Georgia’s hospitals are vital to local and state economies. Hospitals provide 150,000 jobs and more than $49 billion in economic development. Most of all, Georgia hospitals provide quality, life-saving care.
Each day, thousands of individuals pass by one of Georgia’s 170-plus hospitals. Many of us may not consider the crucial role hospitals serve until we, or people we know, require emergency care, surgery, outpatient treatment, or one of many other hospital services. For most of us, hospitals exist “just-in-case.”

Hospitals play a unique role in serving the health and well-being of their communities. Other health care providers may provide similar services as hospitals; however, only hospitals offer access to care 24 hours a day, seven days a week. They provide emergency care to all patients who come through their doors, regardless of ability to pay. Hospitals also respond at a moment’s notice to care for victims of disasters through their disaster readiness and response programs.

I believe one of the best ways to make sure that the public and stakeholders understand, and are supportive of, our issues is to make certain they have a thorough understanding of hospitals and the world of health care. This new edition of Hospitals 101 is an excellent way to achieve this, as it serves as an important reference guide that can be used when explaining the complexities of the hospital environment. It can also provide education to board members who are leaders in their communities and understand the vital role their hospitals play, yet work outside of our industry. We must ensure that everyone tasked with making decisions on behalf of hospitals is as informed as possible.

Hospitals 101 offers a clear explanation on a number of relevant hospital topics. This edition contains information you have come to expect, such as an explanation of the roles of different governmental payers and a breakdown of indigent care trust fund revenues. It also has new and updated sections, such as the new provisions regarding the Rural Hospital Tax Credit Program, which has been very beneficial to our rural hospitals by providing much needed lifelines to ensure they remain viable for their communities.

Thank you for making this publication your leading reference on Georgia hospital issues and for your continued support of the Georgia hospital community. Together, we can continue to ensure that all Georgians have access to the highest quality of hospital care available.

GHA Mission Statement

To advance the health of individuals and communities by serving as the leading advocate for all Georgia hospitals and health care systems.

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### GHA Vision Statement

Georgia, where all achieve the highest potential for health through healthy hospitals, communities and individuals.

*GHA Hospitals 101 (page 2)*
**HOSPITAL QUICK FACTS**

<table>
<thead>
<tr>
<th>Number of Georgia Hospitals (May 2018)</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>General Acute Care Hospitals</td>
<td>103</td>
</tr>
<tr>
<td>Critical Access Hospitals</td>
<td>30</td>
</tr>
<tr>
<td>Psychiatric/Behavioral Health Hospitals</td>
<td>25</td>
</tr>
<tr>
<td>Specialty Hospitals</td>
<td>23</td>
</tr>
<tr>
<td>Veterans Affairs Hospitals</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>184</td>
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| Georgia Counties with a Hospital | 105 |

<table>
<thead>
<tr>
<th>Hospital Employment (2017)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Full-Time Hospital Jobs</td>
<td>150,500</td>
</tr>
<tr>
<td>Salaries and Benefits</td>
<td>$9.8 billion</td>
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<table>
<thead>
<tr>
<th>Hospital Auxiliars (2018)</th>
<th></th>
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<tbody>
<tr>
<td>Number of Volunteers</td>
<td>5,828</td>
</tr>
<tr>
<td>Hours of Service</td>
<td>1,427,742</td>
</tr>
<tr>
<td>Contributions to Hospitals and Local Communities</td>
<td>$3.3 million</td>
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<table>
<thead>
<tr>
<th>Patient Utilization (CY 2017)</th>
<th></th>
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<tbody>
<tr>
<td>Inpatient Admissions</td>
<td>1.1 million</td>
</tr>
<tr>
<td>Outpatient Visits</td>
<td>10.1 million</td>
</tr>
<tr>
<td>Total</td>
<td>11.2 million</td>
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<table>
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<th>Patient Utilization by Insurance Status (CY 2017)</th>
<th>Visits and Discharges</th>
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<tbody>
<tr>
<td>Employer/Private Insurance</td>
<td>3.2 million</td>
</tr>
<tr>
<td>Medicare</td>
<td>3.5 million</td>
</tr>
<tr>
<td>Medicaid</td>
<td>2.0 million</td>
</tr>
<tr>
<td>Uninsured</td>
<td>1.6 million</td>
</tr>
<tr>
<td>Other</td>
<td>0.9 million</td>
</tr>
<tr>
<td>Total</td>
<td>11.2 million</td>
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<table>
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<th>Hospital Uncompensated Care (2017)</th>
<th></th>
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<tr>
<td>Indigent, Charity and Free Care</td>
<td>$1.46 billion</td>
</tr>
<tr>
<td>Bad Debt</td>
<td>$0.73 billion</td>
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<td>Total</td>
<td>$2.19 billion</td>
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<table>
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<tr>
<th>Average Margins (2017)</th>
<th></th>
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<tr>
<td>Patient Care Margin</td>
<td>0.56 percent</td>
</tr>
<tr>
<td>Total Margin</td>
<td>1.64 percent</td>
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<tr>
<th>Percent of Hospitals with Operating Losses (2017) considering:</th>
<th></th>
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<tr>
<td>Patient Care Revenue Only</td>
<td>50 percent</td>
</tr>
<tr>
<td>All Revenues</td>
<td>43.5 percent</td>
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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. 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.

Open 24 Hours a Day

Seven Days a Week
The following definitions provide additional clarification on the various types of hospitals that exist in Georgia. 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.

**Acute Care Hospital**
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 103 general acute care hospitals in Georgia.

**Non-Profit or Not-for-Profit Hospital**
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 of the hospital are returned to the control of the hospital for operations rather than to shareholders.

**Hospitals Affiliated with a Hospital Authority**
A hospital authority 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 utilize a not-for-profit management company to handle daily operations.

**Investor-Owned (or For-Profit) Hospital**
The profit or loss of the hospital is a direct profit or loss for the shareholders (owners) of the hospital. In 2017, 48 Georgia hospitals reported being for-profit. These facilities in Georgia may be publicly traded or privately owned. These hospitals pay taxes on hospital property and purchases.

**Prospective Payment System (PPS) Hospitals**
PPS hospitals are acute care hospitals that are reimbursed by Medicare based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services).
**Critical Access Hospitals (CAH)**
Established under the federal *Balanced Budget Act* of 1997, CAHs are limited-service, acute care hospitals located in rural areas. CAH 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 is a state and federal approval process required by the Georgia Department of Community Health and the Centers for Medicare and Medicaid Services for this designation. Under Medicare, CAHs are paid at 101 percent of Medicare cost instead of a diagnosis-related group (DRG) as with other hospitals. DRGs are discussed in more detail on page 18 of this publication. Further, there are some differences in regulatory requirements. There are 30 critical access hospitals in Georgia compared with 34 only a few years ago.

**Specialty Hospitals**
These 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.

**System Hospitals**
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 also own or operate other lines of business, like a skilled nursing facility, pharmacy, or physicians’ practice.

**State and Federal Hospitals**
State hospitals are owned by the State of Georgia. Likewise, federal hospitals, such as veterans affairs hospitals, are owned by the federal government. Georgia owns five state regional hospitals for behavioral health; one acute care hospital and two specialty hospitals. Georgia has three Veterans Administration (VA) hospitals.

**Teaching Hospitals**
These are facilities that have been approved to participate in residency training by the Accreditation Council for Graduate Medical Education 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.

**Psychiatric Hospitals**
These are facilities that provide care and treatment to patients affected with acute or chronic mental illness.

