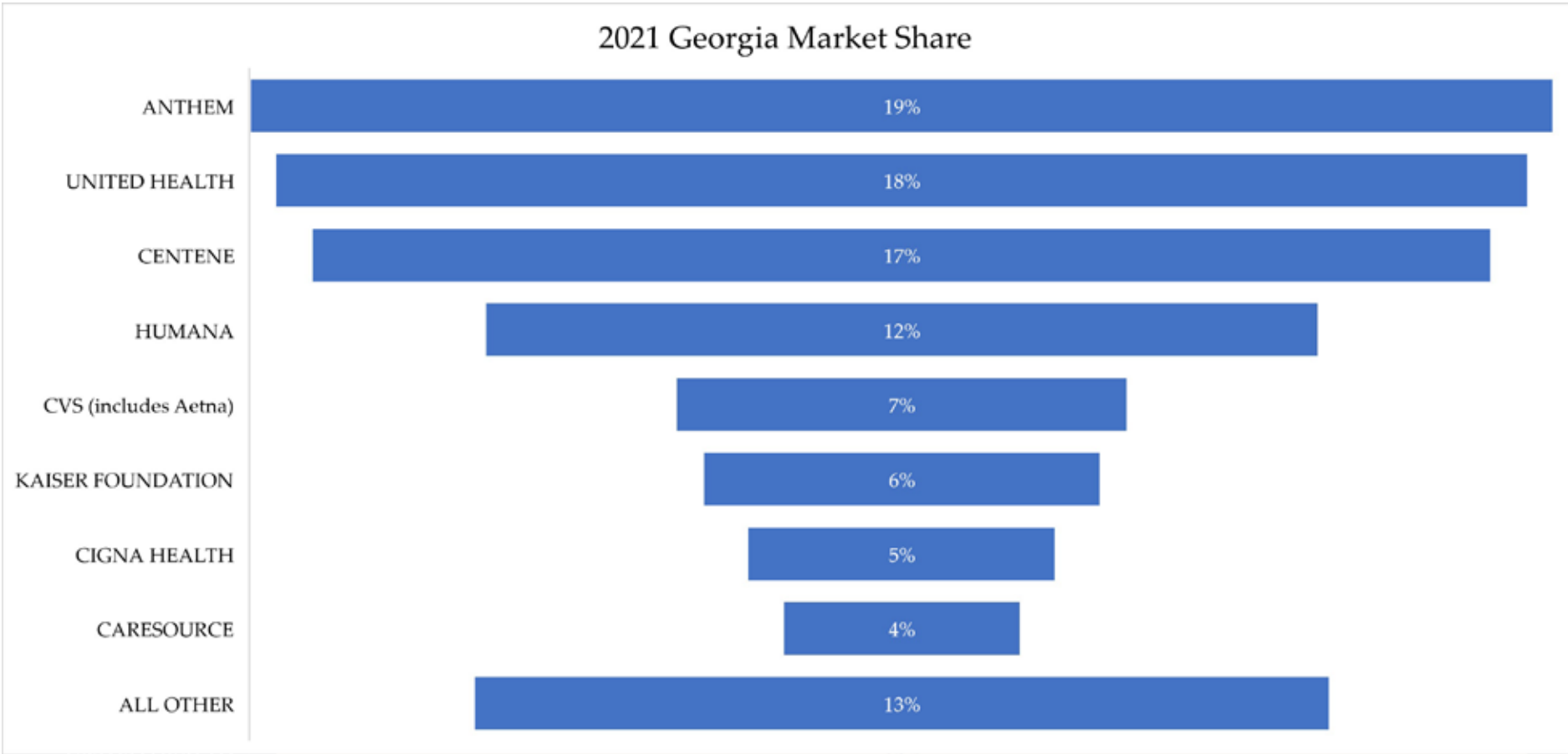
Georgia adopted the “Surprise Billing Consumer Protection Act ” effective January 1, 2021, which requires insurers to pay hospitals and providers for certain out of network services at the greater of the median in-network rate, any previous contract rate between the parties or another rate set by the insurer. It also prohibits hospitals and providers from billing the patient more than their in-network cost share for those services and provides for an independent dispute resolution process to resolve related disputes between the insurer and the hospital or provider. Services covered by the Act are emergency services and non-emergency services provided at an in-network hospital by an out-of-network provider.

The No Surprises Act , a portion of the federal Consolidated Appropriations Act of 2021, was implemented January 1, 2022. It applies to non-governmental health coverage that is not under the authority of the applicable state law, some additional services and rights of uninsured or non-covered patients. It also includes a dispute resolution process.

Insurance Industry Evolution

Merger and acquisition activity in the insurance industry took a different turn after the US Department of Justice (DOJ) blocked large consolidation efforts in 2016. While there have been a few mergers of smaller plans, the industry has moved toward more vertical integration with a focus on reducing cost through new opportunities to control/improve care management and customer experience. Many major national health insurers now own pharmacy benefit management (PBM) companies, clinical provider groups or facilities, data management companies and other related services. *The most current market share information published by the National Association of Insurance Commissioners for Georgia health insurers is shown in Figure 12 on page 38.*⁴²

Figure 12



2. Health Insurance Marketplace

In addition to consumer protections and minimum requirements for most health plans, the *2010 Patient Protection and Affordable Care Act (ACA)* created health care exchanges which offer health insurance options to consumers not covered by group health or government programs. In Georgia, residents can purchase insurance coverage through the federally operated Health Insurance Marketplace. Individuals or families with incomes between 138% and 400% of the federal poverty level who purchase coverage through the Health Insurance Marketplace are eligible for subsidies, which help offset their premium costs and cost shares.

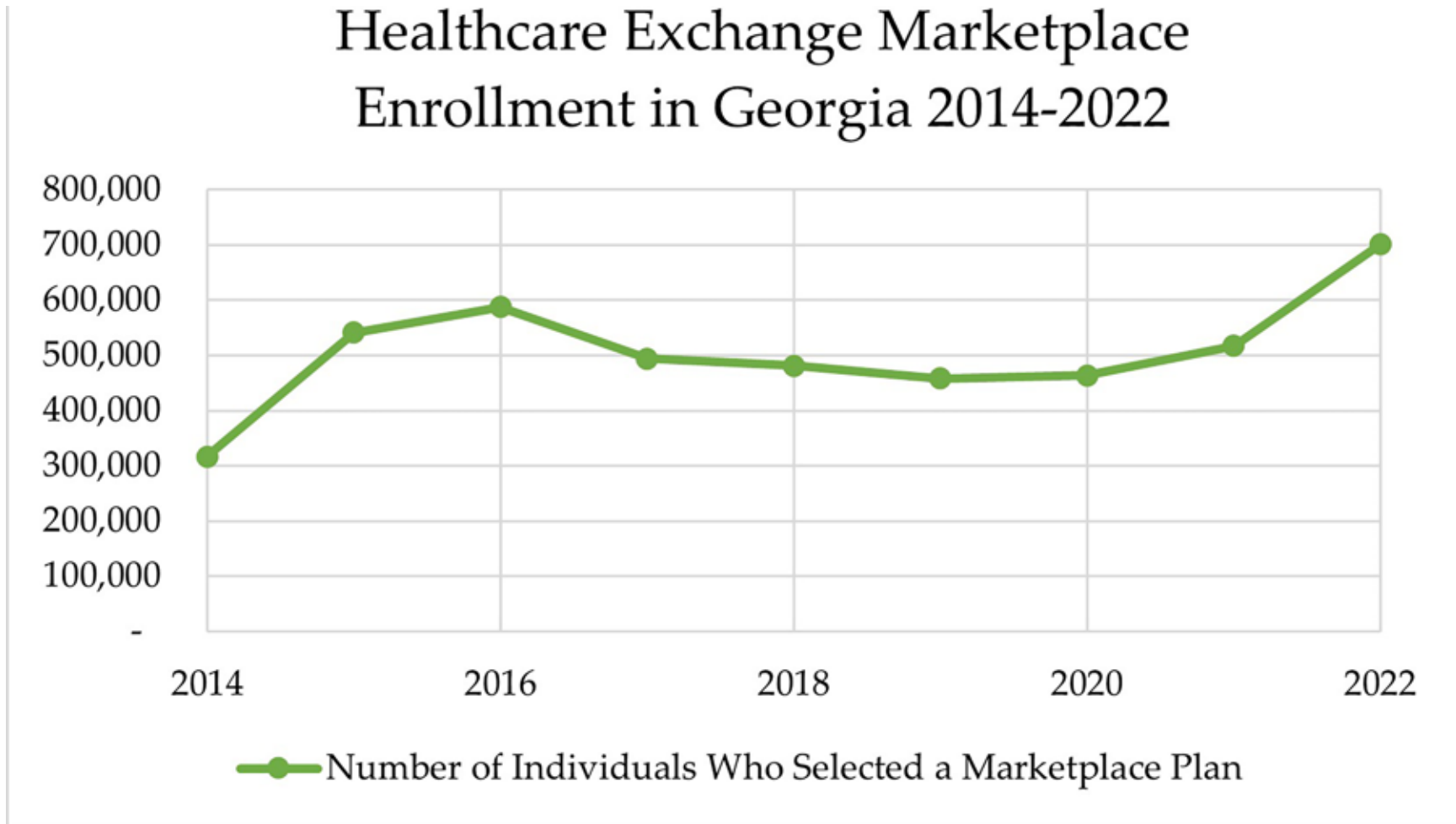
Health Insurance Marketplace consumers in Georgia have access to multiple benefit plan designs offered by different insurers. Although the federal government operates the Marketplace, the plans are offered by insurance companies licensed in Georgia. All plans are required to offer the same set of essential health benefits but may have different networks of providers. Plans are classified into four categories: Bronze, Silver, Gold, and Platinum. Plan designs differ by the percentage of health care costs paid by the consumer, which range from 10% (Platinum) to 40% (Bronze).

A consumer's share of the cost is paid through premiums, deductibles, and co-payments or coinsurance. In general, the more a consumer is willing and able to pay each time for a health care service, the lower the plan's premium. For example, premiums for Bronze plans are typically lower than the other plan types; however, the consumer's share of cost is much higher when he or she actually accesses services.

Insurers do not offer their products in all counties of the state and for a number of years residents of many Georgia counties had access to one only insurer. During the early years after implementation of the ACA, the exchange suffered from the loss of insurers, steep premium increases and decreased enrollment. The plans began to stabilize in 2019 and both the number of insurers and enrollment reached record highs in 2022 with ten insurers and over 700K enrolled. While much of the increase was a result of changes in federal rules, including the open enrollment period, in response to the COVID 19 Public Health Emergency, other changes have also made the exchange market more attractive to insurers and consumers.

Except for premiums, which are paid to the insurer on a monthly basis, providers must collect the consumer's share of the cost directly from the consumer when health care services are rendered. Consumers who cannot pay their share may be eligible for indigent or charity care, in which case, they may pay a discounted amount or nothing at all. Consumers who can afford to pay but fail to may be subject to the provider's collection efforts. In either case, a consumer's failure to pay the provider for the care received results in increased uncompensated care that must be covered by other payer sources.

