

Hospital Handbook

**The current state of
hospital finance and
policy in Georgia.**

2025

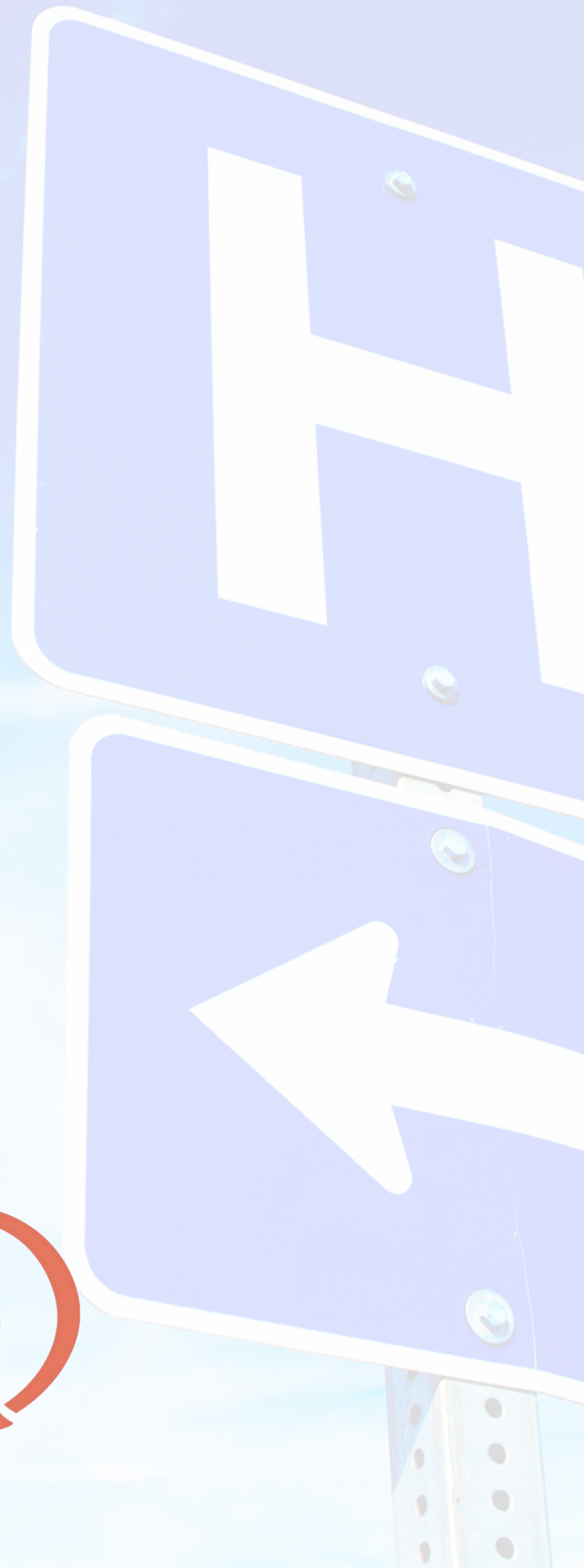


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Inside the H

Hospitals are one of the first places people turn to for care and treatment, but they provide more than traditional inpatient services. Their impact extends beyond their walls and into their communities.

This publication attempts to explain the many complexities of our health care system, and our hope is that it will help provide a better understanding of hospitals and health care in Georgia.

Take note of the 'Inside the H' sidebars in which key points are highlighted.

**24 hours a day.
7 days a week.
365 days a year.**

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

Hospital Quick Facts

Number of Georgia Hospitals:

General Acute Care Hospitals/Campuses.....	99
Rural Emergency Hospitals.....	3
Critical Access Hospitals.....	30
Psychiatric/Behavioral Health Hospitals.....	22
Specialty Hospitals.....	26
Veterans Affairs Hospitals.....	3

* 104 of 159 Georgia counties have a hospital

Patient Utilization (FY 2024):

Inpatient Admissions.....	1.2 million
Outpatient Visits.....	13 million
Total.....	14.2 million

Patient Utilization by Insurance Status (FY 2024):

Employer/Private Insurance.....	5 million
Medicare.....	4.9 million
Medicaid.....	2 million
Uninsured.....	1.4 million
Other.....	800k
Total Visits and Discharges.....	14.2 million

