COVID-19

State Legislative Impact

On March 12, Speaker Ralston and Lt. Governor Duncan announced that the 2020 Legislative Session would suspend "until further notice" to address the state's response to the coronavirus. Before heading home, the General Assembly adopted **HR 1473** that allowed for a joint agreement by the House and the Senate on a future return date as deemed practical at the time.

The General Assembly reconvened on June 15 for Legislative Day 30 with new safety measures in place to reduce the risk of exposure to and the spread of COVID-19. The Georgia Building Authority implemented strict social distancing, the wearing of face coverings, and temperature check requirements to enter the Capitol and surrounding legislative office buildings. Notable changes to General Assembly rules and decorum included limiting the number of members in the Chamber at one time; removing the requirement for Senators to attend committee meetings; and closing the House and Senate galleries to the public, including lobbyists.

During its short two-week reconvening period, the Legislature passed multiple bills addressing the provision of health care during public health emergencies. Most importantly for hospitals, **SB 359** by Sen. Chuck Hufstetler provides liability protections for businesses and health care providers against frivolous COVID-19 claims. **SB 391** by Sen. Kay Kirkpatrick enables pharmacists to refill prescriptions in advance for a 30-day supply of any prescription medication, except schedule II drugs, when a state of emergency is issued by the Governor or a hurricane warning is issued by the National Weather Service. Finally, **HB 791** by Rep. Ron Stephens allows a pharmacist to dispense a 90-day supply of maintenance medication for the treatment of a chronic illness.

Gov. Brian Kemp speaking at St. Joseph's/Candler during the start of vaccinations in Georgia.

Regulatory Impact

Georgia Public Health State of Emergency

On March 14, 2020, the Governor issued a public health state of emergency to address the novel coronavirus commonly known as COVID-19 in Georgia. This declaration greatly assisted health and emergency management officials across the state by deploying all available resources for the mitigation of COVID-19 and treatment of those affected by the virus. Unlike other states of emergency, this declaration allowed the Department of Public Health, if necessary, to direct specific health care action in extraordinary circumstances. It suspended restrictions on hours of commercial vehicle operation and vehicle height, weight, and length thresholds to assist in preparation and response efforts. It authorized the Georgia Composite Medical Board and Georgia Board of Nursing to expeditiously grant temporary licenses to applicants who are in good standing in other states to assist in addressing health care needs. Also, it authorized Adjutant General Tom Carden - at the request of Georgia Emergency Management and Homeland Security Director Homer Bryson - to call up as many as 2,000 Georgia National Guard troops to State Active Duty to support COVID-19 response efforts in Georgia.

During the break from the Legislative Session, the General Assembly convened on March 16 for a one-day special session to ratify the Governor's public health emergency. **HR 4EX** was adopted and the General Assembly concurred with Executive Order No. 03.14.20.01 29 issued by Gov. Kemp declaring a public health state of emergency. The public health state of emergency was extended multiple times, expiring on May 30, 2021, at the time of publication.

The Georgia Department of Public Health (DPH) added all novel respiratory viruses, including COVID-19, to the list of diseases that Georgia physicians, laboratories, and other health care providers must immediately report.

The Georgia Department of Community Health (DCH) significantly expanded reimbursement for Medicaid telehealth services, including allowing the use of the patient's home as an originating site and expanded acceptable technology to include telephone, video cell phone and other audio/video technology. Telehealth encounters must be medically necessary and initiated by the patient.

The Georgia Composite Medical Board passed an emergency rule change that allowed licensed prescribers to follow guidelines issued by the U.S. Department of Health and Human Services (HHS) that allows DEA-registered practitioners to issue prescriptions during a public health emergency for controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided certain conditions are met:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of professional practice;
- The telemedicine communication is conducted using an audio-visual, real time, two-way interactive communication system; and
- The practitioner is acting in accordance with Federal and State law.