Figure 13



In December 2019, the State of Georgia requested approval of a federal Section 1332 Waiver⁴³ to implement a two-phased approach to address the growing health care access and affordability challenges facing many residents across the state. The Section 1332 Waiver application was designed to reduce premiums, increase coverage, and promote a more competitive private insurance marketplace with the introduction of a state reinsurance program for Plan Years 2021 through 2025 and the Georgia Access Model (a state-operated marketplace in lieu of the federal Health Insurance Marketplace) for Plan Years 2022 through 2025.⁴⁴

Although the waiver was initially approved by CMS in 2020, in 2021 CMS withdrew approval for the portion that changed to a state run platform for enrollment. The reinsurance provision was allowed to stand and has been implemented, resulting in a decrease in premiums for consumers.

3. Self-Insured Employee Benefit Plans

In 2021 in the United States, about 56% of people received health care coverage through an employer's benefit plan.⁴⁵ Employers that offer health benefits may either purchase insurance from a licensed insurer or set up their own plans in accordance with state and federal law. Sixty-four percent of those in group health plans were in one that was completely or partially self-funded.⁴⁶

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry. The motivation behind ERISA is to provide uniform oversight under a set of national standards for employee benefits. Prior to the passage of ERISA, self-insured employee benefit plans were governed by state insurance law. Employers complained of the high administrative costs associated with maintaining plans that were subject to the laws of multiple states.

ERISA makes the regulation of these plans consistent throughout the country and, under the Supremacy Clause of the U.S. Constitution, pre-empts state laws that "relate to" employee benefit plans. In general, ERISA does not cover benefit plans established or maintained by governmental entities, churches for their employees, or plans that are maintained solely to comply with applicable workers compensation, unemployment or disability laws. ERISA also does not cover plans maintained outside the United States primarily for the benefit of nonresident aliens or unfunded excess benefit plans.

Under self-insured employee benefit plans, the employer or employer organization funds the plan but may have a Third Party Administrator (TPA) or an insurer provide the provider network, care management services and claims processing. For an insurer, this is referred to as an Administrative Services Only (ASO) business. This can be confusing to hospitals because it is difficult to tell whether a patient is covered by a fully insured or an ASO plan. This is important because state law and the plan's rules, including payment policies, may vary significantly between the different types of plans. For example, Georgia law specifies a timely payment period for claims and requires interest on late payment. However, ERISA plans are not subject to these or other provisions Georgia lawmakers have put in place to ensure fair business practices between insurance companies and providers.

In recent years, an increasing number of self-insured, employer-sponsored benefit plans have elected not to enter into contractual agreements with hospitals, either directly or through an established provider network. These plans seek to limit payment for hospital services provided to plan beneficiaries by repricing the services at a plan-determined allowable benefit amount based upon a reference price, or RBP. This amount is typically far below the traditional commercial health insurance payments for the same services.

Generally, a hospital is not required to discount its billed charges absent a written agreement. However, these plans attempt to create a contractual agreement with hospitals by including language on plan identification cards, explanation of benefits (EOB), and/or other documents stating that by accepting the payment, completing the form, or accepting assignment of benefits from the plan beneficiary, the hospital agrees to accept the plan-determined allowable benefit amount as payment in full.

Administrators of these plans will zealously refute the hospital's ability to balance bill the patient for the shortfall and often offer legal counsel to patients to assist in the event of any threat of a collection action. Regardless of the outcome, the patient is placed in the middle of a dispute between the hospital and the plan.

4. Workers' Compensation

In Georgia, state law requires that any employer with three or more regular employees have workers' compensation coverage for disability, rehabilitation and medical care for a worker who is injured on the job. Georgia law allows employers to require injured employees with a non-emergent condition to obtain treatment from designated providers as long as the employer has followed state law regarding notice to the providers. That may be done through either prominently posting (1) a list or panel of providers or (2) a Workers' Compensation Managed Care Organization (WC/MCO) certified by the Board.

While workers' compensation is highly regulated by state law, the coverage for disability, rehabilitation and medical services is typically provided by property and casualty insurance companies or self-insured employers. Coverage of an injured worker's care may be contingent on both the employee and the employer following the rules promulgated by the Georgia State Board of Workers' Compensation. The Board publishes an annual Medical Fee Schedule that sets the rates for hospital and physician payments. Inpatient payments depend on the patient's diagnosis and treatment, much like Medicare rates. Additional payment is made for implanted devices based on the device's cost.



Hospital Provider Payment Programs

The Hospital Provider Payment Program (HPPP) was originally enacted in 2010 with the passage of House Bill (H.B.) 1055 and was effective for a three-year period through June 30, 2013. Subsequent legislation passed by the General Assembly has continued the program and authorizes the Department of Community Health to assess one or more provider payments on hospitals for the purpose of obtaining federal financial participation for Medicaid. *See Figure 14 for an overview of the hospital provider payment programs the Department has implemented.*

DCH promulgated rules in the spring of 2013 to continue the HPPP program and created a new program, the Hospital Medicaid Financing Program (HMFP). The HMFP is designed to increase Medicaid payments to help a subset of private hospitals participating in the HPPP and is often referred to as the “Tier 2” Program.

In 2022, DCH promulgated rules for a new program, which is solely designed to finance directed Medicaid Managed Care payments to private hospitals. The Hospital Directed Payment Program became effective July 1, 2022. While expected to continue, all hospital provider payment programs are slated to end on June 30, 2025 without new legislation authorizing continuation.

Hospital Provider Payment Program (HPPP)

HPPP requires that most Georgia hospitals make quarterly payments to the state based on a percentage of their annual net patient revenue. Three types of hospitals are exempt from making the payment: critical access hospitals, state-owned or state-operated hospitals, and free-standing psychiatric hospitals. Trauma hospitals have a lower payment rate at 1.40% of net patient revenue, while all other hospitals are subject to the payment rate of 1.45%. Hospitals may count their provider payment toward any indigent care requirements they have related to their Certificates of Need.

Payments made by hospitals are deposited into the state’s Indigent Care Trust Fund and, per state statute, used strictly for the Medicaid program. In FY 2022, approximately 20% of the payments were used to finance the state share of a hospital Medicaid payment add-on of 11.88% while the remaining 80% was used as one of the fund sources for the state’s share of Medicaid payments to all providers. The hospital Medicaid payment add-on is intended to help offset the cost of the program payments for hospitals serving the Medicaid population. In FY 2023, hospitals will pay an aggregate of \$381 million to the state in Hospital Provider Payments.

Because the amount a hospital pays to the state has no direct correlation to its Medicaid payments, the fiscal impact to an individual hospital can vary greatly. Based on a GHA analysis of FY 2022 program activity, 20 hospitals had a cumulative net positive impact of \$52 million, 97 had a cumulative net negative impact of \$161 million. The individual hospital net impact in FY 2022 ranged from a loss of \$10.4 million to a gain of \$22.1 million.⁴⁷

The Hospital Medicaid Financing Program

Participation in the Hospital Medicaid Financing Program (i.e., the Tier 2 Program) is currently limited to a subset of private hospitals. Specialty hospitals, public hospitals, critical access hospitals and free-standing psychiatric hospitals are exempt from the Tier 2 program. Participating hospitals make periodic contributions to the state based on their non-Medicare inpatient bed days. These contributions are used to finance the state share of federally funded supplemental payments made to those hospitals making the contributions as well as private Long-Term Acute Care hospitals participating in the Medicaid program. Contributions vary depending on the level of supplemental payments available and the amount of state share needed.

Tier 2 hospital payment amounts are determined based on the hospital's annual volume of Medicaid business. Participating hospitals may receive additional payments if they meet one or more of the following criteria:

- Treat higher acuity Medicaid beneficiaries;
- Provide organ transplant services;
- Operate as an American College of Surgeons certified cancer center or breast cancer center;
- Have a large capacity to treat inpatient psychiatric patients; or
- Are rural hospitals serving as a telemedicine presenting site.

In FY 2022, 47 participating private hospitals received a total of \$76 million after making \$19 million in contributions.⁴⁸ For the 41 Tier 2-eligible hospitals with net negative losses in the HPPP in FY 2022, Tier 2 payments eliminated the losses for 13 hospitals and cumulatively reduced the losses of the remaining 28 hospitals by 51%.⁴⁹

Figure 14

Element	Hospital Provider Payment Program	Medicaid Hospital Financing Program	Hospital Directed Payment Program
Start Date	July 1, 2010	July 1, 2013	July 1, 2022
Hospitals Subject to Payment to State	-Non-State Governmental and Private PPS Hospitals -Non-Psych Specialty Hospitals	Private PPS Hospitals	Private PPS Hospitals
Payment Rate to State	Trauma Hospitals - 1.40 % of Net Patient Revenue (NPR) All Others - 1.45 % NPR	Amount per Non-Medicare Inpatient Day Varies based on funding need	Percentage of Inpatient NPR Varies based on funding need
Payments Back to Hospitals	11.88% increase in Medicaid hospital payments	- Targeted rate increases based on hospital characteristics paid per Medicaid FFS activity - ATB increase in Medicaid FFS hospital payments	ATB Increase in Medicaid CMO hospital payments

Indigent Care Trust Fund

The Indigent Care Trust Fund (ICTF) was established via passage of a state constitutional amendment in 1990. The use of funds deposited in the ICTF are limited to the following purposes:

- Expand Medicaid eligibility and services;
- Support rural and other health care providers, primarily hospitals, that serve the medically indigent;
- Fund primary health care programs for medically indigent Georgians; and
- Promote healthy pregnancies and childbirth by awarding grants to nonprofit organizations that provide pregnancy support services.

Inside the H

It is a common misconception that hospitals can submit unpaid bills of indigent patients to the Indigent Care Trust Fund and receive payment.

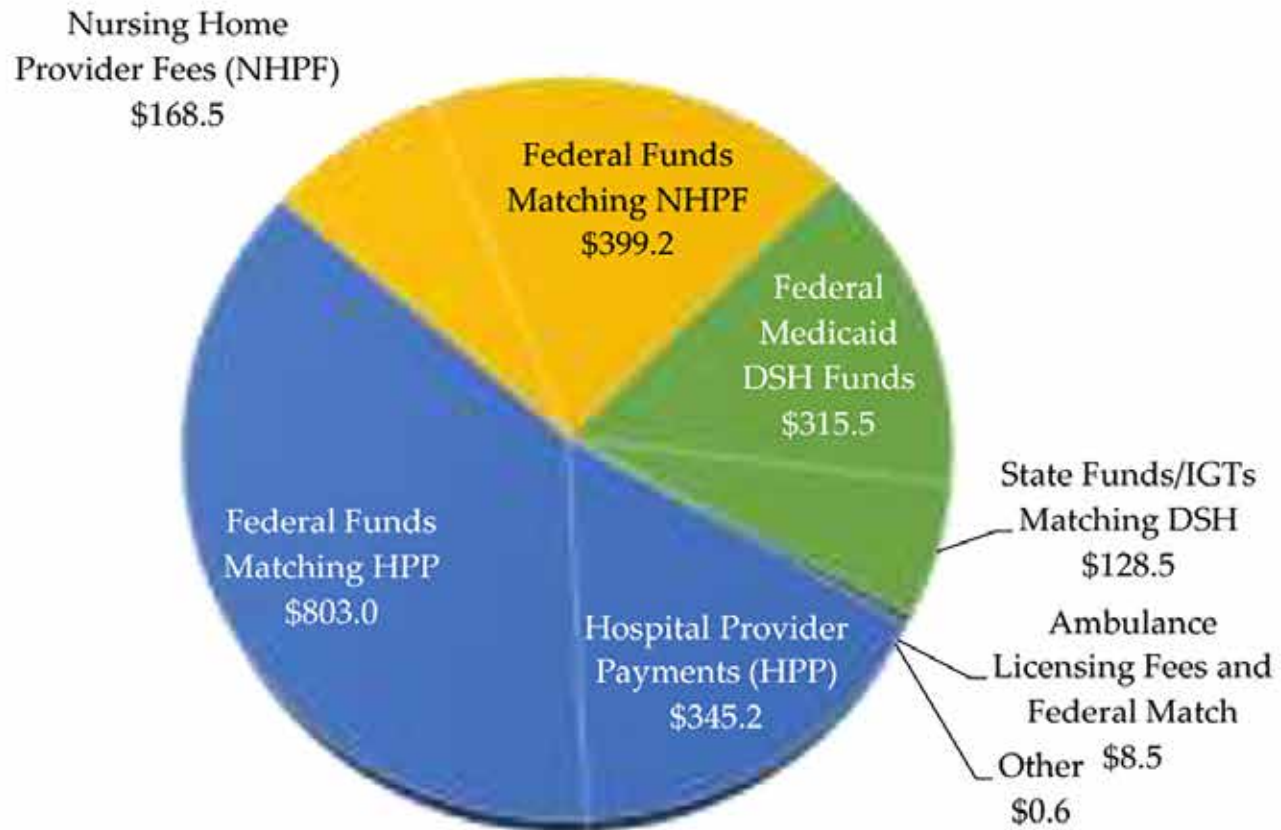
Instead, the ICTF is a dedicated fund used to house and spend revenues received from the federal Medicaid Disproportionate Share Hospital program, provider fees, breast cancer car license plate fees, ambulance licensing fees, and Certificate of Need (CON) penalties.