**Hospital Closures**
With declining reimbursement rates and the continual efforts to do more with less, several hospitals have had to shut down, leaving many communities without access to a hospital in close proximity. In addition, many hospitals have had to eliminate vital services. Since 2013, there have been 10 hospital closures (listed below). However, the Rural Hospital Tax Credit Program has greatly benefited other rural hospitals in helping them keep their doors open to continue to provide vital services to their communities. More detail on the tax credit can be found on page 40.

- Calhoun Memorial Hospital
- Stewart-Webster Hospital
- Charlton Memorial Hospital
- Lower Oconee Community Hospital
- Emory-Adventist Hospital
- North Georgia Medical Center
- Lake Bridge Behavioral Health
- Select Specialty Hospital - Northeast Atlanta
- Chestatee Regional Hospital
- Southern Crescent Hospital for Specialty Care
ECONOMIC IMPACT

The Health Care Industry in Georgia
In 2017, the health care and social assistance industry was the third largest employment sector in Georgia. 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 $32 billion, or 6 percent, to Georgia’s Gross State Product (GSP);¹⁰ and
- Provided 9.3 percent, or 563,000, of the state’s jobs.¹¹

Economic Impact of Georgia Hospitals
In 2016, Georgia’s hospitals:

- Spent $21.7 billion to operate;
- Directly provided approximately 150,500 full-time jobs; and
- Paid salaries and wages of $9.8 billion.¹²

The GHA Annual Economic Impact Report details the economic impact of Georgia’s hospitals and quantifies the level of community benefits provided statewide. 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 its ancillary industries.

Considering the multiplier effect, the industry’s $21.7 billion in expenditures in 2016 generated an estimated $49 billion in state and local economic activity (or $2.30 for every $1 of hospital expenditure) and indirectly supported more than 366,000 full-time jobs. In addition, hospitals often outsource responsibilities for support areas such as dietary, housekeeping, pharmacy and physician coverage. These people are still essential to operations and are employed due to the services provided by the hospital. Since they are not on the hospital payroll, their employment is neither reflected in the total jobs reported, nor accounted for in the multiplier effect.
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 for a diagram of this flow of funds.

Figure 1

Hospital Economic Impact on the Local and State Economy in Georgia

Every $1 of hospital expenditure generates $2.30 in state and local economic activity.**

Payers

Hospitals

Services

Salaries & Benefits

Goods

Property Tax*

Income*/Employment Tax

Sales Tax*

Government Treasuries

†Not-for-profit hospitals pay property taxes on locations where health care services are not being offered.
* Not applicable for not-for-profit hospitals
** Based on 2016 data
Being part of the community is a key component in the vision and mission statements of Georgia’s hospitals. Because health is about more than the absence of sickness or disease, Georgia hospitals reach out to their communities through their day-to-day operations and with programs and services that address community health needs. Hospitals look at both short-term and long-term health improvement; promoting healthy living; access and coverage; and quality of life. Health screenings, clinical services, support groups, research, subsidized health services, in-kind contributions, and the provision of indigent and charity care are just a few instances of hospitals’ efforts to improve the health of their communities. In 2016, Georgia not-for-profit hospitals provided more than $956 million in community benefit.\(^{13}\)

**Indigent, Charity and Free Care**

In 2016, hospitals cumulatively provided $1.06 billion in financial assistance through indigent, charity and free care.\(^{14}\) 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; and
- 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 currently no federally mandated or state-mandated requirements related to the amount of community benefit provided by hospitals, these amounts are closely watched 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 2016 Schedule H, Georgia’s not-for-profit hospitals provided $956 million in community benefit. This is in addition to amounts provided by these same hospitals in financial assistance for indigent and charity care. See Figure 2 for further detail.

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

- 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;\(^\text{16}\)
- 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.

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

*Figure 2*

**FY 2016 Community Benefits = $956 Million**

- Health Professions Education: 14.4%
- Subsidized Health Services: 26.2%
- Research: 1.2%
- Community Health Improvement Services: 1.4%
- Cash and In-Kind Contributions: 1.4%
- Community Building Activities: 8.5%
- Total: $461.9 Million

*GHA Hospitals 101* (page 10)
The most fundamental objective of any hospital is to improve the health of those it serves. Hospitals are increasingly tasked with improving the health of those among the community beyond the hospital’s campus. Recent payment reforms are now shifting to at-risk payment models whereby a portion of the hospital’s reimbursement is associated with improving the health and wellness of a particular population or group of patients.

In order to succeed under this scenario, hospitals must be able to enhance their long-standing missions for improving health with sophisticated information technology that enables them to coordinate care and track and manage the health of a population. Hospital-based Population Health Management aims to improve a population’s health, enhance individual patient satisfaction and reduce the per capita cost of health care.

Hospitals are tying together their community improvement efforts through their community health needs assessments and community health improvement plans to change the culture to one of health. Hospitals must collaborate with a wide variety of community partners and engage with the community to build an infrastructure for health.17
Payer Types
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.

• **Non-governmental or private (commercial) health plans** pay rates that are negotiated between the payer and the hospital through contracts, thus creating a network of providers that offer health services to patients who are insured by a particular health plan.

• **Government payers** usually pay the lowest rates and often do not cover the cost of the service. Types of government payers include, but are not limited to, Medicare, Medicaid, the U.S. Department of Veterans Affairs, and state and local correctional agencies.

• Patients who have no insurance coverage (i.e., the uninsured) are considered **self-pay**. Patients who have insurance that does not cover the entire cost of their care (e.g., deductibles or copayments) or that does not cover a particular service may also be considered self-pay. These types of patients are often referred to as “underinsured.”

  o Hospitals may work out payment plans with self-pay patients to receive some payment for the cost of care that was provided. A self-pay patient may qualify for the hospital’s indigent and charity care policy based on family income. In these cases, the hospital may 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 his or her income and a pre-established sliding scale.

  o Hospitals may also provide financial assistance on a case-by-case basis to patients who have exhausted their insurance benefits, who are underinsured and/or whose income or assets exceed financial eligibility criteria but face extraordinary medical costs.

• Hospitals may also receive payments from **other sources**, such as automobile insurance policies or workers’ compensation for patients who were injured in an accident.

*Figure 3 reflects the distribution of patients by payer types and the amounts received by hospitals.*
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 particular 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
Hospitals incur bad debt, which occurs when a patient does not pay his or her bill and does not qualify for the hospital’s indigent or charity care programs. Hospitals must cover bad debt losses from positive margins gained from other payers. According to the 2016 Georgia Department of Community Health’s Hospital Financial Survey, Georgia hospitals reported $775 million in bad debt cost, or about 3.6 percent of their total expenditures. In recent years, hospitals have seen escalating increases in bad debt due to higher patient cost sharing under most private insurance plans. Average bad debt increased 15 percent from 2015 to 2016, but declined slightly (by 0.4 percent) in 2017.
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 63 percent of all Georgia’s hospital encounters. As shown in Figure 4, PPS hospitals need to make a 28 percent profit on the remaining encounters from other payers to offset their uncompensated care.

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 56 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 2016, 46 percent of Georgia hospitals’ expenses covered payroll and employee benefit payments for 150,500 full-time employees. The average cost of a 2016 hospital admission in Georgia was around $10,800; however, costs varied widely depending on the services provided during the admission.

---

![Figure 4](image)

**2016 - Georgia PPS Hospitals**

**Cost Coverage by Payer to Break Even**

- **% of Cost Paid by Medicare**: 95%
- **% of Cost Paid by Medicaid**: 88%
- **% of Cost Paid by the Uninsured**: 22%

---

* considers DSH and Medicaid supplemental payments
Hospital Fiscal Health
As discussed in other sections of Hospitals 101, 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.