183 Total Hospitals

Hospital Employment (2021):

Number of Full-Time Hospital Jobs.....	156,681
Salaries and Benefits.....	\$15.2 billion
Contract Labor.....	\$2.2 billion

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

Hospital Uncompensated Care (2023):

Indigent, Charity and Free Care.....	\$1.7 billion
Bad Debt.....	\$0.8 billion
Total.....	\$2.5 billion

Percent of Hospitals with Operating Losses (2023) Considering:

Patient Care Revenue Only.....	50%
All Revenues.....	39%

17 Hospital Closures (since 2013)

- Calhoun Memorial Hospital
- Stewart-Webster Hospital
- Charlton Memorial Hospital
- Lower Oconee Community Hospital
- Emory-Adventist Hospital
- North Georgia Medical Center
- Lake Bridge Behavioral Health
- Southwest Georgia Regional Medical Center
- Kindred Hospital Rome
- Northridge Medical Center
- Select Specialty Hospital – Northeast Atlanta
- Select Specialty Hospital - South Atlanta
- Chestatee Regional Hospital
- Southern Crescent Hospital for Specialty Care
- Crescent Pines Hospital
- Coliseum Center for Behavioral Health
- Wellstar Atlanta Medical Center
- Wellstar Atlanta Medical Center South



The Standby Role Makes Hospitals Unique

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.

Three things make the role of the hospital unique from other health care providers. Together, these are known as the standby role of hospitals:

- **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.
- **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. The standby role is an essential component of our nation's health and public safety infrastructure,¹ but is not explicitly funded. Instead, the funding for hospitals to be at the ready is built into their overall cost structure and supported by revenues received from providing direct patient care.

In addition to their standby role, hospitals can be differentiated from other health care providers because of the community benefits they provide. These are services that hospitals provide outside of traditional treatment and include things such as health screenings, clinical services, support groups, research, subsidized health services, and health professions education. Recent data shows Georgia hospitals provided \$1.5 billion in community benefits.