See Figure 15 on page 47 for the distribution of funds types in the ICTF in 2020.⁵⁰

The specific uses of ICTF revenues are dictated by various state statutes and reflected in the annual appropriations act; however, they must be compliant with the general provisions of the state constitutional amendment.

Figure 15

FY 2020 Indigent Care Trust Fund Revenues = \$2.2 Billion



figures in millions

Rural Health

Many more Georgians live in urban areas (70%) than in rural areas (30%). Although the state's smaller rural population masks its social circumstance, the conditions in rural areas significantly affect the state's overall productivity, health, and health care costs.⁵¹ Given these unique challenges, there are a variety of programs and entities that support rural health improvement.

Rural Hospital Tax Credit Program

In 2016, the General Assembly passed Senate Bill (S.B.) 258 to provide tax credits for individuals and corporations that contribute to rural hospital organizations. Tax credits per individual rural hospital organization are limited to \$4 million annually. To qualify, hospitals must meet the following eligibility requirements: Be a licensed acute care hospital; provide inpatient services in a rural county with a population of less than 50,000 or be a designated critical access hospital; participate in Medicare and Medicaid and provide health care services to indigent patients; have at least 10% of its annual net revenue categorized as indigent care, charity care, or bad debt; annually file IRS Form 990 or the equivalent with the Department of Community Health; and be operated by a local hospital authority or be designated as a 501(c)(3) organization by the IRS. An additional criteria was added in 2019, that bases eligibility on a hospital's patient margin relative to other eligible hospitals.

Individual taxpayers are allowed a tax credit equal to 100% of their contribution up to a maximum of \$5,000 (single filer) or \$10,000 (married couple filing jointly). Corporate taxpayers are allowed a tax credit up to 100% of their contribution or 75% of the corporation's tax income liability, whichever is less. The legislation limits the annual aggregate amount of tax credits for all rural hospitals to \$60 million. In 2022, the General Assembly passed House Bill (H.B.) 1041, which increased this limit to \$75 million annually, beginning in 2023.

In 2021, hospitals received \$59.4 million in donations.

In 2019, the General Assembly passed HB 321, which includes language that, as of Oct. 1, 2019, requires tax-exempt hospitals to post a list of financial-related information on the main page of their websites. Hospitals that do not comply are suspended from receipt of any state funds, including donations under the Rural Hospital Tax Credit program. (DCH is required to notify organizations before suspending any funds.)

The Rural Hospital Tax Credit program is automatically repealed on Dec. 31, 2024.

State Office of Rural Health

The Georgia Department of Community Health's State Office of Rural Health (SORH) works to improve access to health care in rural and underserved areas and to reduce health status disparities. SORH provides funding for an institutional framework that links small rural communities with state and federal resources to help develop long-term solutions to rural health problems. The SORH administers four primary programs: Primary Care Office Programs; Hospital Services Program; Migrant Health, Homeless and Special Projects; and the Breast Cancer License Plate Program.⁵²

GHA Center for Rural Health

The Center for Rural Health is a department within the Georgia Hospital Association that embodies the interests of Georgia's small rural hospitals, which we define as an acute care or critical access hospital, with an average daily (inpatient) census of 75 or fewer and located in a county with a population of 75,000 people or fewer. The Center for Rural Health has approximately 70 members.

Inside the H

Rural Hospital Stabilization Committee

Gov. Nathan Deal created the Rural Hospital Stabilization Committee in March 2014 to identify the needs of the rural hospital community and provide potential solutions. The committee works to increase communication between hospitals and the state and improve Georgia's citizens' access to health care.⁵³

Based on recommendations of the Committee, the General Assembly appropriated funding beginning in FY 2016 to fund a pilot-site program. Based upon an integrated "hub and spoke" model, pilot sites test rural health delivery models designed to relieve cost pressures on emergency departments and ensure that the best, most efficient treatment is received by patients. The program aims to increase the utilization of new and existing technology and infrastructure in smaller critical access hospitals, Wi-Fi and telemedicine equipped ambulances, telemedicine equipped school clinics, federally qualified health centers, public health departments and local physician offices.⁵⁴ To date, 22 rural hospitals have served as sites for the program.

Center for Rural Health Hospitals

AdventHealth Gordon
AdventHealth Murray
Appling Healthcare System/Appling Hospital
Bacon County Hospital and Health System
Bleckley Memorial Hospital
Brooks County Hospital
Burke Medical Center
Candler County Hospital
Chatuge Regional Hospital
CHI Memorial Hospital Georgia
Clinch Memorial Hospital
Coffee Regional Medical Center
Colquitt Regional Medical Center
Crisp Regional Hospital
Dodge County Hospital
Donalsonville Hospital
Dorminy Medical Center
East Georgia Regional Medical Center
Effingham Health System
Elbert Memorial Hospital
Emanuel Medical Center
Evans Memorial Hospital
Fairview Park Hospital
Fannin Regional Hospital
Flint River Hospital
Floyd Polk Medical Center
Grady General Hospital
Habersham Medical Center
Higgins General Hospital
Irwin County Hospital
Jasper Memorial Hospital
Jeff Davis Hospital
Jefferson Hospital
Jenkins County Hospital

Liberty Regional Medical Center
LifeBrite Community Hospital of Early
Medical Center of Peach County, Navicent Health
Memorial Health Meadows
Memorial Hospital and Manor
Miller County Hospital
Mitchell County Hospital
Monroe County Hospital
Morgan Medical Center
Navicent Health Baldwin
Northeast Georgia Medical Center Barrow
Optim Medical Center - Screven
Optim Medical Center - Tattnall
Perry Hospital
Phoebe Sumter Medical Center
Phoebe Worth Medical Center
Putnam General Hospital
Roosevelt Warm Springs Rehabilitation & Specialty Hospital
South Georgia Medical Center Berrien Campus
South Georgia Medical Center Lanier Campus
Southeast Georgia Health System - Camden
Southwell Medical
St Mary's Good Samaritan Hospital
St. Mary's Sacred Heart Hospital
Stephens County Hospital
Taylor Healthcare Group/Taylor Regional Hospital
Union General Hospital System/Union General Hospital
Upton Regional Medical Center
Warm Springs Medical Center
Washington County Regional Medical Center
Wayne Memorial Hospital
Wellstar Sylvan Grove Hospital
Wellstar West Georgia Medical Center
Wills Memorial Hospital

Emergency and Trauma Care

Emergency Care

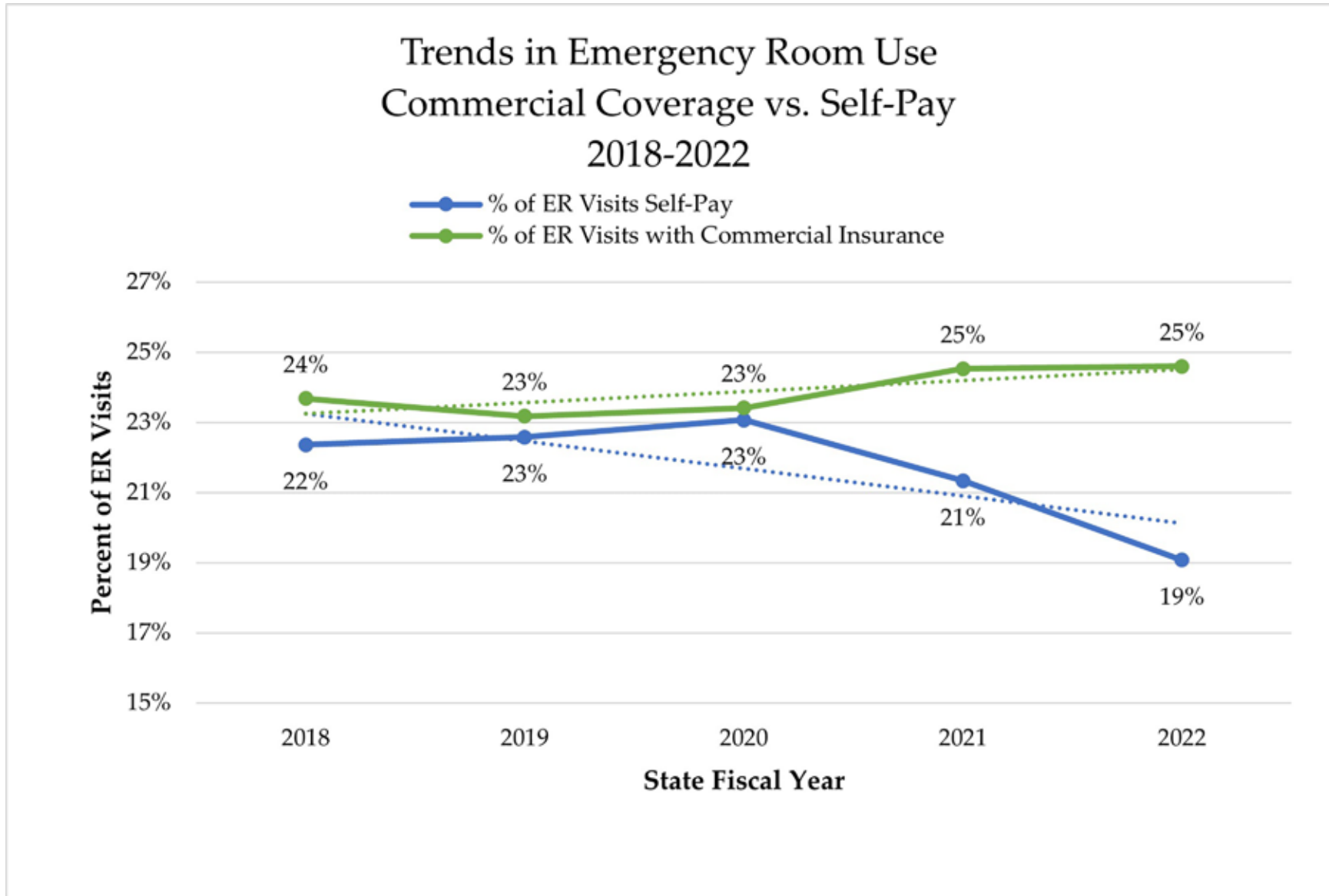
In the event of a medical emergency, a hospital is typically the first place where assistance is sought. The Emergency Medical Treatment and Active Labor Act (EMTALA), a federal law passed in 1986, ensures that hospitals provide care to anyone needing emergency treatment, regardless of citizenship, legal status or ability to pay. EMTALA requires that anyone who comes to the hospital requesting emergency care must be given a medical screening examination to determine whether an emergency medical condition exists.