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 2017, the patient care margin for acute care hospitals in Georgia was 3.7 percent, with half of Georgia’s hospitals losing money based on the payments they received for taking care of patients. (See Figure 5 for more details on trends in hospital margins.) Hospitals must rely on other sources of revenue to achieve even exceedingly modest margins (especially by Wall Street standards). Revenue from supplemental governmental payments, investment income and other non-patient sources added 4.3 percent to the average margin in 2017.
While Georgia’s hospital industry is, on average, achieving modest margins, 44 percent of Georgia’s hospitals still lost money in 2017. This situation is significantly worse for rural hospitals, as 64 percent had negative total margins. 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. 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 eight Georgia hospitals since 2013.

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 to enable 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 every person who needs them. 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 percent are owned by U.S. entities and 17 percent 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 use 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 that 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.
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.\textsuperscript{24}

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 1.6 million Georgians were enrolled in Medicare coverage in 2017.\textsuperscript{25}

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

Medicare pays predetermined, non-negotiable fixed amounts for hospital services based on the patient’s diagnosis and treatment. For inpatient services, this is known as a DRG, or diagnosis-related group. For outpatient services, Medicare uses Ambulatory Payment Classifications (APCs). Services in each DRG or APC are similar clinically and require the use of similar resources. A payment rate is established for each DRG and APC.\textsuperscript{26} This Medicare payment methodology for inpatient and outpatient services is considered by Medicare as a Prospective Payment System (PPS).

Medicare payments vary among geographic regions to reflect local wage rates. For example, PPS hospitals in Georgia’s rural areas receive lower payment rates from Medicare than urban facilities. Likewise, southern states like Georgia receive lower payment rates from Medicare as compared to their northern peers, generally due to higher wages in that region of the country.

Overall, Medicare pays less than cost to most hospitals. In FY 2016, Medicare paid 93 percent of cost to PPS hospitals for inpatient and outpatient services.\textsuperscript{27} Medicare payments have been less than Medicare costs since 2002 and continue to remain below break-even, as shown in Figure 6.
Through aggressive cost cutting and efficiency improvements, hospitals were able to slowly reverse the downward negative Medicare margin trend beginning in 2007. Margins were on track to return to a positive status by 2010; however, additional federal budget-cutting measures that year eroded that improvement. The 2010 Patient Protection and Affordable Care Act (ACA), the Budget Control Act of 2011, the American Taxpayer Relief Act of 2012, the Bipartisan Budget Act of 2013, the Medicare Access and CHIP Reauthorization Act of 2015, the Bipartisan Budget Act of 2015 and the Bipartisan Budget Act of 2018 are expected to reduce future Medicare reimbursement to Georgia’s hospitals by up to 16.3 percent, accounting for $17.3 billion in revenue reductions between 2010 and 2027. Figure 7 reflects the reduction of Medicare revenue due to federal budget-cutting measures.
2. Medicaid
Established in 1965, Medicaid is available to low-income individuals, pregnant women, and the aged, blind or disabled. Jointly funded by the federal and state governments, the program is operated by the states and overseen at the federal level by the Centers for Medicare and Medicaid Services (CMS). Georgia’s Medicaid program is administered by the Georgia Department of Community Health.

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; and
- State residency requirements.
The federal government sets minimum standards, but states can choose to cover people at higher income levels and define additional eligible populations. Georgia Medicaid covered an average of 1.9 million beneficiaries each month during FY 2016. See Figure 8 for an overview of the populations who are eligible for Medicaid in Georgia.

As of January 2014, the federal Patient Protection and Affordable Care Act (ACA) provides enhanced federal funding to states that elected to expand Medicaid coverage to 133 percent of the Federal Poverty Level for all legal U.S. residents. As of 2018, the state of Georgia had not elected to expand Medicaid. The state originally estimated that almost 570,000 uninsured children and adults would have been eligible for new Medicaid coverage in 2014 had the state decided to expand.
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 July 2015 and based on hospital costs from 2011 through 2013.33

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

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

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

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

In FY 2016, Georgia Medicaid, under both payment arrangements, paid 13 percent less than cost for Medicaid inpatient and outpatient hospital services.34 See Figure 9 for more details.

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

- **FEDERAL SHARE**: The federal share is called the Federal Medical Assistance Percentage (FMAP) and the exact amount is determined annually by CMS based on each state’s per capita income. The lower the per capita income, the higher the FMAP. For FFY 2019, Georgia’s FMAP for Medicaid is 67.62 percent. Other states’ FMAPs range from 50.0 percent (multiple states) to 76.39 percent (Mississippi). As of January 2014, states that elected to expand Medicaid coverage up to 138 percent of the federal poverty level received 100 percent FMAP for the expansion population’s expenditures through 2016. Beginning in 2017, FMAP will be reduced for this population each year, reaching 90 percent by 2020 and remaining at that level.

- **STATE SHARE**: The state share is made available through the General Assembly’s annual appropriation to the Department of Community Health and other state agencies that pay for health care services for Medicaid members. Most state appropriations for Medicaid come from general state funds; however, a portion of the state share is paid for by fees or payments made to the state from (a) hospitals and nursing homes; (b) proceeds from the Tobacco Master Settlement Agreement; and (c) local Intergovernmental Transfers (IGTS). See Figure 10 for more details on the sources of Medicaid funding.
3. Special Supplemental Payments
Because hospitals do not receive sufficient payment to cover the costs of serving Medicaid and uninsured patients, some hospitals are eligible for special supplemental payments. In 2016, one-third of Georgians were either uninsured (12 percent) or enrolled in Medicaid (17 percent).38

Medicaid Disproportionate Share Hospital Program
The Disproportionate Share Hospital (DSH) program is a federal program that provides hospitals payment toward the cost of care for the uninsured and any remaining uncompensated Medicaid costs after Upper Payment Limit (UPL) payments are considered. (See page 26 for more information on UPL payments.) In FY 2016, uninsured patients paid only about 7 percent toward their cost of care.39

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

The Uninsured in Georgia:

- 1 in 8 Georgians, or 12 percent (1,266,000), is uninsured.
- Georgia ranks 3rd highest in the nation for the percentage of its citizens who are uninsured.
- 1 in 15 children in Georgia, or 6 percent (166,100), is uninsured.

SOURCE: Kaiser Commission on Medicaid and the Uninsured, 2016
The state must provide state matching funds to draw down the annual federal allotment. The state’s share is based on the state’s FMAP rate. In Georgia, public hospitals provide the state matching funds via intergovernmental transfers. Private hospitals must depend on an annual state fund appropriation for their state matching funds. The 2010 Patient Protection and Affordable Care Act (ACA) included significant cuts to the Medicaid DSH program beginning in 2014 through 2020, based on the premise that more patients will be insured due to the provisions of the ACA (e.g., participation in the Health Insurance Marketplace and Medicaid expansion) and, therefore, hospitals will not incur as much uncompensated care. Subsequent federal legislation delayed these cuts until 2020 but extended them through 2025. These cuts will occur regardless of a state’s decision to expand Medicaid. Nationally, available DSH funds will decrease by 24 percent beginning in FY 2020 and escalate to a 48 percent reduction by 2021. Georgia’s reductions are estimated to start at $73 million in FY 2020 (See Figure 11 for the estimated FY 2020 reductions by state) and increase to $145 million by 2021. In FFY 2018, Georgia’s federal DSH allotment was $302 million.

Figure 11

GHA Hospitals 101 (page 25)
Medicaid Upper Payment Limit Payments

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

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

In FY 2018, supplemental payments to all hospitals totaled $256 million, with $89 million made for targeted payments and $129 million made in residual payments to public and certain private hospitals. In the future, supplemental payments under the current UPL program are expected to decline due to ongoing reductions in Medicare payments (resulting in reductions in the maximum amount of Medicaid funds that can be paid).