The Governor appointed the following Coronavirus Task Force Committees to address the impacts COVID-19 has on communities, industry sectors, the health care system, and emergency preparedness. **GHA is participating in the Primary Care Provider Committee and the Emergency Preparedness Committee.**

Emergency Preparedness Committee: Chaired by Georgia Insurance and Safety Fire Commissioner, General John F. King, this committee analyzed the availability of necessary supplies and evaluated logistical needs. Its job was to ensure supply chain needs were met.

Economic Impact Committee: Chaired by State Economist Jeffrey Dorfman, this committee worked with leaders in academia and business, and lawmakers on preparing for the short- and long-term impacts of the virus on the Georgia economy.

Primary Care Physicians Committee: Chaired by State Sen. Ben Watson (R-Savannah), chairman of the Senate Committee on Health and Human Services. This committee of public and private health care experts worked to ensure that the best decisions were made for the health care community as they navigated this crisis.

Committee for the Homeless and Displaced: Chaired by Atlanta Mayor Keisha Lance Bottoms, this committee ensured adequate shelter, resources, and care for vulnerable populations in Georgia.

Community Outreach: Co-Chaired by Dr. Bernice King, The King Center, and Leo Smith, President, Engaged Futures Group, this committee ensured the state remains prepared in the fight against COVID-19.

GHA worked with partners on the following resources provided to our membership. These resources are a few key items that impacted hospitals' ability to provide care during the COVID-19 crisis.

Georgia Coordinating Center

The Georgia Coordinating Center (GCC) is a statewide tool to help hospitals navigate COVID-19 patient surge, track and manage diversion status, and then transfer patients to facilities who are not at capacity. The GCC is a partnership between the Georgia Department of Public Health (DPH) and Grady Health System.

Georgia World Congress Center

The State established an overflow facility at the Georgia World Congress Center (GWCC) to relieve the burden of the COVID-19 virus on overwhelmed Georgia hospitals. The GWCC was a 120-bed alternate care site in downtown Atlanta designed to provide mid-level care (corresponding to Level 3 medical-surgical care) for COVID-19+ patients. Hospitals that were at capacity used the COVID-19 Georgia Coordinating Center (GCC) to request transfer of COVID-19+ patients to the GWCC. The GCC was staffed by paramedics and emergency medical technicians who facilitated the transfer process. The Georgia Department of Public Health (DPH) provided a patient overflow protocol for hospitals requesting patient transfers to the Georgia World Congress Center (GWCC).

Georgia Hospital Association Resource Pool

The Georgia Hospital Association Resource Pool, powered by Aya Healthcare, helped match qualified furloughed clinicians with facilities that needed additional local staffing. The COVID-19 crisis put a strain on the health care delivery network in Georgia, not only due to the increase in COVID-19 patients needing care, but also because service sites such as hospitals, ambulatory surgery centers and physician practices voluntarily canceled most elective procedures and other revenue-generating services. Some hospitals were desperate for additional staff while others did not have the volume to continue their current staffing levels, leaving qualified clinicians out of work.

Remdesivir Allocation for Georgia

In May, remdesivir, a promising drug thought to help COVID-19 patients, received an emergency use authorization (EUA) from the FDA. Initially, the drug was distributed to states by the federal government. Hospitals administering remdesivir had to meet certain qualifications dictated by the FDA emergency use authorization. Hospitals that did not meet these requirements were not able to purchase remdesivir. In August , Georgia received 19,480 vials of remdesivir, which was the largest shipment the state received up until that point. GHA had expressed concerns to U.S. Sen. David Perdue (R) about the low inventory from previous remdesivir distributions. The increase in the number of vials shipped in August was thanks to Sen. Perdue making a request to HHS on behalf of GHA-member hospitals. On Aug. 28, the FDA broadened the existing emergency use authorization for remdesivir to include the treatment of all hospitalized adult and pediatric patients with suspected or laboratory-confirmed COVID-19, irrespective of the severity of the disease.