If an emergency does exist, the hospital must do everything within its capability to stabilize the patient. If the patient needs a specialized service that is not available at the hospital, such as the services of a burn unit, shock-trauma unit or neonatal intensive care unit, the hospital must arrange for the patient's transfer to another hospital that does have the needed specialized capability and capacity. EMTALA also requires hospitals with these types of specialized services to accept any requested transfer and to provide the services needed to stabilize the patient.

The number of emergency room visits by patients without insurance continues to decrease since new commercial health insurance coverage is available through the Health Insurance Marketplace; however, these self-pay visits still account for almost 20% of all visits to the ER.⁵⁵



Figure 16



Trauma Care

Most hospitals are capable of providing some level of trauma care; however, only 29 of the state's 105 acute care hospitals are designated trauma centers. This small number is likely due to the significant ongoing financial investment necessary to be designated as a trauma center and insufficient funding levels available to offset the cost.

See page 54 for a map and list of trauma centers.

Georgia's Super Speeder law increases fines for dangerous drivers to discourage trauma-causing behavior. The law adds an additional \$200 fine for driving faster than 85 mph anywhere in the state and for driving 75 mph or more on a two-lane road. It also increases driver's license reinstatement fees for drivers committing a second and third offense for violations that result in a suspended license and for other negligent behaviors. The Georgia Trauma Network Commission received a total of \$23 million in state funds in the AFY 2022 budget and \$21.4 million in FY 2023.⁵⁶ The Super Speeder law has generated \$228.3 million in revenue since its inception in 2009. This is an average of approximately \$22 million per year after the full implementation.⁵⁷

In 2016, Georgia voters overwhelmingly approved a constitutional amendment to dedicate funds from the excise tax for the sale of fireworks to the Georgia Trauma Commission, fire services and local public safety services. Excise tax collections totaled \$2.7 million in FY 2020.⁵⁸

Trauma Commission

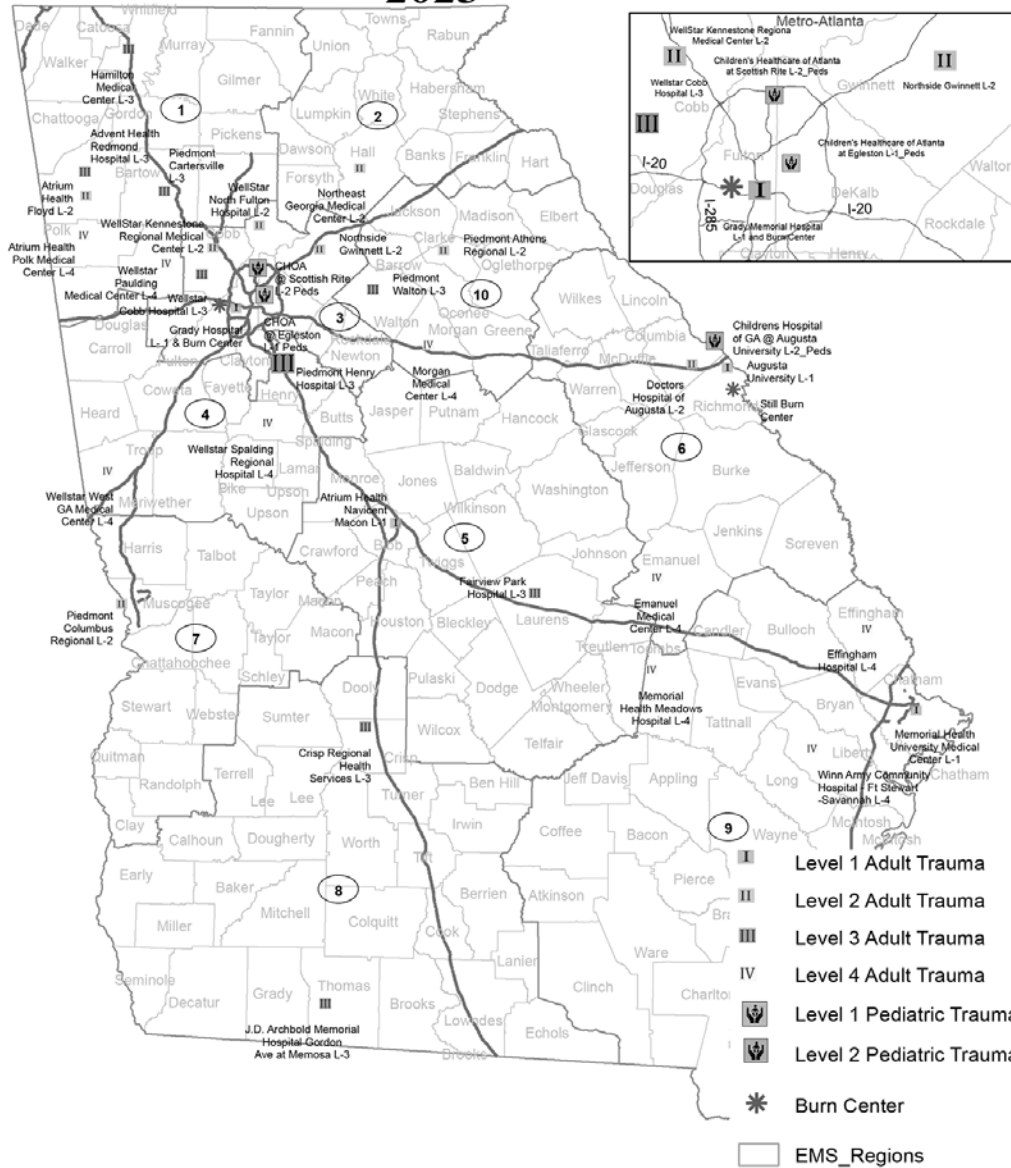
In 2007, the General Assembly passed Senate Bill (S.B.) 60. The bill established a nine-member Georgia Trauma Care Network Commission and authorized the Commission to create a trauma system for the State of Georgia and to act as the accountability mechanism for distribution of trauma system funds appropriated each fiscal year by the legislature.⁵⁹ Members of the Commission include representatives from the hospital, physician and emergency medical services (EMS) industries who are involved in trauma care throughout the state.

The Trauma Commission's FY 2023 budget is \$21.4 million.⁶⁰ The Commission utilizes its funding to pay trauma providers for their readiness costs, to provide grants for new trauma provider start-ups and to help offset uncompensated costs of providing trauma care.



Trauma and Specialty Care Centers

2023



Level I

- Augusta University Medical Center
- Atrium Health Navicent
- Grady Memorial Hospital
- Memorial Health University Medical Center

Level II

- Atrium Health Floyd
- Doctors Hospital of Augusta
- Northside Hospital Gwinnett
- Northeast Georgia Medical Center
- Piedmont Athens Regional
- Piedmont Columbus Regional
- Wellstar Kennestone Hospital
- Wellstar North Fulton Hospital

Level III

- AdventHealth Redmond
- Crisp Regional Hospital
- Fairview Park Hospital
- Hamilton Medical Center
- John D. Archbold Memorial Hospital
- Piedmont Cartersville Medical Center
- Piedmont Henry Hospital
- Piedmont Walton Hospital
- Wellstar Cobb Hospital

Level IV

- Atrium Health Floyd Polk Medical Center
- Effingham Health System
- Emanuel Medical Center
- Memorial Health Meadows Hospital
- Morgan Medical Center
- Winn Army Community Hospital
- Wellstar Paulding Hospital
- Wellstar Spalding Regional Hospital
- Wellstar West Georgia Medical Center

Specialty Care Centers

Pediatric Trauma Centers

- Children's Healthcare of Atlanta at Egleston (Level I)
- Children's Healthcare of Atlanta at Scottish Rite (Level II)
- Children's Hospital of Georgia at Augusta University (Level II)

Designated Burn Centers

- Grady Burn Center
- Joseph M. Still Burn Center

Office of EMS
Emergency Preparedness
Facilities January 23, 2023

FOR OFFICIAL USE ONLY



Created Date: April 22, 2022 updated January 23, 2023
Source: Department of Public Health
Office of EMS
Office of Environmental Health
Office of Emergency Preparedness and Response
Office of Health Information and Planning
Prepared: Georgia Statewide Lambert Conformal Conic
For Official Use Only

Map courtesy of the Georgia Department of Public Health

Health Care Workforce

Health Care Workforce in Georgia

Like many other states, Georgia struggles with a health care workforce shortage, especially in rural areas. Thanks to the growth of the health care industry, the unemployment rate in Georgia has remained low. Health care and health care support occupations are expected to drive the job growth in Georgia. Total employment in Georgia is projected to grow to more than 5 million jobs by 2026, an 11.7% increase in jobs since 2016.⁶¹ By 2026, health care and social assistance will account for one-fifth of new jobs created in Georgia.⁶²

The total number of registered nurses (RNs) in the state will grow to 87,000 by 2026 and is expected to be 98,800 by 2030. This same year, there is a projected demand for 101,000 RNs, resulting in a shortage of 2,200.⁶³ With the RN turnover rate for Georgia at 18.7 percent⁶⁴, there are efforts to recruit and retain nurses at health care organizations. There is also a focus on filling health care support occupations, including technicians. Due to demand, openings for these positions will grow at a rapid pace, creating a supply gap. These roles also have high turnover rates and are impacted by increased competition from other industries.

Access to health care varies across Georgia, with many counties facing severe provider shortages. Two-thirds of Georgia's 159 counties fall below the statewide average number for each category of nurses, physician assistants, total doctors and primary care doctors per 100,000 residents. Georgia has 89% of its counties below the statewide average for doctors per 100,000 residents and 81% with fewer primary care physicians than the state average. Nearly two-thirds are deemed shortage areas for dental care, mental health, and primary care.⁶⁵

To help establish a pipeline of skilled health care talent, Georgia is investing in increased residency program capacity. One example of this is the Georgia Board of Health Care Workforce, which operates loan repayment programs designed to incentivize physicians to practice in rural communities.⁶⁶

Employers, workforce development boards, academic institutions, economic development groups, community service providers, funders, government agencies and trade organizations are working together on long-term strategies to build a sustainable health care workforce pipeline.

Preceptor Tax Incentive Program

In 2014, Senate Bill (S.B.) 391 created tax deductions for uncompensated community-based faculty physicians who provide training to medical, physician assistant, and nurse practitioner students. Under the bill, Georgia physicians who provide clinical training to health professions students for a minimum of three (to a maximum of 10) rotations, and who are not compensated through any other source, could claim a tax deduction for every 160 hours of training provided.