UPL payments are funded with a combination of federal and state matching funds based on the FMAP for each state. In Georgia, the source of the state matching funds for residual UPL payments to public hospitals is intergovernmental transfers (IGTs) made by the local governmental entity affiliated with the public hospital. For targeted UPL payments and residual payments to critical access hospitals, the state matching funds have been made available through state appropriations. State matching funds for the residual payments to other private hospitals come from provider payments made by hospitals participating in the Hospital Medicaid Financing Program.
4. PeachCare for Kids
The State Children’s Health Insurance Program (SCHIP) was a 1997 expansion of the federal Medicaid program. If authorized by an act of a state legislature, SCHIP allowed states to cover additional children in families with incomes that were modest but too high to qualify for Medicaid. SCHIP funding used a federal funding formula that assigned a higher share of the program’s cost to the federal government than the Medicaid program; however, each state was capped at an annual allotment. Like Medicaid, states were required to match federal funds with state funds but at a lower rate as compared to Medicaid.

The Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009 extended and expanded the State Children’s Health Insurance Program (now referred to as CHIP) through 2013. Under the Act, CHIP continued as a capped program with enhanced matching rates. Each state received an annual allotment and states could receive federal funds for CHIP up to the allotted amount. A state match was still required. In 2010, the Patient Protection and Affordable Care Act (ACA) extended CHIP funding through 2015. Though funding was only appropriated through 2015, the ACA contains a Maintenance of Effort (MOE) clause that will require states to continue offering Medicaid and CHIP at 2010 levels until 2019. In 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) once again extended CHIP funding through 2017. More recently, Congress passed a six-year extension of CHIP funding as part of a broader continuing resolution to fund the federal government.43

In Georgia, the CHIP program is referred to as the PeachCare for Kids (PCK) program and covers children not eligible for Medicaid in families with annual incomes up to 247 percent of the federal poverty level (about $51,330 for a family of three).44 In FY 2018, Georgia covered an average of almost 132,500 children each month.45 This is down considerably from the FY 2014 average monthly level of 218,000 children. Effective January 1, 2014, PCK members ages six through 19 with incomes between 100 percent and 133 percent of the federal poverty level were transitioned to Medicaid as required by the ACA. Premiums are required for children ages 6 and over and are based on a sliding scale dependent on a family’s income as a percentage of the federal poverty level. For FY 2019, premiums range from a maximum of $36 for one child up to a maximum of $72 per family.46

Historically, Georgia’s enhanced FMAP for CHIP has been around 75 percent; however, beginning on October 1, 2015 through September 30, 2019, the CHIP FMAP will be increased by 23 points (up to a maximum of 100 percent) as a result of the ACA. Georgia’s enhanced FMAP will be at 100 percent for most program expenditures.47

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.

As of January 2018, the plan provided coverage for more than 663,000 members statewide at a cost of nearly $3.2 billion in SFY 2018. 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 Plan offers the following options:

- 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.

- 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 a HDHP also allows a member to utilize a Health Savings Account. The HDHP option is offered exclusively by United HealthCare.

The Plan utilizes separate vendors for pharmacy benefit management (Express Scripts) and wellness programs (Healthways, Inc.).

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

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

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

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

- The SHBP offers a TRICARE Supplement Plan to employees and dependents who are eligible for SHBP coverage and enrolled in TRICARE. 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.
1. Fully Insured Accident and Health Insurance Plans

Accident and health insurance plans are regulated by both 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. In 2017, the current administration unsuccessfully attempted to repeal the ACA; however, there are ongoing efforts to make changes to parts of the law. In early 2017 the Department of Health and Human Services cut funding for outreach and education and in December 2017, Congress passed the Tax Cuts and Jobs Act, which eliminated the individual mandate penalty, effective January 1, 2019. Uncertainty about the future of the ACA and continued losses by plans offered on healthcare.gov led to major premium increases and withdrawal of many plans from the Exchange in 2018. For 2019, however, plans appear to be expanding their presence and premiums have shown smaller increases and even some decreases.

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 Insurance and Fire Safety Commissioner (OIC) 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) and Provider Sponsored Health Care Plans (PSHCP).
The majority of 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. 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.

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.

Types of Plans
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 for HMO and POS plans; 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 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 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, of course, 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. 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. It is very likely there will be increasing regulation of the amount paid or the amount billed to the patient in the next few years.

Insurance Industry Evolution
Merger and acquisition activity in the insurance industry took a different turn after the U.S. 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 improve care management and customer experience. CVS and Aetna announced a $69 million merger in December 2017. In March 2018, Cigna and ExpressScripts announced a $52 billion deal. In July 2018, Humana, along with two private equity firms, finalized the purchase of Kindred’s home health and hospice services unit. Optum, a sister company of United Healthcare, has long focused on vertical integration, acquiring surgery, urgent care and physician practices over the past two years.

*The most current market share information published by the National Association of Insurance Commissioners for Georgia health insurers is shown in Figure 12.*
2. Health Insurance Marketplace

As a requirement of the 2010 Patient Protection and Affordable Care Act (ACA), most U.S. citizens and legal residents were required to have health insurance beginning in 2014. In Georgia, residents can purchase insurance coverage through the federally operated Health Insurance Marketplace. Individuals or families with incomes between 100 percent and 400 percent of the federal poverty level who purchase coverage through the Health Insurance Marketplace are eligible for tax credits, which will help offset their premium costs. (See Appendix A for an overview of Marketplace eligibility.)

In 2014, 317,000 Georgians enrolled in a Health Insurance Marketplace plan offered by one of five insurers. In more recent years, enrollment has been relatively stable after a spike in 2015 (see Figure 13). For the 2018 plan year, enrollment was the same as compared to 2017 with 480,000 Georgians enrolled in Marketplace plans offered by one of four insurers. One out of four of the 2017 enrollees are new to the Marketplace while the remaining enrollees were previously covered by the Marketplace in 2017. A majority of Georgia’s 2018 enrollees (85 percent) are eligible for tax credits to help offset their premium costs and 65 percent will receive cost sharing reductions. On average, available tax credits reduced monthly premiums by $545 per month.
Health Insurance Marketplace consumers in Georgia have access to multiple benefit plan designs offered by different insurers. Insurers do not offer their products in all counties of the state and for 2019, almost 75 percent of the counties in the state must pick from plans offered by only one insurer. 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 percent (Platinum) to 40 percent (Bronze).

A consumer’s share of the cost is paid through premiums, deductibles, and copayments 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.

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**

![Georgia Enrollment in the Health Insurance Marketplace](image-url)

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<th>New Enrollment</th>
<th>Referred to Medicaid</th>
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<td>2018</td>
<td>38,123</td>
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<td>333,846</td>
</tr>
</tbody>
</table>

*GHA Hospitals 101 (page 34)*
3. Self-Insured Employee Benefit Plans

In the United States, about two-thirds of the people that are not covered by government programs obtain their health care coverage through an employer. 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.

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.

To make the regulation of these plans consistent throughout the country, ERISA pre-empts state laws that “relate to” employee benefit plans. Whether a law “relates to” an employee benefit has been a frequent subject in federal court. 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 “Administrative Services Only” or ASO business. This can be confusing to hospitals because it is difficult to tell whether a patient is covered by a fully insured plan or an ASO plan. The reason this is important is that 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.
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.

Because workers’ compensation has its own statutory requirements, it is generally excluded from any legislative provisions enacted with respect to other insurance plans or health plans.
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. The General Assembly passed Senate Bill (S.B.) 24 in early 2013 that allowed for the continuation of the program through June 30, 2017. S.B. 70, passed in 2017, continues the program through June 30, 2020. S.B. 70 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. The department 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.