Get Georgia Well Initiative

GHA joined Get Georgia Well, a joint project with the Metro Atlanta Chamber and Central Atlanta Progress to promote the practice of four basic behaviors to stop the spread of COVID-19:

- Wearing face masks when leaving the home
- Practicing social distancing and avoiding unsafe gatherings
- Washing hands frequently
- Encouraging businesses to follow the specific guidelines that are applicable to them

#MaskUpGA

GHA invited our members, as well as the public, to wear masks as part of #MaskUpGA, a campaign to encourage all Georgians to make the choice and commitment to wear masks when in public settings and to social distance when possible to help slow the spread of COVID-19.

Federal Response

National Public Health Emergency

On March 13, the President issued a proclamation declaring that the COVID-19 outbreak in the United States constitutes a national emergency. Pursuant to the declaration, the Secretary of HHS may exercise the authority under section 1135 of the SSA (Social Security Act) to temporarily waive or modify certain requirements of the Medicare, Medicaid, and Children's Health Insurance programs and of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule throughout the duration of the public health emergency declared in response to the COVID 19 outbreak.

White House Coronavirus Task Force

The White House Coronavirus Task Force, established on Jan. 29, 2020, coordinated and oversaw the administration's efforts to monitor, prevent, contain, and mitigate the spread of COVID-19. Vice-President Mike Pence was the Chair of the Task Force and Dr. Deborah Birx was the White House Coronavirus Response Coordinator.

Federal Legislative Response

In March, Congress passed three separate measures, which are referred to by lawmakers as "Phases," in response to the coronavirus pandemic.

Phase One, the *Coronavirus Preparedness and Response Supplemental Appropriations Act*, provided emergency supplemental appropriations of $8.3 billion to combat the spread of COVID-19. The bill provided funds for research and development of vaccines, public health funding to aid in prevention, preparedness, and response efforts, and medical supplies and medical surge capacity.

Phase Two, the *Families First Coronavirus Response Act*, was adopted to respond to the economic impacts of the pandemic. The bill provided funding for free COVID-19 testing, extra paid leave for workers affected by the pandemic, such as frontline health care workers, and increased funding for food stamps.

Phase 3, the *Coronavirus Aid, Relief, and Economic Security Act*, also known as the CARES Act, was a $2.2 trillion economic stimulus package, which included several important health care provisions:

- Increased funding to the Public Health and Social Services Emergency Fund by almost $127 billion to include reimbursement to hospitals for COVID-19 expenses;
- Created a Medicare add-on payment of 20% for both rural and urban in-patient hospital COVID-19 patients;
- Removed the Medicare sequester from May through December 2020;
- Expanded the existing option for hospitals to receive "accelerated" Medicare payments, by also ensuring critical access hospitals can access this option;
- Eliminated $8 billion in total Medicaid DSH cuts over FY 2020 and FY 2021;
- Provided flexibility to post-acute care providers, including waiving long-term care hospital (LTCH) site-neutral policy;
- Took steps to improve the supply chain, including access to masks and drugs, among other items;
- Took steps to expand coverage for COVID-19 testing and testing-related services; and
- Provided new telehealth flexibilities, including expanding access in rural areas.

CARES Act Provider Relief Fund Distribution Timeline

On April 10, 2020, the Department of Health and Human Services (HHS) began distributing funds provided in the CARES Act. The following explains how those funds were distributed.

Phase One General Distribution: $50 billion to eligible providers throughout the health care system, including Georgia hospitals to providers who bill Medicare fee-for-service.

Phase Two General Distribution: $15 billion to eligible providers that participate in state Medicaid/CHIP programs, Medicaid managed care plans, and certain Medicare providers, including those who missed payment during phase 1 general distribution.

Targeted Distributions: $22 billion to providers in COVID-19 high impact areas, rural providers, skilled nursing facilities, safety net hospitals, tribal hospitals and clinics, and providers requesting reimbursement for the treatment of uninsured patients.