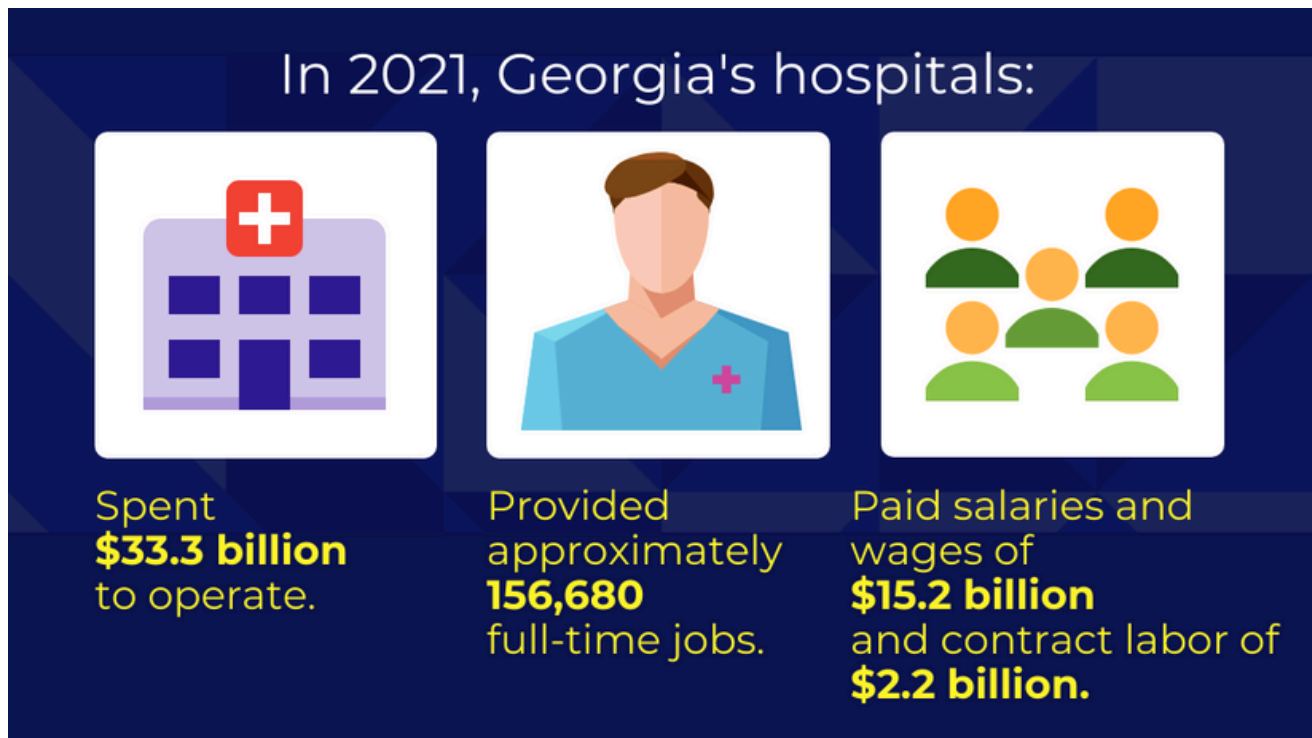
Economic Impact

The Health Care Industry in Georgia

In 2021, the health care and social assistance industry was the third-largest employment sector in Georgia.² It is a major economic engine for Georgia and is considered key to the state's efforts to recruit and retain new and expanding businesses. The health care industry:

- Directly contributed \$40 billion, or 6.4%, to Georgia's Gross State Product (GSP).³
- Provided 9.5%, or 581,000, of the state's jobs.⁴

Economic Impact of Georgia Hospitals

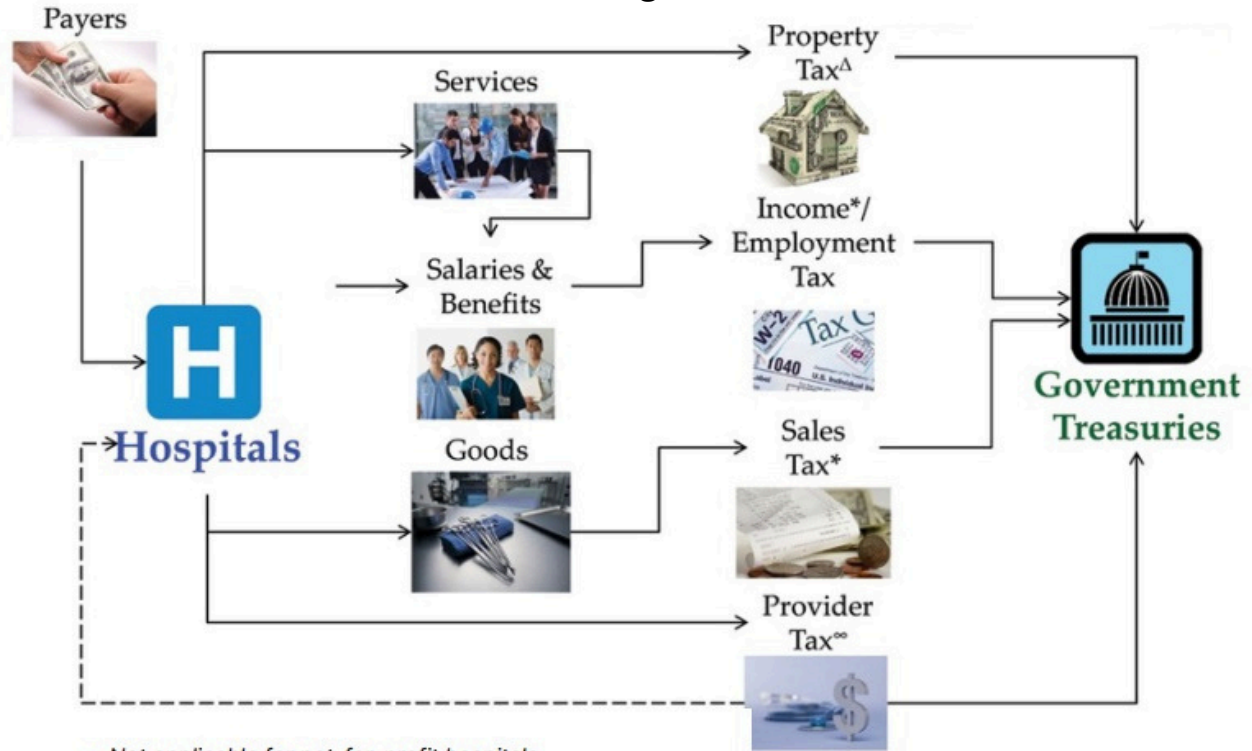


A majority of revenue received by hospitals is spent on wages and salaries as well as goods and services necessary to operate a hospital. These wages and salaries are then distributed throughout the local community when hospital employees spend their earnings on goods and services. The wages are subject to various state and local taxes, which in turn support state and local governmental treasuries.