**The Hospital Provider Payment Program**

The Hospital Provider Payment Program (HPPP) requires that most Georgia hospitals make quarterly payments to the state based on a percentage of their annual net patient revenue. There are three types of hospitals that 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 percent of net patient revenue, while all other hospitals are subject to the payment rate of 1.45 percent. 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. As shown in Figure 14, in FY 2016, approximately 34 percent of the payments were used to finance the state share of a hospital Medicaid payment add-on of 11.88 percent while the remaining 66 percent was used as one of the fund sources for the state’s share of Medicaid payments to all providers.60 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 2019, hospitals will pay an aggregate of $315 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 2016 program activity, 47 hospitals had a cumulative net positive impact of $78 million, while almost two-thirds, or 77, had a cumulative net negative impact of $65 million. The individual hospital net impact in FY 2016 ranged from a loss of $7.7 million to a gain of $23.7 million.61

**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 2016, the third year of the Tier 2 program, 45 participating private hospitals received a total of $29 million after making $9 million in contributions.62 For the 34 Tier 2-eligible hospitals with net negative losses in the HPPP in FY 2016, Tier 2 payments eliminated the losses for eight hospitals and cumulatively reduced the losses of the remaining 26 hospitals by 41 percent.63 In FY 2018, 45 participating private hospitals received a total of $54 million after making $17 million in contributions.64
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, which 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.

It is a common misconception that hospitals can submit unpaid bills of indigent patients to the ICTF 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 for the distribution of funds types in the ICTF in 2018.) 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.
Rural Georgians are often older, poorer, and sicker than their urban counterparts, which makes rural health critically important to the state’s overall health. Many more Georgians live in urban areas (70 percent) than in rural areas (30 percent). 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. 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. The contributions are to be used for (1) the provision of health care services for residents in a rural county or (2) residents of the area served by a critical access hospital. In 2017, the General Assembly modified the program to (1) expand the number of rural hospitals eligible to participate, (2) increase the amount of tax credits, and (3) change the aggregate limits on the amount of tax credits available annually. In order for a rural hospital organization to be eligible to receive donations under the tax credit program, it must:

1. Be a licensed acute care hospital;
2. Provide inpatient hospital services in a rural county having a population of less than 50,000 or be designated as a critical access hospital;
3. Participate in Medicare and Medicaid and provide health care services to indigent patients;
4. Have at least 10 percent of its annual net revenue categorized as indigent care, charity care, or bad debt;
5. Annually file IRS Form 990 (Return of Organization Exempt from Income Tax) or the equivalent with the Department of Community Health; and
6. Be operated by a local hospital authority or be designated as a 501(c)(3) organization by the IRS.

Further changes made during the 2018 General Assembly included increasing the tax credit to 100 percent and making S-Corps eligible donors. Individual tax payers are allowed a tax credit equal to 100 percent of their contribution up to a maximum of $5,000 (single filer) or $10,000 (married couple filing jointly). Corporate tax payers are allowed a tax credit up to 100 percent of their contribution or 75 percent of the corporation’s income tax liability, whichever is less.

The legislation limits the annual aggregate amount of tax credits for all rural hospital organizations to $60 million. As of late 2018, the Georgia Department of Revenue was working to certify the exact amount donated to hospitals.

Tax credits per individual rural hospital organization are limited to $4 million annually. The Rural Hospital Tax Credit Program is automatically repealed on December 31, 2021.

**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; Hospital Services; Migrant Health, Homeless and Special Projects; and the Breast Cancer License Plate Program.
**Rural Hospital Stabilization Committee**
Governor 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 the flow of communication between hospitals and the state, and improve Georgia citizens’ access to health care.68

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 physicians.69 To date, 11 rural hospitals have served as sites for the program.

**Healthcare Georgia Foundation Initiatives**
The Healthcare Georgia Foundation (HGF) distinguishes that Georgia’s economy has two distinct areas: a vibrant metropolitan Atlanta area and the other rural communities throughout the state. This “two Georgias” distinction also applies to the growing disparities in health and health care between the state’s metropolitan areas and rural communities. As HGF’s mission is to advance the health of all Georgians and to expand access to affordable, quality health care for underserved individuals and communities, the Foundation developed *The Two Georgias Initiative* in 2016. The goal of the Initiative is to foster health care innovation by supporting local partnerships seeking to improve health and expand access to quality health care services in Georgia’s rural communities. As a component of the Initiative, the HGF made grant funding available to support local partnerships working to improve access to affordable, quality health care in rural Georgia communities.

The Healthcare Georgia Foundation’s mission is to advance the health of all Georgians and to expand access to affordable, quality health care for underserved individuals and communities.
**Rural Development Council**

Recognizing Georgia's low rural rankings in health status nationally, during the 2017 Legislative Session, the Georgia General Assembly passed House Resolution (H.R.) 389 to establish the House Rural Development Council. The Council is a two-year working group whose members examine the unique issues impairing the stabilization and growth of rural communities in Georgia. The group meets on a regular basis across the state to hear from citizens, businesses and organizations about challenges rural Georgians face.

At the end of the first year, the group released several recommendations for improving health care in rural areas of the state. These include streamlining health care services billing; requiring telehealth capability in nursing homes; providing premium relief for rural practitioners who live and have a practice in rural counties and accept Medicare and Medicaid; and expanding the scope of practice for health care workers who are not physicians to allow them to provide certain services for minor care, chronic case management, urgent care, telemedicine, and post-hospital visits to avoid readmissions.

Many of these recommendations were addressed with the passage of House Bill (H.B.) 769 during the 2018 General Assembly. The bill was the culmination of work completed by the Council in 2017 and contains multiple provisions aimed at addressing the ongoing shortage of health care providers in rural Georgia. It eases restrictions on the use of remote order entry in hospital pharmacies when a pharmacists is not available to be physically present in the facility; directs the state Medicaid agency to streamline the provider credentialing and billing processes and to update its payment policies for telehealth services; and creates a new grant program for physicians who practice in underserved rural areas of the state.

Areas of focus during 2018 included economic development, Certificate of Need, and increasing the health care workforce.

**GHA Center for Rural Health**

The Center for Rural Health is a department within the Georgia Hospital Association that represents the interests of Georgia’s small rural hospitals with an average daily (inpatient) census of 75 or fewer and located in a county with a population of 75,000 or fewer. The Center for Rural Health represents the needs of Georgia’s small and rural hospitals to promote accessibility to high-quality and cost-efficient health care, and to act as a central agency for the study, discussion, resolution, and dissemination of ideas and information that addresses problems faced by small and rural hospitals. There are 74 hospital members of the Center for Rural Health.

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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.

In 2017, Georgia hospitals were conservatively estimated to have provided at least $658 million in care to uninsured patients in their emergency departments. The number of emergency room (ER) visits by patients without insurance (also known as “self-pay”) has decreased by 6 percent since new commercial health insurance coverage is available through the Health Insurance Marketplace (see Figure 16); however, these self-pay visits still account for a quarter of all visits to the ER.

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**Figure 16**

*Trends in Emergency Room Use Commercial Coverage vs. Self-Pay*  
*July 2013 - June 2018*

- ER Visits with Commercial Insurance
- Self-Pay ER Visits

6% since 2013

↑19% since 2013

Federal Health Insurance Marketplace Coverage Begins January 1, 2014
Trauma Care
Most hospitals are capable of providing some level of trauma care; however, only 28 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. Of Georgia’s trauma centers, five are Level I centers, nine are Level II centers, six are Level III centers and six are Level IV centers. There are two pediatric trauma centers and designated burn centers. See Figure 17 for a map of the trauma centers as of January 2019.