April 10 - April 17 First round of Phase 1 General Distribution

$30 Billion distributed to nearly 320,000 Medicare Fee-For-Service (MFFS) billing providers based on their portion of 2019 MFFS payments

April 24 Second round of Phase 1 General Distribution

$9.1 Billion to almost 15,000 MFFS billing providers based on revenues from CMS cost report data

$10.9 Billion available to MFFS billing providers based on revenue submissions to the provider portal

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May 6 Rural Distribution

$10 Billion to almost 4,000 rural health care providers including hospitals, health clinics, and health centers

May 7 First Round of COVID-19 High-Impact Distribution

$12 Billion to 395 hospitals that had 100 or more COVID-19 admissions between Jan 1 and Apr 10

May 22 Allocation for Skilled Nursing Facilities

$4.9 Billion to over 13,000 certified Skilled Nursing Facilities

May 29 Allocation for Tribal Hospitals, Clinics, and Urban Health Center

$500 Million to approximately 300 Indian Health Service (IHS) programs

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June 3 Deadline for Phase 1 General Distribution

Deadline for providers to submit revenue information and apply for a portion of the additional $20 Billion General Distribution (Phase 1)

June 9 Phase 2 General Distribution & Distribution to Safety Net Hospitals

$15 billion to eligible Medicaid, CHIP, and dental providers

$10 billion to safety net hospitals

June 15 Second Round of COVID-19 High-Impact Distribution

Deadline for hospitals to update their number of COVID-19 positive inpatient admissions between January 1, 2020, and June 10, 2020, to qualify for second round of funding

July 10 Distribution to Safety Net Acute Care Hospitals, Certain Specialty Rural Providers
$3 billion to hospitals serving vulnerable populations on thin margins

$1 billion to specialty rural hospitals, urban hospitals with certain rural Medicare designations, and hospitals in small metropolitan areas

July 17 Second Round of COVID-19 High-Impact Distribution
$10 billion to hospitals with more than 161 COVID-19 admissions between January 1 and June 10, 2020, one admission per day, or a disproportionate intensity of COVID admissions

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Aug. 7 HHS Announces $5 Billion Allocation for Nursing Homes
HHS expects to distribute $2.5 billion to nursing homes mid-August to support increased testing, staffing, and personal protective equipment (PPE) needs, followed by additional performance-based distributions throughout the fall

Aug. 10 HHS Accept Additional Applications for Provider Relief Fund Phase 2 General Distribution
This phase of funding was available through Aug. 28, 2020. Those who bill Medicare, Medicaid, Medicaid Managed Care, CHIP, or a dental provider are eligible to apply if they haven't already received 2% of their patient revenue from the fund.

Aug. 14 Distribution to Certain Children's Hospitals
HHS to begin distributing $1.4 billion to 80 free-standing children's hospitals

Aug. 27 Distribution to Nursing Homes
$2.5 billion to nursing homes to support increased testing, staffing, and PPE needs

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Sept. 1 Phase 2 General Distribution for Assisted Living Facilities
Assisted living facilities (ALFs) may now apply for funding under the Provider Relief Fund Phase 2 General Distribution allocation

Sept. 3 Nursing Home Incentive Payment Plans
HHS announces details of $2 billion performance-based incentive payment distribution to nursing homes

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Oct. 1 Announcement of Phase 3 General Distribution
HHS announces $20 billion in new funding for providers on the frontlines of the coronavirus pandemic

Oct. 22 HHS Expands Relief Fund Eligibility and Updates Reporting Requirements
HHS announces broader category eligible providers for Phase 3 General Distribution funding and amends reporting requirements

Oct. 28 First Round of Nursing Home Incentive Payments
$333 million in first round performance payments to over 10,000 nursing homes

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Dec. 7 Second Round of Nursing Home Incentive Payments
$523 million in second round performance payments to over 9,000 nursing homes

Dec. 15 HHS Begins Distributing Over $24 Billion in Phase 3 COVID-19 Provider Relief Funding
Funding will support providers experiencing lost revenues and expenses related to COVID-19.