See Figure 1 on page 6 for a diagram of this flow of funds.

Figure 1

Hospital Economic Impact on the Local and State Economy of Georgia



• Not applicable for not-for-profit hospitals

•• Based on 2021 data

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

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

Every \$1 of hospital expenditure generates \$2.28 in state and local economic activity.**



Types of Hospitals

Hospital Classifications

The Georgia Department of Community Health defines a hospital as “any building, facility, or place in which two or more beds and other facilities and services that are used for persons received for examination, diagnosis, treatment, surgery, or maternity care for periods continuing for 24 hours or longer and which is classified by the department as a hospital.”

Endnote: Comp. R. & Regs. R. 111-8-40-.02(f).]

Hospitals are either not-for profit or for-profit. 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 go toward the benefit of the hospital community.

For-profit, or investor-owned hospitals, are publicly traded or privately owned and pay taxes on hospital property and purchases. For these facilities, the profit or loss of the hospital is a direct profit or loss for the shareholders (owners) of the hospital.

Underneath the umbrella of the not-for-profit and for-profit classifications are the following:

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.

Critical Access Hospitals (CAH) are limited-service, acute-care hospitals located in rural areas and may receive enhanced payments from Medicare. There are 30 critical access hospitals in Georgia compared with 34 only a few years ago.

Some hospitals are owned by a **hospital authority**. This is a statutorily created public corporation that is a political subdivision of local government and authorized to create and operate a hospital in a county or municipality. Many hospital authorities use a not-for-profit company to handle daily operations, and these are commonly referred to as “restructured hospital authorities.

'Rural emergency hospital' is a new designation established in January 2023 in response to rural hospital closures and to give rural communities more options to maintain access to care. These hospitals provide emergency department services, observational care, and additional outpatient and health services (if elected). The average annual patient length of stay at rural emergency hospitals must be 24 hours or less. Patients needing to be admitted for inpatient hospital services are transferred to a full-service hospital.

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

A **hospital system** is a hospital or collection of hospitals that all operate under a single corporate entity and may own or operate other lines of business, like a skilled nursing facility, pharmacy, or physician practice.

Teaching hospitals are facilities that have been approved to participate in residency training by the Accreditation Council for Graduate Medical Education⁵ and/or have a residency or internship program(s) approved by the American Osteopathic Association and/or are members of the Council of Teaching Hospitals.

Inside the H

- There are **183** hospitals in Georgia.
- There are **99** general acute care hospitals in Georgia.
- There are **41** investor-owned hospitals in Georgia.
- **Critical Access Hospital** is a special Medicare designation for payment that is limited to hospitals with **no more than 25 beds** and an average length of stay fewer than four days.
- There are **30** critical access hospitals in Georgia.
- The term "non-profit" does not mean that the hospital does not make a profit. Instead, profits of the hospital are returned to the control of the hospital for operations rather than to investors.



Community Benefit

As integral parts of their communities, hospitals work to improve the short-term and long-term health of residents by promoting healthy living and quality of life. They also work to expand health care coverage and access to care. Not-for-profit hospitals are required by federal law to provide community benefits, but investor-owned hospitals also provide community benefits above and beyond any indigent and charity care. The most recent data shows that Georgia not-for-profit hospitals provided more than **\$1.5 billion** in community benefit. Additionally, they provided about \$2.88 million in community building activities, which are not eligible to be reported as community benefits, but still play an important role in enhancing community wellness. These include physical improvements and housing, economic development, community support, environmental improvements, leadership development and training, coalition building, community health improvement advocacy, and workforce development.⁶

Indigent, Charity and Free Care

In state fiscal year (SFY) FY 2021, in addition to the \$1.5 billion provided in community benefit, hospitals cumulatively provided **\$1.7 billion** in financial assistance through indigent, charity and free care.⁷ This number is based on the actual cost of care, which is provided to patients who typically do not have insurance or who cannot afford their deductible or copayment and have family incomes that qualify them 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 and community benefits. Not-for-profit hospitals are federally required to report to the IRS on five general categories of community benefits.