In 2009, the Super Speeder law was enacted to discourage trauma-causing behavior by increasing fines for dangerous drivers. 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. The Super Speeder law 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 $21.8 million in Super Speeder funds in the AFY 2018 budget and $16.7 million in FY 2019. The Super Speeder law has generated $164.3 million in revenue since its inception. This is an average of approximately $20 million per year after the full implementation.

In 2016, the Georgia General Assembly passed legislation that called for 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. It is estimated that $177,000 was collected for these services in FY 2018 and $354,000 in FY 2019 from the tax.

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. 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 Commission’s FY 2018 budget is $16.4 million. 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 the uncompensated costs of providing trauma care.
Georgia’s Shortage of Nurses
Health care is the fastest-growing industry. It represents 18 percent of the nation’s Gross Domestic Product (GDP) and employs 12 percent of the U.S. workforce.78 The ratio of job openings to available workers in the health care industry was 2-1 in 2017. More than 1 million health care jobs were open in 2017 and one-third of new jobs added between 2016 and 2024 is expected to be in the health care industry.79

Hospital employee turnover has been rising since 2011, from 13.5 percent to 18.2 percent in 2017. The total hospital turnover for the Southeast region was 18.4 percent. Turnover for registered nurses (RN) has also increased, from 11.2 percent in 2011 to 17.2 percent in 2015. Turnover for bedside RNs ranges from 6.8 percent to 28.7 percent with the average turnover rate at 16.8 percent.80

The 2018 GHA Compdata Survey for Georgia showed a statewide RN turnover rate of 12.4 percent. A survey of newly licensed RNs shows that 17.5 percent leave their job in the first year, 33.5 percent in the second year and 43 percent within three years of employment. Turnover for each RN is estimated to cost hospitals an average of $46,500.81

The reason health care workers quit is not much different than other industries; however, the demand and cost of health care turnover is higher than other industries, placing a significant financial drain on already diminishing financial resources. Voluntary terminations accounted for 91.1 percent of all hospital separations and 75 percent of those terminations are considered preventable. The top five reasons cited for RNs leaving their positions in 2017 included career development, work-life balance, manager behavior, relocation, and well-being.82

Revamping the approach to tackling hospital turnover is critical in addressing the labor shortage in health care. Every hospital faces the challenge of retention, from entry level positions to professional RN positions, making the willingness to improve and innovate increasingly important. Retention strategies need to be developed in collaboration with the current workforce by seeking to understand what drives the different generations to find purpose, meaning and fulfillment. Millennials are becoming the largest part of the health care workforce, valuing freedom, mission and technology and having a place where they want to come to work. Incorporating the ideas and expectations of the employees in developing retention strategies will have a positive impact on reducing turnover and improving recruitment.

Long-term retention and recruitment strategies are imperative to building a sustainable health care workforce pipeline. As the health care industry faces unprecedented challenges and continual change, value must be placed less on competition and more on collaboration with workforce partners, university systems, community providers, chambers of commerce, economic development groups, philanthropic funders and government organizations. These partnerships will allow hospitals to leverage the resources that are available to recruit, train, and prepare the health care workforce of the future. Moving beyond everyday problem solving and envisioning what is needed, now and in the future, expands the realm of infinite solutions for developing and retaining the health care workforce of the future.
Additionally, the physician workforce supply and demand issue is a national concern. Physician demand is continuing to grow faster than the supply, with the increasing demand coming from population growth, aging, the prevalence of chronic disease, physician retirement, the trend toward physicians working fewer hours, fewer medical school applications and the physician burnout crisis. The projected physician shortfall is estimated to be between 42,000 and 121,300 physicians by 2030.83

With the uncertainties in health care, the physician workforce supply and demand information is continually monitored and updated. Multiple approaches are being taken to address the shortage, including delivery innovations, team-based care, improved technology use and training more physicians.

**Georgia’s Shortage of Physicians**
Georgians’ access to physician care is limited relative to citizens of other states. According to America’s Health Rankings, Georgia ranked 41st in the nation in 2017 in the number of primary care physicians per 100,000 in population and had approximately 19 percent fewer primary care physicians per capita than the average.84 An estimated 3 million, or 28 percent, of Georgians live in counties designated as medically underserved by the federal Health Resources and Services Administration (HRSA). Medically Underserved Areas are areas designated as having too few primary care providers, high infant mortality, high poverty or a high elderly population.85

Physician workforce shortages can threaten a hospital’s ability to provide a full spectrum of care to its community. In Georgia, physician shortages have the most impact on primary care in rural communities; however, shortages in specialty and subspecialty areas impact the entire state.

Hospitals play a significant role in physician recruitment and retention. In more rural areas, the hospital often does the physician recruiting for an entire community. Hospitals actively work with residency programs and medical schools to identify new physicians who can replace current physicians as they retire or move or can add capacity to a growing patient community. A hospital’s acquisition of a struggling physician practice is an emerging trend in rural areas of Georgia. It is also becoming more common for a hospital to hire a private-practicing physician as an employee of the hospital. In many cases, these actions are the only way a hospital can help to maintain necessary physician services for the community.
Georgia Board for Physician Workforce

The Georgia Board for Physician Workforce (GBPW) is a state agency responsible for advising the Governor and the General Assembly on physician workforce and medical education policy and issues. The 15-member Board 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.86

Preceptor Tax Incentive Program

In 2014, legislation was enacted that creates tax deductions of up to $10,000 for uncompensated community-based faculty physicians who provide training to medical, physician assistant, and nurse practitioner students.

Under Senate Bill (S.B.) 391, 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, can claim a tax deduction of $1,000 for every 160 hours of training provided. 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.87

Hospitals’ Financial Support of Health Care Education

Georgia hospitals have contributed millions of dollars to support health care education. In 2016, not-for-profit hospitals alone reported $462 million in community support of health professions education.88 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.
HIPAA and the HITECH Act

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law, passed in 1996, which, among other things, included new laws regarding the privacy and security of health care data that eventually led to the development of extensive rules that now govern how “covered entities,” including hospitals, use and disclose a patient’s health information. For example, a hospital may use or disclose a patient’s health information to enable providers to treat the patient, to obtain payment for services and for certain purposes of the hospital’s own operations, such as its quality and patient safety initiatives.

HIPAA requires hospitals to use and disclose only the minimum amount of health information necessary to accomplish the intended purpose and to create safeguards to ensure the privacy and security of health information. HIPAA also limits the amounts hospitals and other providers may charge patients for copies of their medical records and creates new rights for patients, such as the right to request restrictions on how their health information is used and disclosed and the right to receive an account from hospitals of certain types of disclosures of their health information.

In 2009, Congress passed a new law, the Health Information Technology for Economic and Clinical Health Act (HITECH), which significantly expanded the HIPAA privacy and security requirements. For example, the HITECH Act requires hospitals to inform patients when there is a security breach involving their unsecured health information and more directly regulates subcontractors or “business associates” that handle 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. It may include all key administrative clinical data relevant to that person’s care under a particular provider, including demographics, progress notes, problems, medications and other treatments, vital signs, past medical history, immunizations, laboratory data and radiology reports. The EHR automates access to information and has the potential to streamline the clinician’s workflow. The EHR also has the ability to support other care-related activities, directly or indirectly, through various interfaces, including evidence-based decision support, quality management and outcomes reporting.