Relief to Businesses and Organizations
The CARES Act created a small business loan program called the Paycheck Protection Program (PPP), which provides low-interest loans for payroll costs and other expenses to small businesses, including some hospitals, that are forgivable under certain circumstances. It allocated up to $500 billion to the Economic Stabilization Fund for assistance to eligible businesses, states, and municipalities. Additionally, the CARES Act expands the Small Business Administration's Economic Injury Disaster Loans to cover nonprofit organizations. The Act also provides tax credits, tax deferrals, and increased tax deductions for employers.

Relief to Individuals
The CARES Act provided credits against 2020 personal income tax returns that were sent in the form of payments to eligible individuals in April. These payments were also made to eligible individuals who are not required to file an income tax return.

Medicare
Telehealth services in Medicare were expanded by waiving the requirement that covered medical services include an in-person meeting with a medical professional.

The Paycheck Protection and Healthcare Enhancement Act, which is known as Phase 3.5, replenishes the PPP established by the CARES Act and provides additional funding for hospitals and testing. The following are provisions of note to hospitals and health care providers:

- $320 billion of additional funding for the Paycheck Protection Program; of that amount, $60 billion is for PPP loans made by small banks, small credit unions, and community financial institutions
- $10 billion in additional funds for emergency Economic Injury Disaster Loans
- $50 billion for Small Business Administration disaster loans
- $75 billion in additional funds to the Public Health and Social Services Emergency Fund for health care providers' expenses or lost revenues related to coronavirus.
- $25 billion to the Public Health and Social Services Emergency Fund for researching, developing, validating, manufacturing, purchasing, administering, and expanding capacity for COVID-19 testing

Federal Regulatory Response
The Centers for Medicare and Medicaid Services (CMS), the Department of Health and Human Services (HHS), and the Trump Administration have issued several updates to policies to help hospitals combat the coronavirus and provide needed resources for the influx of patients during the pandemic.

- CMS introduced the Community Health Access and Rural Transformation (CHART) Model, which aims to ensure individuals in rural America have access to high quality, affordable health care.
    - o Providers interested in the model have two options for participation:
        - (1) In the Community Transformation Track, CMS will provide funding for rural communities to build systems of care.
        - (2) In the Accountable Care Organization Track, CMS is enabling providers to participate in value-based payment models where they are paid for quality and outcomes. Both tracks allow for telehealth expansion post-COVID-19.
- On Aug. 17, CMS announced it will resume routine inspections of all Medicare and Medicaid certified providers and suppliers. CMS had previously suspended these inspections as part of its response to the COVID-19 pandemic to prioritize infection control and give health care providers time to respond to the spread of COVID-19.

- CMS updated guidance related to the 20% add-on to the inpatient prospective payment system (PPS) diagnosis-related group (DRG) rate for patients diagnosed with COVID-19 for the duration of the public health emergency. For inpatient admissions occurring on or after Sept. 1, 2020, claims eligible for the 20% add-on will be required to have a positive COVID-19 laboratory test documented in patients' medical records. Positive tests must be demonstrated using only the results of viral testing. The inpatient PPS Pricer will continue to apply the 20% adjustment based on appropriate diagnosis codes; however, CMS may conduct post-payment medical review to confirm the presence of a positive COVID-19 test in the medical record. If no such test is present, the additional payment resulting from the 20% add-on will be recouped.
- CMS delivered nearly $34 billion in Medicare accelerated and advance payments to Part A providers, including hospitals, and Part B suppliers in April to combat resource challenges related to COVID-19.
- CMS delayed the start of its Emergency Triage, Treat and Transport (ET3) Model until fall 2020. Originally scheduled to begin May 1, CMS recognized that model participants are focusing the COVID-19 emergency.
- The FDA clarified several compounding policies, so hospitals and health systems understand what their 503A compounding pharmacies are permitted to do when making or distributing certain drugs.
- FEMA issued a temporary rule to bar the exportation of some personal protective equipment, including some respirators and surgical masks and gloves.
- HHS issued guidance authorizing licensed pharmacists to order and administer COVID-19 tests approved by the FDA.