In 2019, the program was replaced with a new and expanded tax credit with the passage of House Bill (H.B.) 287. Updates include converting the tax deduction to a tax credit for eligible community-based facilitators; expanding the definition of eligible preceptors to include advance practice registered nurses (APRN) and physician assistants (PA); and removing the limitation on the types of rotations covered. Additionally, an incentive structure was implemented so that a preceptor earns a lesser amount for the first three rotations (\$500 for physicians and \$375 for APRNs and PAs) and an increased amount (\$1000 for physicians and \$750 for APRNs and PAs) for rotations 4-10. Students must be enrolled in one of the state's public or private medical/osteopathic, physician assistant, or nurse practitioner programs.

Georgia's public and private colleges and universities must be able to utilize the full cadre of Georgia community-based physicians in order to educate the students matriculating in Georgia programs. The tax deduction provides a reward to the community-based physician without creating an in-state bidding war for these valuable community resources.⁶⁸

Inside the H

Georgia Board of Health Care Workforce

The Georgia Board of Health Care Workforce (GBHCW) is a state agency responsible for advising the Governor and the General Assembly on physician workforce and medical education policy and issues. GBHCW works to identify the physician workforce needs of Georgia communities and to meet those needs through the support and development of medical education programs.

The Board's responsibilities include:

- Monitoring and forecasting the supply and distribution of physicians in Georgia;
- Assuring an adequate supply, specialty mix, and geographic distribution of physicians to meet the health care needs of Georgia; coordinating physician workforce planning with state funding for medical education; and developing and supporting medical education programs required to meet physician workforce needs.⁶⁷

Hospitals' Financial Support of Health Care Education

Georgia hospitals have contributed millions of dollars to support health care education. In 2019, not-for-profit hospitals reported more than \$553.2 million in community support of health professions education.⁶⁹ Key areas of support include offering scholarships and tuition reimbursement; providing paid internships/part-time jobs to health care students; funding faculty positions; donating hospital staff to serve as part-time or full-time faculty; providing clinical preceptors for students; and funding the expansion of classrooms, laboratory space, or equipment and supplies needed for student education and training. In addition, hospitals and schools are beginning to develop partnerships to purchase and maintain simulation equipment that can be shared.

Many hospitals not only support local post-secondary health career education, but also partner with local school systems to provide clinical education opportunities for secondary students through the Health Occupations programs at local high schools. They also support their local Health Occupations Students of America (HOSA) organizations and offer volunteer programs that provide health care experience to interested individuals.



Georgia hospitals have contributed millions of dollars to support health care education.

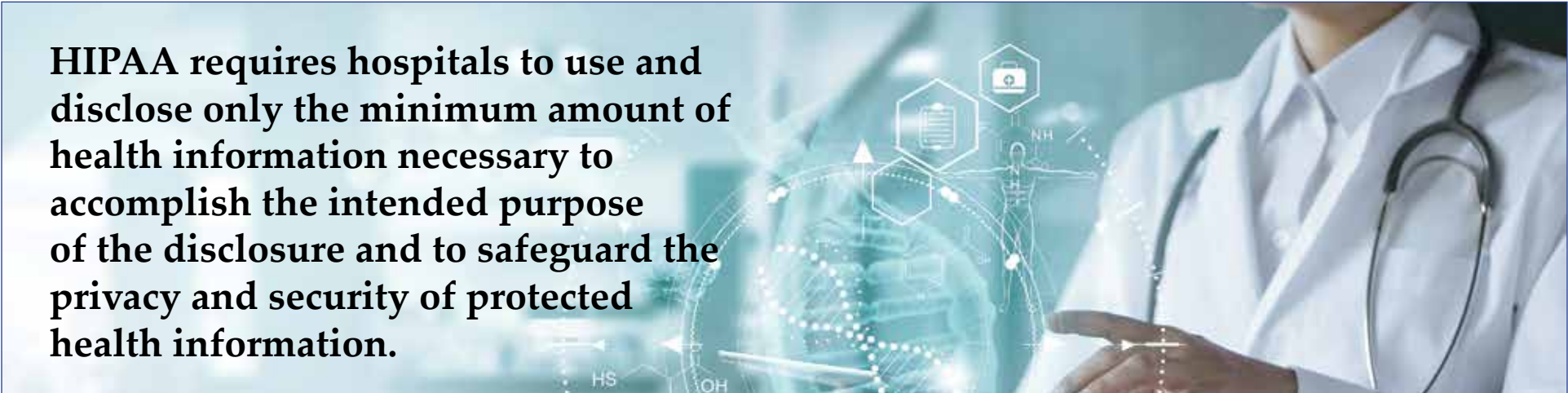
Health Information

HIPAA and the HITECH Act

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law passed in 1996 that requires hospitals to use and disclose only the minimum amount of health information necessary to accomplish the intended purpose of the disclosure and to safeguard the privacy and security of protected health information (PHI). For example, hospitals may use or disclose a patient's health information to enable providers to treat the patient, obtain payment for services, and for certain hospital operations such as quality initiatives. Under HIPAA, patients have the right to request restrictions on how their health information is used and disclosed. They also have the right to receive an account of certain types of disclosures of their health information.

HITECH Act and Cybersecurity

In 2009, Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act, which expanded the HIPAA privacy and security requirements. The HITECH Act more directly regulates subcontractors that handle PHI and requires hospitals to inform patients when there is a security breach involving their unsecured health information. Efforts to safeguard PHI have become increasingly vital, as health care cybersecurity attacks are becoming more common. According to an analysis of breach data from the U.S. Department of Health and Human Services (HHS), in 2018, 14 million individuals were affected by cybersecurity attacks and by 2021, that number had grown to 45 million.⁷⁰ A recent version of the report noted that 97% of individuals affected by a cybersecurity breach in the first half of 2022 was due to hacking and IT incidents.⁷¹



HIPAA requires hospitals to use and disclose only the minimum amount of health information necessary to accomplish the intended purpose of the disclosure and to safeguard the privacy and security of protected health information.

Electronic Health Records (EHR)

An Electronic Health Record (EHR) is an electronic version of a patient's medical history that is maintained by the provider over time. The EHR automates access to information and has the potential to streamline the clinician's workflow.

EHRs can strengthen the relationship between patients and clinicians, as well as improved patient care.

- Making health information available
- Reducing duplication of tests and delays in treatment
- Ensuring patients are well-informed to make better decisions
- Reducing medical errors by improving the accuracy and clarity of medical records⁷²

Medicare Interoperability Program

The HITECH Act made federal incentive payments available to doctors and hospitals to encourage them to adopt and implement the use of certified EHRs. CMS established the Medicare and Medicaid EHR Incentive Programs, now known as the Medicare Promoting Interoperability Program. These funds were first available to eligible providers serving Medicare and Medicaid patients in September 2011 and continued through Dec. 31, 2021. As of 2015, hospitals that were not meaningful users of EHR technology were subject to reductions in their Medicare payments. During the run of the program, Medicare paid Georgia hospitals \$455 million⁷³ and Medicaid paid Georgia hospitals more than \$151 million in incentive payments for EHR adoption.⁷⁴

Secure Sharing of PHI Across the State

Electronic health information exchange (HIE) allows doctors, nurses, pharmacists, and certain qualified health care professionals to securely share a patient's electronic health record. In Georgia, the Georgia Health Information Network (GaHIN), the Georgia Department of Community Health (DCH), and HI-BRIDGE Solutions (formerly known as Georgia Health Information Technology Extension Center, or GA-HITEC) collaborate to enable Georgia's statewide HIE. The HIE interconnects regional area HIEs with large health systems, payers, wellness partners, state agencies, and other health care organizations.

Quality and Patient Safety

Ensuring quality and patient- and family-centered safe care is a priority of all Georgia hospitals, who continually strive to raise their quality standards and enhance their patient safety efforts. Hospitals spend significant resources on monitoring the quality and safety of care provided to patients.

Quality in a hospital can be broken down into clinical quality, patient safety and patient perception. Clinical quality is the actual medical care that a patient receives and are assessed via core measures. These measures rate the process of care a patient receives based on various disease specific categories. Clinical quality also considers outcome measures such as length of stay, infection and/or mortality.

Patient safety is defined as keeping patients safe from harm. Hospitals must monitor and track events such as medication errors, infections and injuries to ensure safe make environments for patients and families. Staff are also surveyed on their perception of patient safety in the hospital to find gaps and improve overall patient safety.

Patient perception of care while in the hospital is measured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The survey includes questions about things such as doctor communication, cleanliness of the hospital, pain management and discharge planning.

There are multiple efforts to monitor, assess and ensure that hospitals provide safe and quality care. *Figure 17 on page 67 depicts the significant number of entities that are involved in this process and the following sections further discuss these efforts.*

Patient safety is defined as keeping patients safe from harm. Hospitals must monitor and track events such as medication errors, infections and injuries in order to continually make environments safe for patients and families.

Hospital Quality Improvement Contract (HQIC)

In 2020, GHA partnered with Alliant Health Solution on the Centers for Medicare & Medicaid Services (CMS) Hospital Quality Improvement Contract (HQIC). This is a four-year program to improve the efficiency, economy, and quality of services. Through the partnership, GHA supports rural hospitals, critical access hospitals, and hospitals that are low performing and serving vulnerable populations. GHA also provides support during public health emergencies, such as pandemics, and other crises as they arise. Sixty-five hospitals have signed on to the program, and GHA is working with them to reduce all-cause harm in hospitals by 9.75% by 2024; decrease opioid-related adverse events by 7%; and increase quality care transitions.

Partnership for Health and Accountability (PHA)

PHA brings the health care field together with agencies and individuals to ensure quality and safety in healthy communities. PHA assists in strengthening collaboration between providers, community members, and other stakeholders by providing education and data-driven tools to facilitate improvement. Since being established by GHA's Research and Education Foundation in 1999, PHA has become a state and national leader in patient safety and quality health care issues.

In 2023, 12 hospitals received the GHA/PHA Patient Safety & Quality Awards for their outstanding initiatives and three hospitals received the Josh Nahum Award for Infection Prevention and Control. PHA works with Georgia hospitals to improve safety across the board to eliminate preventable health care-associated infections (HAI). Five hospitals were also recognized as Circle of Excellence Award Winners. This award is given to hospitals that have demonstrated a sustained commitment to patient safety and quality as evidenced by winning this year as well as winning three or more Patient Safety and Quality Awards within the previous five years.

Inside the H

Proprietary Voluntary Quality and Safety Programs
Hospitals utilize accreditation organizations to show that:

- (1) they have passed a rigorous external inspection and
- (2) the care they provide meets the highest and most current quality and patient safety standards. Two examples of these kinds of organizations are The Joint Commission, the nation's oldest and largest standards-setting and accrediting health care body⁷⁵, and DNV Healthcare, a Centers for Medicare and Medicaid Services (CMS)-approved company conferring the National Integrated Accreditation for Healthcare Organizations to qualified health care providers.⁷⁶

Approximately 116 of Georgia's hospitals are accredited by The Joint Commission and 39 hospitals are accredited by DNV Healthcare.

Proprietary Voluntary Quality and Safety Programs

Many hospitals seek voluntary accreditation from national entities as a way to display commitment to high-quality, comprehensive patient care. Hospitals are expected to be accredited by at least one organization. Two examples are The Joint Commission and DNV Healthcare.