EHRs are the next step in the continued progress of health care that can strengthen the relationship between patients and clinicians. The data, and the timeliness and availability of it, will enable providers to make better decisions and provide better care. For example, the EHR can improve patient care by:

- Making health information available;
- Reducing duplication of tests and delays in treatment;
- Ensuring patients are well informed to make better decisions; and
- Reducing medical errors by improving the accuracy and clarity of medical records.89
In one of its many provisions, the HITECH Act made federal incentive payments available to doctors and hospitals when they adopt EHRs and demonstrate use that can improve quality, safety and effectiveness of care. These funds were first available to eligible providers serving Medicare and Medicaid patients in September 2011 and will continue through 2021. As of August 2018, Medicare had paid Georgia hospitals more than $681 million and Medicaid had paid Georgia hospitals more than $320 million in incentive payments for EHR adoption.¹⁰

Many hospitals will use these payments to help cover the cost of their investment in EHR technology and its meaningful use. As of 2015, hospitals that are not meaningful users of EHR technology are subject to reductions in their Medicare payments.

**Georgia Health Information Exchange**

A Health Information Exchange (HIE) allows physicians, nurses, certain qualified health care professionals and patients to securely access and share a patient’s electronic health record. In Georgia, the Georgia Health Information Network (GaHIN) serves with the Georgia Department of Community Health (DCH) and the Georgia Health Information Technology Extension Center (GA-HITEC) in a public-private collaborative to enable Georgia’s statewide health information exchange. The statewide HIE interconnects regional area HIEs, large integrated health systems, payers, wellness partners, state agencies and other health care organizations. The state HIE will ultimately serve as the vehicle for data sharing across state lines through the Nationwide Health Information Network (NwHIN). The meaningful use of EHRs, patient engagement, as well as patient safety and quality improvements are key to the state HIE success.
Ensuring quality and patient- and family-centered safe care is the top priority in every hospital. Georgia hospitals 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. Approximately 105 of Georgia’s hospitals are accredited by The Joint Commission, the nation’s oldest and largest standards-setting and accrediting health care body. Forty-two hospitals are accredited by 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.

Quality in a hospital can be broken down into three areas: clinical quality, patient safety and patient perception. Clinical quality is the actual medical care that a patient receives. Core measures are one way to measure this type of quality, which are founded on proven evidence-based medicine. These measures assess the process of care a patient receives based on a disease-specific category. For example, did a heart attack patient receive an aspirin upon arrival in the emergency room? Did a stroke patient receive blood clot prevention treatment within two days of arriving at the hospital? 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 continually make environments safe for patients and families. Staff members are also surveyed as to their perception of patient safety in the hospital in order 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 32 questions in seven areas. Some examples include: 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 19 depicts the significant number of entities that are involved in this process and the following sections further discuss these efforts.*

**Hospital Improvement Innovation Network (HIIN)**
GHA partners with the American Hospital Association (AHA) Hospital Research and Educational Trust (HRET) on the Centers for Medicare and Medicaid Services (CMS) Partnership for Patients Hospital Improvement Innovation Network (HIIN) initiative. Through the HIIN, GHA works with 97 hospitals to reduce all-cause inpatient harm by 20 percent and readmissions by 12 percent by 2019. GHA develops learning collaboratives for hospitals; conducts intensive training programs to help hospitals make patient care safer; and tracks and monitors hospitals’ progress in meeting quality improvement goals.
Proprietary Voluntary Quality and Safety Programs

Many hospitals seek voluntary accreditation from national entities recognized in the health care industry as having developed exceptional standards to which a hospital can be compared. Hospitals utilize these 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.

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 data-driven quality improvement projects with health care providers. The Beneficiary and Family-Centered Care (BFCC) QIOs respond to the appeals of Medicare beneficiaries and monitor the quality of care provided, including the investigation of complaints.\(^93\)

Alliant Quality is the Georgia QIN – QIO.\(^94\) Alliant Quality assists hospitals, nursing homes, home health agencies, physician offices, and communities with redesigning processes and developing organizational cultures to accelerate the rate of quality improvement. A key strategy involves building trusted relationships, forming partnerships with other professional organizations and collaborating with others to extend the reach and broaden the effectiveness of quality improvement efforts.

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 2018, 11 hospitals and four health systems received GHA/PHA Quality & Patient Safety 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 in order to eliminate preventable health care-associated infections (HAI).

Physician Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires all physicians who are not part of an Accountable Care Organization or other alternative payment model to adopt standardized quality improvement practices to avoid a 4 percent payment penalty.

In 2017, the Centers for Medicare and Medicaid Services (CMS) implemented the Quality Payment Program (QPP) to help physicians comply with the provisions of MACRA. The QPP analyzes hospital data and offers feedback and resources to help physicians provide the best possible care. Physicians can choose how to participate based on their practice sizes, specialties, locations, or patient populations.

The QPP has two tracks available for eligible professionals to choose: Advanced Alternative Payment Models (APMs) give added incentive payments to provide high-quality and cost-efficient care.
The Merit-based Incentive Payment System (MIPS) will adjust payments based on individual performance. It is a payment mechanism that will provide annual updates to physicians beginning in 2019. These updates are based on performance in four categories: quality, resource use, clinical practice improvement activities, and meaningful use of an EHR system. Both APMs and MIPS required physician practices to submit performance data since 2017, which will impact their payments in 2019.  

**Transforming Clinical Practice Initiative**

The Transforming Clinical Practice Initiative (TCPI) is the single largest demonstration initiative from the Center for Medicare & Medicaid Innovation in the nation’s history. Designed to support more than 140,000 clinician practices over a four-year period, it includes Practice Transformation Networks (PTN), which help clinicians transition from fee-for-service payment models to value-based, advanced payment models.

The Compass PTN is one of 31 awarded by the Center for Medicare & Medicaid Innovation. Formed in September 2015 by the Iowa Healthcare Collaborative and several other health care organizations, it includes more than 7,000 primary and specialty care clinicians across Georgia, Iowa, Kansas, Nebraska, Oklahoma, South Dakota, North Dakota and Wisconsin.

The Georgia Hospital Research and Education Foundation is implementing TCPI with a variety of clinicians, such as primary and specialty physicians, nurse practitioners, physician assistants, and their practices. The TCPI focuses on helping reduce unnecessary testing, costs, and emergency department utilization. More than 1,000 clinicians in Georgia are participating in the Compass PTN.

*The PTNs are peer-based learning networks designed to assist clinicians in moving through the TCPI Five Phases of Practice Transformation (see Figure 18).*

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*Figure 18*

- Set Aims
- Use Data to Drive Care
- Achieve Progress on Aims
- Achieve Benchmark Status
- Thrive as a Business via Pay for Value Approaches
The TCPI Five Phases of Transformation approach allows clinician practices to become actively engaged in the transformation and ensures collaboration among a broad community of practices that create, promote, and sustain learning and improvement across the health care system. Compass PTN quality improvement advisors work with clinicians to coach, mentor and assist in the identification and development of core competencies necessary to transform their practices. Additionally, Compass PTN helps clinicians thrive in the value-based environment, meet quantifiable improvement outcomes, and achieve the Triple Aim of providing better care, lower costs and improved health. Clinicians and practices also receive assistance on how to participate in shared savings and other pay-for-value programs.

Clinicians also have access to Support and Alignment Networks, a system for workforce development using national and regional professional associations and public-private partnerships currently working in practice transformation efforts. These networks help ensure the sustainability of the practice transformation efforts.

In the final year of Compass PTN, Georgia clinicians continue to receive evidence-based resources to improve their provision of health care. Quality improvement advisors are working with the practices to provide access to quality improvement and patient engagement resources designed to help streamline clinical processes and improve patient safety. Clinicians are able to implement clinical performance measurement and reporting, quality improvement, patient-centered care and population health management now, before they are mandated through payment mechanisms. The Compass PTN positions clinicians to lead, guide and influence the future of health care.