Medicare Condition of Participation for Hospitals: COVID-19 Data Reporting Requirements

The Centers for Medicare & Medicaid Services (CMS) released an interim final rule setting forth new COVID-19 related requirements for health care providers and laboratories, among other entities. The rule, which took effect Sept. 2, made collecting and reporting COVID-19 data a condition of participation for hospitals to participate in the Medicare program, among other changes. The required data included, but is not limited to, elements such as the number of confirmed or suspected COVID-19 positive patients, intensive care unit (ICU) bed occupancy and availability of essential supplies and equipment, such as ventilators and PPE.

Telehealth Innovation

On March 6, Medicare began temporarily paying clinicians to provide telehealth services for beneficiaries residing across the entire country. Prior to this announcement, Medicare was only allowed to pay clinicians for telehealth services such as routine visits in certain circumstances. Based on the new policy, patients can receive telehealth services in any health care facility including a physician's office, hospital, nursing home or rural health clinic, as well as from their homes. This ensures Medicare beneficiaries, who are at a higher risk for COVID-19, are able to visit with their doctor from their home, without having to go to a doctor's office or hospital which puts themselves or others at risk.

The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS), announced that it will not impose penalties for HIPAA violations in connection with providers' good faith provision of telehealth services using communication technologies during the COVID-19 nationwide public health emergency. Covered health care providers may communicate with patients, and provide telehealth services, through remote communications technologies.

The White House launched the Pledge to Embrace Technology to Advance America's Health on Aug. 9, to reassure patients, providers, and payers that telehealth will be covered over the long term. The Pledge calls on health care payers to expand access and continue to cover claims for telehealth services and for health care providers to accelerate the adoption of telehealth solutions.

Medicaid Fiscal Accountability Rule (MFAR)

On Nov. 18, 2019, the Centers for Medicare & Medicaid Services (CMS) officially proposed a comprehensive regulation on Medicaid fiscal accountability. The proposed rule would:

- Increase the administrative burden on states with expanded reporting requirements on supplemental payments to Medicaid providers
- Significantly restrict the ability of states to use intergovernmental transfers to finance the state share of Medicaid payments
- Add new restrictions and review authority for Medicaid provider taxes and limit approval of certain provider taxes like Georgia's Hospital Provider Payment Program to three years
- Create a greater degree of uncertainty for states and providers in calculating supplemental payments and in terms of what CMS will consider permissible funding sources for the state share of Medicaid payments

According to both national and state-level analyses, the MFAR could result in severe Medicaid cuts to hospitals and other providers in states like Georgia that rely heavily on intergovernmental transfers (IGTs) and provider taxes to finance the state share of Medicaid payments. This, in turn, could jeopardize access to health care for millions of Americans.

IGTs and provider fees account for around 19% of total Medicaid payments or $730 million of all Georgia Medicaid state matching fund sources. The proposed rule could have a significant impact on all hospitals, regardless of whether a specific hospital is currently eligible to make IGTs.

During the Georgia General Assembly Budget Week in January, GHA Government Relations traveled to Washington, DC to lobby our congressional delegation regarding hospital industry opposition to the proposed CMS Medicaid Fiscal Accountability Rule (MFAR). GHA met with legislative staff for Senators David Perdue, who sits on the Senate Budget Committee, & Kelly Loeffler, Georgia's new senator who is a member of the Senate Health, Education, Labor & Pensions Committee. The Budget and HELP Committees provide crucial oversight of CMS operations, and both senate offices expressed concern regarding the impact of the proposed MFAR regulation. GHA also met with the health staff of Congressman Buddy Carter, who is a member of the House Energy & Commerce Committee, and Congressman Drew Ferguson, who sits on the House Ways & Means Committee. On Sept. 14, CMS Administrator Seema Verma announced the Medicaid fiscal accountability proposed rule (MFAR) will be withdrawn from its regulatory agenda.