Hospitals also voluntarily participate in the CMS Medicare Quality Improvement Program (QIP). The Medicare Quality Innovation Network – Quality Improvement Organizations (QIN – QIOs) are organizations that contract with Medicare to set goals and implement new quality improvement projects with health care providers. Alliant Quality is the Georgia QIN-QIO.⁷⁷ The Beneficiary and Family Centered-Care Quality Improvement Organizations (BFCC-QIO) assist Medicare beneficiaries with their concerns about the quality of care received from a Medicare provider.⁷⁸

Physician Credentialing

Credentialing is the basis for appointing health care professionals to the medical staff of a hospital or other health care organization. This process is used by hospitals to ensure the qualifications of licensed physicians or other health care providers. Credentialing includes an evaluation of the provider's education, training, experience, competence and judgment, as well as his or her scope of practice. A credentialed staff member is permitted to perform certain clinical duties or privileges within the organization. Specific clinical duties are defined by the institution's medical staff.

Credentialing is also performed by health plans before facilities and providers are accepted into a plan's provider network. Many hospitals and health systems that have a large number of employed providers prefer to have delegated credentialing contracts with the plans in which they participate in order to simplify the process of adding providers to a plan's network. Delegated credentialing usually requires that the hospital or health system contractually agree to perform the components described above for hospital credentialing as well as other activities required by the National Committee for Quality Assurance (NCQA) and the plan.

State Regulatory Requirements

Certificate of Need

Certificate of Need (CON) is a health planning law administered by the Department of Community Health (DCH). The CON law helps the state promote geographic and financial access to health care services, contain health care costs, and promote quality of care. It also supports the continued availability of unprofitable, but essential, services provided by hospitals 24 hours a day, 7 days a week. These include emergency services, trauma services, intensive care services, neonatal intensive care services, and the most complex inpatient surgical services.

The CON law requires that the development of a “new institutional health service,” or the construction or expansion of an existing facility such as a hospital, skilled nursing facility or home health agency be subject to the CON review process and obtain approval from DCH. The law often requires an applicant to commit to providing a specified amount of indigent and charity care; to demonstrate that a need exists for the proposed service or facility; and to consider the impact of the proposal on existing providers in the same health planning area. This process recognizes the unique role hospitals play in their communities, both by offering a wide range of services unavailable elsewhere and by providing care to anyone who comes to the emergency department, regardless of his or her ability to pay.

In recent years, the General Assembly has enacted substantial reforms to Georgia’s CON laws to help address access in rural areas, streamline the regulatory process, and designate by geographic area those who can oppose an application. GHA supports these reforms and updates that do not erode protections of the CON process.

Health Care Facility Licensure and Regulation

DCH is the state agency responsible for licensing many of Georgia’s health care facilities, including hospitals. In 2010, the General Assembly passed House Bill (H.B.) 994, which authorized DCH to establish annual licensure fees for hospitals and other licensed facilities to cover the cost of licensure activities. DCH’s Health Care Facility Regulation Division surveys hospitals for compliance with both state licensure requirements and Medicare’s Conditions of Participation (COPs). Hospitals that are accredited by The Joint Commission or DNV Healthcare are deemed by DCH and Medicare to be in compliance with the state licensure requirements and Medicare’s COPs. However, DCH conducts periodic validation surveys of such hospitals to ensure compliance.

Practitioner Licensure

In Georgia, the Composite Medical Board licenses physicians, physician assistants (including anesthesiologist assistants), physician residents in training, perfusionists, respiratory care professionals, acupuncturists, orthotists, prosthetists, and auricular (ear) detoxification specialists. Many other providers, including nurses, nurse practitioners, physical therapists, occupational therapists, pharmacists and others, are regulated by boards under the Secretary of State Professional Licensing Board Division or attached to the Georgia Department of Community Health. Licensure boards are partially funded by fees paid by the licensees. In addition to licensure and the investigation of complaints, each board makes rules and policies in conformity with the stated purpose of the board and the mission mandated by state law.

For More Information

Composite Medical Board
www.medicalboard.georgia.gov/

Secretary of State
Professional Licensing Board Division
<http://sos.georgia.gov/plb/>

Board of Pharmacy
www.gbp.georgia.gov

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State and Federal Oversight of Hospital Billing and Payments

Like all health care providers, hospitals are subject to billing and payment scrutiny by Medicare and Medicaid program administrators as well as by commercial insurers. The following sections discuss some of these federal and state efforts.

Medicare and Medicaid Audit Contractors

The Centers for Medicare & Medicaid Services, as required by the Tax Relief and Health Care Act of 2006, established a national Recovery Audit Contractor (RAC) program that has been in place since Jan. 1, 2010. The goal of the program is to identify overpayments made on claims of health care services provided to Medicare beneficiaries and to identify underpayments by Medicare to providers. Medicare RACs are paid on a contingency fee basis -- a fact many providers believe creates perverse incentives to aggressively deny claims. Georgia's RAC is Cotiviti, which is headquartered in Atlanta. Other entities with the authority to audit Medicare claims include Medicare Administrative Contractors (MACs), Zone Program Integrity Contractors (ZPICs), Comprehensive Error Rate Testing (CERT) contractors, Supplemental Medical Review Contractors (SMRCs), and the U.S. Department of Health and Human Services Office of Inspector General (OIG).

Federal Medicaid Integrity Program

Section 1936 of the Social Security Act requires the Secretary of Health and Human Services to establish a Comprehensive Medicaid Integrity Plan to safeguard the integrity of the Medicaid program. The most recently published plan covers fiscal years 2019 through 2023, and includes new initiatives established by CMS to enhance the program and renewed efforts by CMS to adjust oversight to be more mindful of each state's unique situation.

In 2010, as part of the Patient Protection and Affordable Care Act (ACA), Congress expanded the RAC to Medicaid. Georgia's Medicaid RAC is Myers and Stauffer. Like the Medicare RAC program, federal law requires the state to pay the Medicaid RAC contractor(s) on a contingency fee based on the amount of claims denied. Initially, Medicaid RAC audits were solely focused on claims paid under the fee-for-service program; however, the Georgia Department of Community Health Program Integrity Unit (DCH Program Integrity), which oversees the Medicaid RAC program, expanded it to include claims paid by the Medicaid CMOs, even though the CMOs conduct their own audits.

State Medicaid Surveillance and Utilization Review

The Georgia Department of Community Health's Office of the Inspector General Program Integrity Unit performs Medicaid Surveillance and Utilization Review (SUR) activities. The state's SUR teams generate profiles based on patterns of Medicaid provider billing. Analyzing providers and comparing them to respective peer groups can help identify abnormal patterns of practice. SUR staff members identify aberrant behaviors; conduct hospital, physician and other provider type audits to educate providers on program guidelines; and recover inappropriately reimbursed funds. The Program Integrity Unit works in conjunction with a number of regulatory agencies, including the Medicaid Fraud Control Unit (MFCU), Medicare Zone Program Integrity Contractors (ZPICs), and the Georgia Bureau of Investigation (GBI).

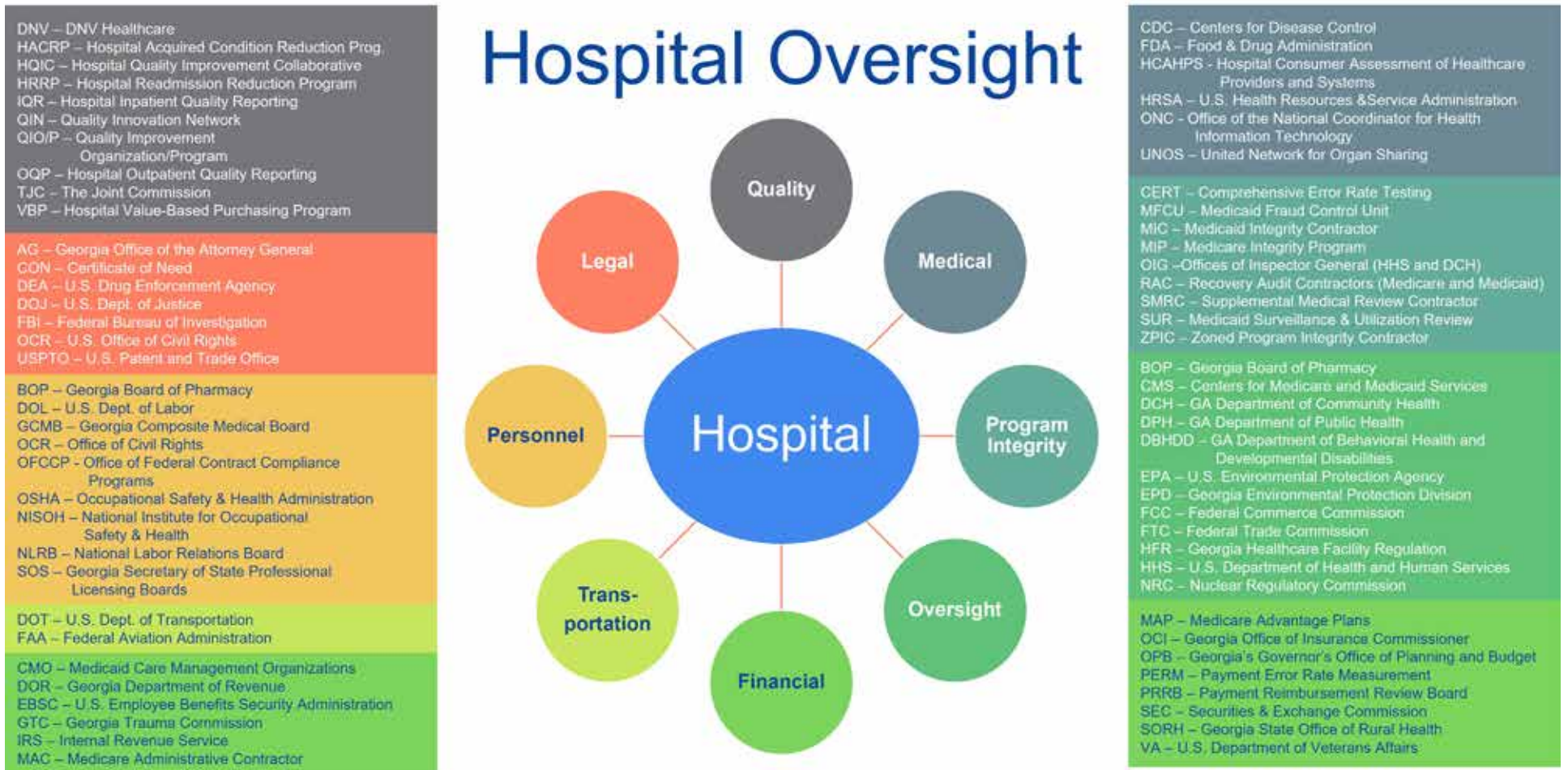
In summary, there are multiple efforts to regulate, assess and ensure that hospitals provide safe and quality care.

Figure 17 on page 67 depicts a summary of all the entities that are involved in these efforts.

**There are multiple efforts to regulate,
assess and ensure that hospitals provide
safe and quality care.**



Figure 17



Glossary

Accreditation - Certification by a recognized organization that an individual, service or facility has met a set of standardized criteria typically determined by a process set by the certifying organization.

Acute Care Hospital - A facility that provides services designed to meet the needs of patients who require short-term care for a period of less than 30 days.

Allied Health Professional - Persons who are not nurses or physicians but have special training and are licensed when necessary. They work under the supervision of a health professional and provide direct patient care. They include respiratory, physical and occupational therapists; radiology technologists and technicians; medical laboratory technologists and technicians; and surgical technologists.