**Care Coordination Council**

The Georgia Care Coordination Council was created to support a patient- and family-centered health collaborative where every Georgian experiences a seamless continuum of care. The purpose of the Council is to identify care coordination opportunities and develop an annual plan to improve health outcomes. The council meets quarterly.

When the Care Coordination Council was established in 2007, its focus was readmission reduction. Since then, it has expanded into population health. The Council has reached out to Georgia communities and local health groups to demonstrate the value of inclusivity and care collaboration in the State of Georgia. In 2019, the Care Coordination Council will focus on patient and family engagement and the benefits of health care organizations partnering with patients and families to improve quality and safety.

The Care Coordination Council consists of individuals who represent the spectrum of health and health care. Members are individuals who have been patients; providers such as hospitals, home health, physicians, palliative care, hospice, long term care facilities, pharmacists; agencies and entities such as departments of community health, private health plans, care management organizations, quality improvement networks; and the community such as academia, area agencies on aging, the regional commission, and area health education centers.
Roles and responsibilities of the Care Coordination Council are based on an annual action plan that includes targets to accelerate readmission reduction in the state of Georgia. The Council offers guidance on collaborative models that promote a seamless patient- and family-centered continuum of care and support transparency and public information related to care coordination. There are two workgroups within the Council. The Medication Management workgroup focuses on how to improve care coordination through medication adherence. The Education workgroup hosts 30-minute webinars throughout the year on various evidence-based topics to show organizations how to improve the continuum of care.

The Care Coordination Council encourages the engagement of frontline staff to ensure care coordination processes are standardized, systematic and reliable. The council also reviews and endorses appropriate metrics to drive care coordination and readmission reduction efforts.

**Physician Credentialing**

Credentialing is the basis for appointing health care professionals to the medical staff of a hospital or other health care organizations. The process of credentialing is used by hospitals to ensure the qualifications of a licensed physician 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.
Certificate of Need

Georgia, like most states, has a health planning law known as Certificate of Need (CON), which is administered by the Department of Community Health (DCH). The CON law plays an essential role in helping 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 provide 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 2008, following a lengthy and exhaustive review of the existing CON laws, the General Assembly passed Senate Bill (S.B.) 433, a bill that revised and streamlined the CON process, while reaffirming the critical role it plays in ensuring access to quality health care services for Georgia’s citizens. Since the passage of S.B. 433, a Senate study committee, as well as the Governor’s Rural Hospital Stabilization Committee, have recommended no changes to the CON program. However, in 2018, the General Assembly, with the support of the hospital community, passed House Bill (H.B.) 769, creating a new CON exemption for micro-hospitals. A micro-hospital is defined as a 24/7 facility that provides stabilization services, contains two to seven inpatient hospital beds, and is located in a county with a population of 50,000 or less. The exemption would be allowed only when an existing hospital purchases a closing hospital in a contiguous county in order to repurpose the facility as a micro-hospital. The goal of this change to the CON law was to create additional options for rural communities to maintain access to health care for their residents. Importantly, the legislation was able to accomplish this goal without eroding the CON program.
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

Licensure of individual health care providers such as physicians, physician assistants and nurses is a function of the state. In Georgia, the Composite Board of Medical Examiners 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 Board of Medical Examiners
medicalboard.georgia.gov

Secretary of State
Professional Licensing Board Division
sos.georgia.gov/plb

Board of Pharmacy
www.gbp.georgia.gov

Board of Dentistry
www.gbd.georgia.gov
Like all health care providers, hospitals are subject to billing and payment scrutiny by the administrators of the Medicare and Medicaid programs as well as by commercial insurers. The following sections discuss some of these federal and state efforts.

**Medicare and Medicaid Audit Contractors**

In the *Tax Relief and Health Care Act* of 2006, Congress required the Centers for Medicare and Medicaid Services (CMS) to establish a national Recovery Audit Contractor (RAC) program to be in place by January 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. The Medicare RAC is just one of many entities with the authority to audit Medicare claims. Others 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. Under the current plan for fiscal years 2014 through 2018, the agency plans to expand the use of Medicaid data, provide additional program integrity resources to state Medicaid programs, and streamline the federal program integrity contractors.

In 2010, as part of the *Patient Protection and Affordable Care Act* (ACA), Congress expanded the RAC to Medicaid. In 2012, Georgia selected Myers and Stauff er as its RAC contractor to implement the Medicaid RAC program. Like the Medicare RAC program, federal law requires the state to pay the Medicaid RAC contractor(s) on a contingency fee basis 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.

It is important to note that Medicaid RACs supplement, rather than replace, other auditors, including the DCH Program Integrity Unit and the federal auditors discussed above, even though all are charged with reviewing Medicaid claims to identify overpayments. This level of seemingly parallel oversight adds to the administrative costs hospitals incur to demonstrate regulatory compliance to multiple entities.
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. By analyzing and comparing providers to their respective peer groups, abnormal patterns of practice can be identified. 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 19 depicts a summary of all the entities that are involved in these efforts.*
Accreditation - Certification by a recognized organization that an individual, a service or a 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, but are not limited to, 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 percent 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.


**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.
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.

Source: www.dch.georgia.gov - FY 2018 Disproportionate Share Hospital (DSH) calculations from the Department of Community Health.


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The TRICARE Supplement Plan is sponsored by the American Military Retirees Association (AMRA) and is administered by the Association & Society Insurance Corporation.

National Association of Insurance Commissioners Accident & Health Insurance 2016 Market Share Report

Profile of Affordable Care Act Coverage Expansion Enrollment for Medicaid/CHIP and the Health Insurance Marketplace 10-1-2013 to 3-31-2014. ASPE Marketplace Summary Enrollment Report.


GHA analysis of 2019 Qualified Health Plan landscape data from

https://data.healthcare.gov/dataset/QHP-PY19-Medical-Individual-Landscape-Zip-File/m2uk-wyvh/

http://kff.org/other/state-indicator/total-population/


Previous GHA Hospital 101 publications utilized data reported by the Department of Community Health through February 2017 to calculate the fiscal impact of the Hospital Provider Payment Program (HPP) and the Medicaid Hospital Financing Program. In the spring of 2017, DCH identified an issue with the reporting that resulted in an understatement of the amounts returned to hospitals in the Hospital Provider Payment Program. Beginning in the fall of 2017, the Georgia Hospital Association began using alternate data sources to estimate fiscal impact pending the correction of HPP data reported by DCH. The most recent year of alternate data available for the HPP is state fiscal year 2016 (as of December 2018).

Georgia Hospital Association analysis of the Department of Community Health Hospital Provider Payment Program Tracking Report, July 2018 and FY 2018 Medicaid DSH Limit Calculations for 2016. Provider Payments made to the state available on https://dch.georgia.gov/Medicaid-providers.

Department of Community Health, Hospital Medicaid Financing Program Payment Model, SFY 2018.
Georgia Hospital Association analysis of the Department of Community Health Hospital Provider Payment Program Tracking Report, July 2018; FY 2018 Medicaid DSH Limit Calculations for 2016; Provider Payments made to the state available on https://dch.georgia.gov/hospital-providers; and FY 2018 Hospital Medicaid Financing Program Payment Model.

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http://dch.georgia.gov/rural-hospital-stabilization-committee


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Georgia Discharge Data System. May 2017 Query of Emergency Room Patients by Primary Payer Category.

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Source: 2016 IRS Form 990, Schedule H for 83 not-for-profit hospitals and health systems.


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https://qioprogram.org/about/what-are-qios

http://www.alliantquality.org

https://qpp.cms.gov/

*All information in this guide is current as of January 2019.
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