Medicaid Fiscal Accountability Rule (MFAR)

Background: On Monday, November 18th the Centers for Medicare & Medicaid Services (CMS) officially proposed a comprehensive regulation on Medicaid fiscal accountability [CMS–2393–P]. This proposed rule would:

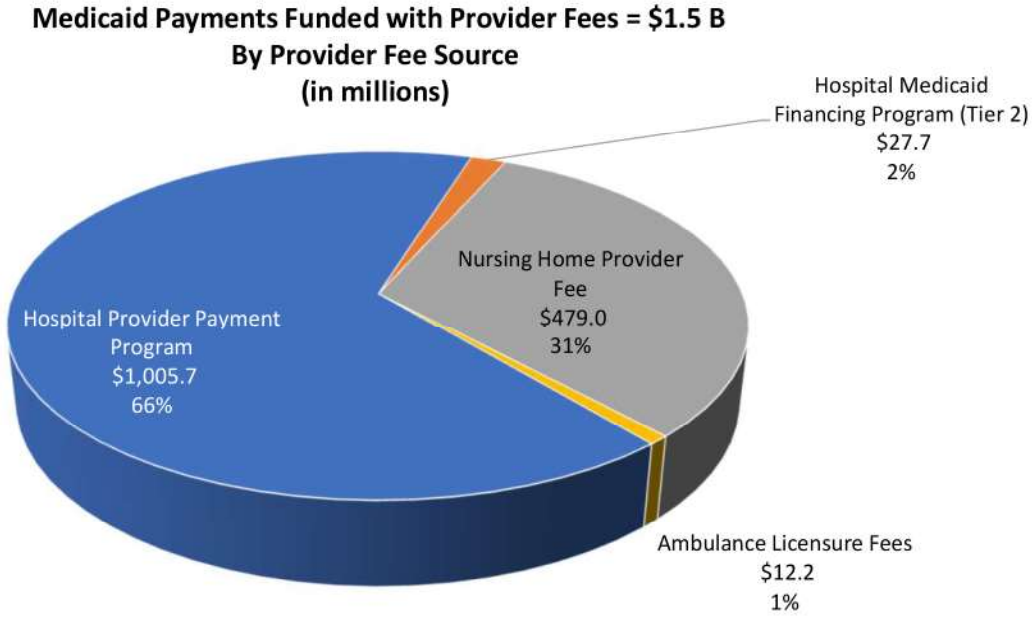
- Increase **the administrative burden on states** with expanded reporting requirements on supplemental payments to Medicaid providers;
- Significantly restrict the ability of states to use **intergovernmental transfers to finance the state share** of Medicaid payments; and
- Create a **greater degree of uncertainty for states and providers** in calculating supplemental payments and in terms of what CMS will consider permissible funding sources for the state share of Medicaid payments.

Georgia Implications: Intergovernmental Transfers (IGTs) and Provider Fees fund the state's share of **$2.3 billion** in Medicaid payments annually and account for around **19% or $730 million of all Medicaid state matching fund sources.**[1]

FY 2019 Georgia Medicaid Payments Financed with Provider Fees

(in millions)

Provider Fee Source	Provider Fee Collected	Total Funds	% of Total Fees
Hospital Provider Payment Program	$ 325.0	$ 1,005.7	66%
Hospital Medicaid Financing Program (Tier 2)	$ 9.0	$ 27.7	2%
Nursing Home Provider Fee	$ 154.3	$ 479.0	31%
Ambulance Licensure Fees	$ 4.0	$ 12.2	1%
Total	$ 492.2	$ 1,524.6	100%