Ambulatory Care - Health care services provided on an outpatient basis, where no overnight stay in a health care facility is required.

American College of Radiology (ACR) - The recognized organization for imaging (radiology) accreditation.

American Hospital Association - The nation's principal trade association for hospitals, with offices in Washington, D.C., and Chicago.

Ancillary Care Services - Diagnostic or therapeutic services, such as laboratory, radiology, pharmacy and physical therapy, performed by non-nursing departments.

Any Willing Provider - Terminology relating to legislation that would require managed care plans to allow any individual physician or other provider to participate on the provider panels he or she does business with.

Authorization - A process by which a managed care plan determines that care is medically necessary.

Bad Debt - The costs absorbed by hospitals or physicians for care provided to patients from whom payment was expected but no payment was received. Bad debt differs from charity care.

Balance Billing - A practice typically prohibited by managed care plan contracts in which the provider bills the patient for the amount of the billed charge that exceeds the payment by the insurer plus the member cost share.

Captive - A licensed insurance company owned by a parent company that underwrites the insurance risks of that parent company's operations.

Certificate of Need (CON) - A method of confirming the need for, and ensuring access to, health care facilities, services and technology in which the approval of a government agency or other empowered entity is required for a health care organization to engage in a construction or remodeling project, make a significant capital expenditure or provide a new service. CON helps control costs by requiring all applicants to demonstrate the need for services and facilities in order to prevent overutilization and unnecessary duplication of services, while also discouraging unfair competition from facilities that serve few, if any, Medicaid and uninsured patients.

Charge - The dollar amount that a health care provider assigns to a specific unit of service to a patient. A “charge” may not be totally reflective of the actual cost involved in providing that service.

Charity Care - Charity care presents that portion of health care services that are provided by a hospital under a hospital’s charitable care program and where payment is not expected because the patient has a demonstrated inability to pay for some or all of the services.

Clinical Laboratory Improvement Amendments (CLIA) - The recognized organization for laboratory accreditation.

Coinsurance - The percentage of either billed charges or the plan’s contract rate that a member is required to pay for covered services.

College of American Pathologists (CAP) - CAP is an internationally recognized program designed to help laboratories achieve the highest standards of excellence to impact patient care positively.

Community Benefit - Programs or services that address community health needs, particularly those of the poor, minorities and other underserved groups, and provide measurable improvement in health access, health status and use of health care resources.

Community-Building Activities - Activities that are proactive, strategic investments in prevention, and that will reduce the burden of preventable illness. These activities address what is often referred to as social and economic determinants of health such as education, employment, income, housing, and social supports.

Conditions of Participation - Conditions health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries.

Copayment or Copay - A defined amount of payment per visit that a member must pay for health care services under an insurance plan.

Cost Share - The portion of the fee for health care services that an insurer requires the plan member to pay, including copayments, coinsurance and deductible.

Cost Shifting - A phenomenon occurring in the U.S. health care system in which providers are inadequately reimbursed for their costs by some payers and subsequently raise their prices for other payers in an effort to recoup costs.

Covered Services - Those health care services for which a member is entitled to benefits under the terms of their insurance policy.

Credentialing - Generally used as the basis for appointing health care professionals to a hospital's staff, it is the process used to analyze the qualifications of a licensed practitioner's education, training, experience, competence and judgment. A credentialed staff member is permitted to perform clinical duties at the hospital.

Critical Access Hospital (CAH) - Established under the Balanced Budget Act of 1997, CAHs are limited-service hospitals located in rural areas with no more than 25 acute-care beds. They receive cost-based payment for Medicare patients and are relieved from some Medicare regulations.

CSR Orion - A joint effort between the Joint Commission Resources (JCR) and GHA to structure and implement a program by which hospitals can receive education, consulting and feedback on an ongoing basis for standard requirements for accreditation.

Deductible - The amount that a member must pay for covered services during a specified period (usually a policy year) before benefits will be paid by the insurer.

Delegated Credentialing - A formal process by which an organization, such as a managed care plan, gives another entity the authority to perform credentialing functions on its behalf.

Diagnosis Related Group (DRG) - A method of classifying inpatients into groupings based on common characteristics, each of which can be expected to require similar services. Used as the basis of the Medicare and Medicaid inpatient payment system.

Disproportionate Share Hospital (DSH) - A hospital with a disproportionately large share of low-income or uninsured patients. Under Medicaid, states augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

DNV Healthcare (DNV) - DNV is a voluntary accreditation agency that surveys enrolled hospitals regarding many aspects of quality.

EMTALA - Emergency Medical Treatment and Active Labor Act, a federal law passed in 1986, ensures hospitals provide care to anyone needing emergency treatment, regardless of citizenship, legal status or ability to pay.

ERISA - Employee Retirement Income Security Act of 1974, a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry.

EOB, Explanation of Benefits, EOMB, Explanation of Medical Benefits or Remittance Advice - A document that summarizes how reimbursement was determined in the payment of a health plan claim.

Health Information Technology for Economic and Clinical Health Act (HITECH) - Part of the American Recovery and Reinvestment Act of 2009 (ARRA), the HITECH Act contains incentives related to health care information technology in general (e.g. creation of a national health care infrastructure) and contains specific incentives designed to accelerate the adoption of electronic health record (EHR) systems among providers.

Health Insurance Portability and Accountability Act (HIPAA) - Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II of HIPAA requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans and employers and also addresses the security and privacy of health data.

Hospital-Acquired Condition - A condition that develops while a patient is in the hospital, such as an infection, a pressure ulcer or some type of injury.

Hospital Authority - A statutorily created public corporation in a county or municipality that is authorized to exercise certain specified public and essential governmental functions, including the acquisition, construction and equipping of hospitals and other health care facilities to promote the public health needs of the community.

Hospital Authority (Restructured) - A hospital that is owned by a hospital authority that has delegated its management authority and responsibilities to a nonprofit corporation via a restructuring process whereby the authority maintains ownership of the lands, buildings, facilities and other assets that constitute the hospital and the nonprofit corporation is responsible for operating the hospital. Georgia law requires that at least one member of the hospital authority serve on the governing body of the nonprofit entity and that the nonprofit entity provides the hospital authority with an annual financial statement.

Hospital Provider Payment Program - Implemented in FY 2011 and reauthorized in FY 2014, and again in FY 2017, to create an additional funding source for the state's share of Medicaid costs and to fund a rate increase for hospitals serving Medicaid recipients. This program is scheduled to end on June 30, 2020.

Hospital Medicaid Financing Program - Created in March 2013 to provide additional Medicaid payments to hospitals participating in the Hospital Provider Payment Program.

Indigent Care - Unpaid charges for services to patients whose family income is less than or equal to 125% of the Federal Poverty Level.

Indigent Care Trust Fund (ICTF) - Established in 1990 to expand Medicaid eligibility and services; support rural and other health care providers, primarily hospitals, which serve the medically indigent; and fund primary health care programs for medically indigent Georgians. The ICTF is an umbrella program that contains the Disproportionate Share Hospital (DSH) program, nursing home and hospital provider fees, breast cancer tag fees, ambulance rates and other uninsured/indigent initiatives.

Intergovernmental Transfer (IGT) - Local governmental funds transferred to the state on behalf of a public provider to provide the state matching funds for supplemental payments made to that public provider.

The Joint Commission (TJC) - TJC is a voluntary accreditation agency that surveys enrolled hospitals regarding many aspects of quality.

Licensed Beds - The maximum number of beds authorized by a government agency for a health care organization to admit patients.

Long-Term Acute Care Hospital (LTAC) - A hospital providing specialized care to medically complex patients who usually require an extended hospital stay.

Long-Term Care Facility (LTCF) - Any residential health care facility that administers health, rehabilitative or personal services for a prolonged period of time.

Managed Care - A mechanism for financing and/or delivery of health care that is intended to control cost, utilization and quality of care.

Medicaid Integrity Contractor (MIC) - An auditor hired by the Centers for Medicare and Medicaid Services (CMS) to review Medicaid claims for mispayment.

Member or Covered Person - Someone that has insurance coverage through a health plan. May also be referred to as an Enrollee or Beneficiary.

National Committee for Quality Assurance (NCQA) - A non-profit organization that sets quality standards, evaluates and accredits managed care plans and other healthcare organization.

Out of Network Care - Health care services provided to a health plan member by a provider who does not participate in that plans' contracted provider network.

Outpatient Prospective Payment System (OPPS) - A determined payment methodology for a Medicare outpatient procedure.

Other Free Care - Other uncompensated care provided as a result of employee discounts, administrative adjustments, courtesy discounts, small bill write-offs, or other similar write-offs not based on a patient's inability to pay.

Payer - An organization (such as the federal government for Medicare or a commercial insurance company) or person who directly reimburses health care providers for their services.

Present On Admission (POA) - Whether or not a patient has a certain condition at the time of being admitted to a hospital. These conditions include different types of infections and pressure ulcers.

Prospective Payment System (PPS) - A system in which payment for services is determined before the services are actually provided and that amount is reimbursed to the provider regardless of the actual cost of services.

Provider Network or Network - A group of providers that have contracted with a managed care plan under which they agree to accept reduced rates and abide by other plan rules in exchange for either increased volume of patients or the ability to receive payment for care provided to insurance plan members.

Quality Measure - A tool that helps measure or quantify health care processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.

Recovery Audit Contractor (RAC) - An auditor hired by the Centers for Medicare and Medicaid Services (CMS) to review Medicare claims for mispayment.

Serious Adverse Event - An unexpected event that happens during a hospital admission that results in harm or injury to a patient.

Specialty Hospital - A limited-service hospital designed to provide one medical specialty such as orthopedic or cardiac care.

Surveillance and Utilization Review (SUR) - A Georgia Department of Community Health program designed to identify aberrant Medicaid claiming behavior of providers and identify and recover Medicaid overpayments.

Swing Beds - Acute care hospital beds that can also be used for long-term care, depending on the needs of the patient and the community. Only those hospitals with fewer than 100 beds and located in a rural community, where long-term care may be inaccessible, are eligible to have swing beds.

Tobacco Master Settlement Agreement - In 1998, Georgia was one of 46 states to participate in a Master Settlement Agreement (MSA) with the four largest tobacco companies in the U.S. The MSA was a result of multiple state lawsuits against the tobacco companies that sought recovery for Medicaid and other public health expenses incurred in the treatment of smoking-induced illnesses.

Trauma - An injury or injuries caused by external force or violence. Trauma injuries may range from minor to severe, from obvious to non-apparent, and may include single or multiple injuries.

Trauma System - An organized approach to facilitating and coordinating a multidisciplinary system response to severely injured patients.

TRICARE - TRICARE is the Department of Defense's worldwide health care program available to eligible beneficiaries from any of the seven uniformed services—the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, U.S. Coast Guard, Commissioned Corps of the U.S. Public Health Service, and the National Oceanic and Atmospheric Administration.

Uncompensated Care - Care given for which payment is not received, or for which only a portion of the cost is reimbursed. Includes charity care and indigent care, Medicaid underpayments, legislated care underpayments and bad debt.

Utilization Review - The process by which a managed care company controls the provision of health care services through determination of medical necessity of care, including pre-certification, prior authorization, concurrent review and retrospective review.