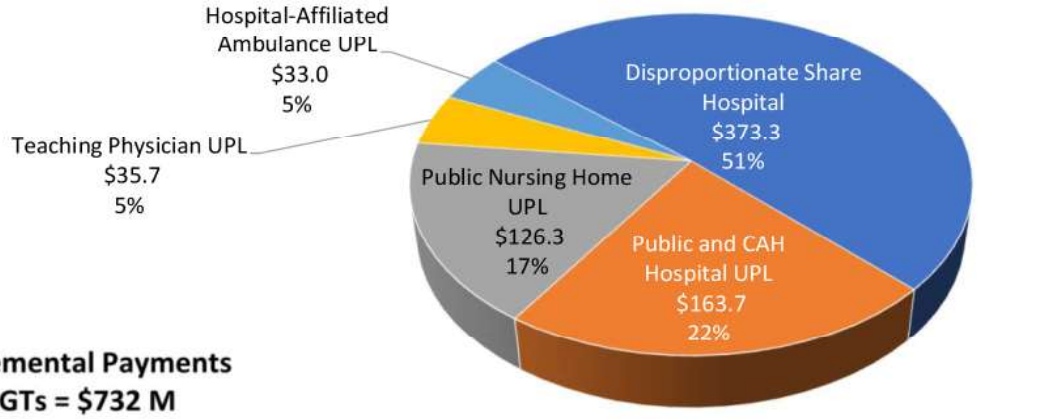
Medicaid Supplemental Payment Programs
Financed with Intergovernmental Transfers (IGTs)

(in millions)

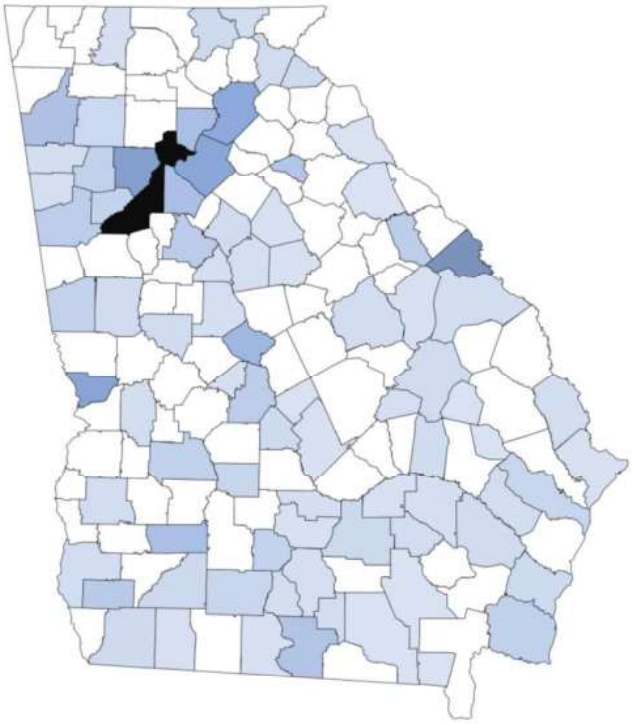
ɔplemental Payment Program	Year of Data	# Providers	# IGT Contributors	TOTAL IGTs	Medicaid Payments Funded with IGTs
proportionate Share Hospital	FY 2019	84	72	$ 120.9	$ 373.3
ɔlic and CAH Hospital UPL	FY 2018	59	49	$ 52.7	$ 163.7
ɔlic Nursing Home UPL	FY 2019	47	40	$ 40.6	$ 126.3
ɜaching Physician UPL	FY 2014	16	8	$ 12.2	$ 35.7
spital-Affiliated Ambulance UPL	FY 2020 (a)	22	22	$ 10.8	$ 33.0
TAL		228	76 (b)	$ 237.1	$ 732.0

proposed December 2019
unduplicated
. = Upper Payment Limit

Medicaid Supplemental Payments Funded with IGTs = $73
By Program
(in millions)



Medicaid Supplemental Payments Funded by IGTs = $732 M
By County of Provider



(in millions)

Facility Location	Medicaid Payments Funded with IGTs
Rural	$ 140.8
Urban	$ 591.2
Total	$ 732.0