Endnotes

- ¹ Prepared to Care – The 24/7 Standby Role of America’s Hospitals. American Hospital Association. November 2012.
- ² O.C.G.A. § 31-7-1 (4) (A), 2009.
- ³ The Accreditation Council for Graduate Medical Education (ACGME) is responsible for the Accreditation of post-MD medical training programs within the United States. Accreditation is accomplished through a peer review process and is based upon established standards and guidelines. Source: www.acgme.org.
- ⁴ Bureau of Economic Analysis. Regional Economic Accounts: 2020 Total Full Time and Part Time Employment by NAICS Industry for the Health Care and Social Assistance Industry. www.bea.gov.
- ⁵ Bureau of Economic Analysis. Regional Economic Accounts: 2020 Total Full Time and Part Time Employment by NAICS Industry for the Health Care and Social Assistance Industry. www.bea.gov.
- ⁶ Bureau of Economic Analysis. Regional Economic Accounts: 2020 Total Full Time and Part Time Employment by NAICS Industry for the Health care and Social Assistance Industry. www.bea.gov.⁷ The Accreditation Council for Graduate Medical Education (ACGME) is responsible for the Accreditation of post-MD medical training programs within the United States.
- ⁷ State of Georgia. Economic Impact on the State and Local Economy. Calendar Year 2020. Georgia Hospital Association.
- ⁸ Derived from hospital data reported on FY 2019 IRS Form 990 Schedule H.
- ⁹ Derived from the 2021 Department of Community Health Hospital Financial Survey.
- ¹⁰ The 2019 Form 990 and related Schedule H are reflective of financial activities of the fiscal year beginning in 2018. These figures are reflective of the financial activities of approximately 84 Georgia not-for-profit hospitals.
- ¹¹ Hospitals participating in the Disproportionate Share Hospital program are already required to do this per state rules and regulations.
- ¹² Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. <https://health.gov/healthypeople/priority-areas/social-determinants-health>
- ¹³ Source: Georgia Discharge Data System. CY 2022 patient encounters for inpatient admissions and outpatient visits by payer category.
- ¹⁴ Based on average cost per case type for each payment source. Calculated using 2020 patient counts and cost coverage. FY 2020 cost coverages for Medicaid and self-pay patients from FY 2020 Medicaid Disproportionate Share Hospital calculations. 2020 Medicare cost coverages from DataGen 4Q2020 Medicare Margins Analysis for PPS Hospitals in Georgia. Cost coverage for all other payers extrapolated to break even.
- ¹⁵ State of Georgia. Economic Impact on the State and Local Economy. Calendar Year 2019. Georgia Hospital Association.
- ¹⁶ Derived from the 2022 Department of Community Health Annual Hospital Questionnaire and Hospital Financial Survey. <https://dch.georgia.gov/health-planning-databases>.
- ¹⁷ These figures reflect only hospital expenses and revenues. They do not consider other hospital-owned health care providers (e.g., the revenue and expense of a hospital-based nursing home). In 2018, GHA changed the methodology for calculating margins to more accurately reflect contractual adjustments.
- ¹⁸ GHA’s analysis of the Georgia Department of Community Health’s 2021 Hospital Financial Survey.
- ¹⁹ American Hospital Association (AHA), 2021 Annual Survey of Hospitals.
- ²⁰ Health Insurance Coverage of the Total Population. 2021. Kaiser Family Foundation. <http://kff.org/other/state-indicator/total-population/>
- ²¹ Data Gen. Medicare Margin Analysis for 96 Georgia PPS Hospitals from 2020 Medicare cost reports on file with CMS as of July 2022.
- ²² For individuals who do not meet immigration criteria, Medicaid provides coverage only for emergency medical services so long as the individual meets all other Medicaid eligibility requirements.
- ²³ Department of Community Health. Annual Report FY 2021.
- ²⁴ Kaiser Family Foundation, October 2022. <https://files.kff.org/attachment/fact-sheet-medicaid-state-GA>
- ²⁵ Georgia Budget and Policy Institute. <https://gbpi.org/georgia-health-budget-primer-for-state-fiscal-year-2023/>
- ²⁶ *Medicaid Part II Policies and Procedures for Hospital Services*. Georgia Department of Community Health.
- ²⁷ Source: www.dch.georgia.gov - FY 2022 Disproportionate Share Hospital (DSH) calculations from the Department of Community Health. Figures do not consider the impact of supplemental Medicaid payments or Medicaid payments paid to Georgia hospitals by out-of-state Medicaid programs.

- ²⁸ HB 911, FY 2023 Appropriations Act. 2022 General Assembly.
- ²⁹ <http://kff.org/other/state-indicator/total-population/?state=GA>.
- ³⁰ Source: www.dch.georgia.gov - FY 2022 Disproportionate Share Hospital (DSH) calculations from the Department of Community Health.
- ³¹ *The Budget Control Act of 2012 and the American Taxpayer Relief Act of 2013* extended the ACA cuts through 2022. In December 2013, Congress passed the Bipartisan Budget Act of 2013, which eliminated Medicaid DSH reductions in 2014 and delayed 2015 scheduled reductions until 2016. The DSH cuts were also extended one more year to 2023. The Protecting Access to Medicare Act of 2014 delayed DSH scheduled reductions to 2017 and extended them through 2024. *The Medicare Access and CHIP Reauthorization Act of 2015* delayed DSH reductions to 2018, extended them through 2025, and restructured the level of annual reductions from 2018 through 2025. A series of delays to the Oct. 1, 2019 scheduled reduction were passed in the fall of 2019, moving the implementation date to Nov. 21, 2019 and then to Dec. 20, 2019. Next, the *Further Consolidated Appropriations Act, 2020* delayed the FFY 2020 DSH cuts until May 23, 2020.
- ³² MACPAC, Annual Analysis of Disproportionate Share Hospital Allotments to States, March 2021.
- ³³ Department of Community Health and www.dch.georgia.gov – FY 2022 UPL payments.
- ³⁴ 2023 Poverty Guidelines for the 48 Contiguous States and the District of Columbia. <https://aspe.hhs.gov/poverty-guidelines>
- ³⁵ Department of Community Health. Annual Report FY 2021.
- ³⁶ Department of Community Health. <https://dch.georgia.gov/programs/peachcare-kids/program-benefits-and-cost>
- ³⁷ Enhanced Federal Medical Assistance (FMAP) for CHIP. 2023. Kaiser Family Foundation. <https://www.kff.org/other/state-indicator/enhanced-federal-matching-rate-chip>
- ³⁸ Department of Community Health Annual Report 2021
- ³⁹ State Health Benefit Plan. <https://shbp.georgia.gov>
- ⁴⁰ United Healthcare and Kaiser Permanente offer credits toward cost sharing when members complete certain wellness activities.
- ⁴¹ The TRICARE Supplement Plan is sponsored by the American Military Retirees Association (AMRA) and is administered by the Association & Society Insurance Corporation.
- ⁴² National Association of Insurance Commissioners Accident & Health Insurance 2021 Market Share Report
- ⁴³ Section 1332 of the Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver (now also referred to as a State Relief and Empowerment Waiver) to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA
- ⁴⁴ *Public Notice. Reinsurance and Georgia Access Model – State Relief and Empowerment Waiver (Section 1332 Waiver.)* Georgia Department of Community Health. November 4, 2019.
- ⁴⁵ <http://kff.org/other/state-indicator/total-population/>
- ⁴⁶ <https://www.kff.org/health-costs/report/2022-employer-health-benefits-survey/>
- ⁴⁷ Georgia Hospital Association analysis of the Department of Community Health Hospital Provider Payment Program Tracking Report, November 2022. Provider Payments made to the state available on <https://dch.georgia.gov/hospital-providers>.
- ⁴⁸ Department of Community Health, Hospital Medicaid Financing Program Payment Model, SFY 2022.
- ⁴⁹ Georgia Hospital Association analysis of the Department of Community Health Hospital Provider Payment Program Tracking Report, November 2022. Provider Payments made to the state available on <https://dch.georgia.gov/hospital-providers>.
- ⁵⁰ FY 2020 ICTF Financial – Revenue and Expenditure Activities (Unaudited). Department of Community Health.
- ⁵¹ State of Georgia Rural Health Plan. Georgia State Office of Rural Health. Department of Community Health.
- ⁵² <https://dch.georgia.gov/divisionsoffices/state-office-rural-health>
- ⁵³ <https://dch.georgia.gov/divisionsoffices/state-office-rural-health/rural-hospital-stabilization-program>
- ⁵⁴ <https://dch.georgia.gov/divisionsoffices/state-office-rural-health/rural-hospital-stabilization-program>
- ⁵⁵ Georgia Discharge Data System. January 2023 Query of Emergency Room Patients by Primary Payer Category.
- ⁵⁶ House Bills 910 and 911, 2022 General Assembly.
- ⁵⁷ Source: Department of Driver Services, HB 160 Notice and Revenue Tracking, September 2018.
- ⁵⁸ AFY 2022 - FY 2023 Governor’s Budget Report
- ⁵⁹ Georgia Trauma Care Network Commission. <https://trauma.georgia.gov/about-us/governance>.
- ⁶⁰ House Bill 910, 2022 General Assembly
- ⁶¹ GEORGIA Workforce Trends An Analysis of Long-term Employment Projections to 2028. Georgia Department of Labor; Commissioner Mark Butler Retrieved from <https://explorer.gdol.ga.gov/vosnet/mis/Current/gaworkforcecurrent.pdf>

- ⁶² GEORGIA Workforce Trends An Analysis of Long-term Employment Projections to 2028. Georgia Department of Labor; Commissioner Mark Butler Retrieved from <https://explorer.gdol.ga.gov/vosnet/mis/Current/gaworkforcecurrent.pdf>
- ⁶³ GEORGIA Workforce Trends An Analysis of Long-term Employment Projections to 2026. Georgia Department of Labor; Commissioner Mark Butler Retrieved from <https://explorer.gdol.ga.gov/vosnet/mis/Current/gaworkforcecurrent.pdf>
- ⁶⁴ NSI Nursing Solutions. (2019). National Healthcare Retention & RN Staffing Report. Retrieved from https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf
- ⁶⁵ Prescribing Remedies for Georgia’s Medical Provider Shortage. Timothy Sweeney <https://gbpi.org/prescribing-remedies-for-georgias-medical-provider-shortage/>
- ⁶⁶ Prescribing Remedies for Georgia’s Medical Provider Shortage. Timothy Sweeney <https://gbpi.org/prescribing-remedies-for-georgias-medical-provider-shortage/>
- ⁶⁷ <https://healthcareworkforce.georgia.gov/>
- ⁶⁸ <http://www.augusta.edu/ahec/ptip/>
- ⁶⁹ Source: 2019 IRS Form 990, Schedule H for 84 not-for-profit hospitals and health systems.
- ⁷⁰ Critical Insight Healthcare Breach Report 2021.
- ⁷¹ Critical Insight Healthcare Breach Report January -June 2022
- ⁷² Centers for Medicare & Medicaid Services. Electronic Health Records. <https://www.cms.gov/medicare/e-health/ehealthrecords>
- ⁷³ <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports>
- ⁷⁴ Georgia Department of Community Health. Medicaid Promoting Interoperability Program. <https://dch.georgia.gov/divisionsoffices/office-information-technology/health-information-technology/medicaid-promoting>
- ⁷⁵ <http://www.qualitycheck.org>. Accreditation for Inpatient Units in Georgia as of Dec. 3, 2018.
- ⁷⁶ <http://dnvglhealthcare.com>
- ⁷⁷ <http://www.alliantquality.org>
- ⁷⁸ <https://qioprogram.org/about/what-are-qios>