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

Accountability

The amount of community benefit provided by hospitals is watched closely by the IRS and other taxpayer advocacy groups to ensure not-for-profit hospitals are accountable for their tax-exempt status. Georgia hospitals report to the state annually on the amount of indigent and charity care they provide, and not-for-profit hospitals are required to post information about their finances on their websites.



Inside the H

Additional community benefit mandates on not-for-profit hospitals require them 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;⁸
- Limit amounts charged to uninsured individuals eligible for financial assistance to no more than they generally bill to patients who have insurance; and
- Forego extraordinary collection actions before the hospital has made reasonable efforts to determine whether the individual is eligible for financial assistance.

Social Determinants of Health

Social determinants of health are defined as “the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”⁹ Health inequities contribute to health disparities, a well-documented factor in both the cost of care and quality outcomes. Health equity means that every person has an opportunity to have optimal health regardless of race, ethnicity, level of education, gender identity, sexual orientation, employment status and/or disability.



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

Understanding Your Hospital Bill

Payer Types

A lot goes into determining what patients will pay for any given service. First, we must understand how payer types impact what patients will actually pay for services. **Hospitals are required by federal law to charge the same amount for any service, regardless of whether the patient is insured or the type of insurance the patient has (private, government such as Medicare or Medicaid, uninsured, etc.).** However, payments for hospital services are often very different depending on the type of insurance.

Private Insurance

Patients with private or commercial insurance will see an adjustment reflecting the difference in the hospital's standard charges and the amount the insurance company will pay. The amount the insurance company pays is determined by the patient's health plan benefits and whether the insurer has a pre-existing contract with the hospital.

Government Payers

Medicare and Medicaid pay the lowest rates, and the payments often do not cover the cost of rendering the service. Medicare rates are pre-determined and non-negotiable. Medicaid is operated at the state level and is jointly funded by federal and state governments.

Georgia's Medicaid program is administered by the Georgia Department of Community Health (DCH) and pays a predetermined fixed amount for hospital services based on patients' diagnoses and treatments. Payments are not guaranteed to cover the current costs of care, except for payments to critical access hospitals and state hospitals, which are paid at 100% of cost.



Additional Payer Types

Indigent, Charity, and Free Care

Indigent care is the uncompensated care hospitals provide to patients whose family income is less than or equal to 125% of the federal poverty limit (FPL). Charity care is uncompensated care hospitals provide to patients whose income is greater than 125% of the FPL. Eligibility for charity care is driven by internal policy of the facility. Other free care is usually provided as a part of community benefit like a residency clinic or other partnerships for “free” community care offered outside of indigent or charity care parameters with no expectation of payment. This category is used for any free care or discounted care that does not fall into one of the previous categories.

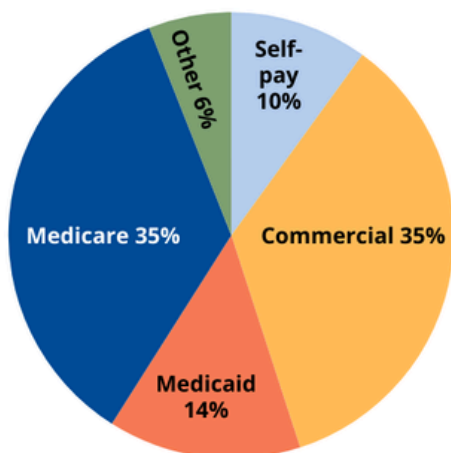
Bad Debt

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

Other Sources of Payment

Hospitals may also receive payments from other sources, such as automobile insurance policies for patients injured in an accident.

Figure 2 CY 2024 Hospital Patients by Payer Source



Inside the H

Charges vs. Payments

Hospitals charge the same prices to all patients as required by federal law.

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

The federal government sets the hospital payment rates for Medicare. The state government sets the payment rates for Medicaid. Private insurance companies negotiate payment amounts with hospitals. Many uninsured or self-pay patients are eligible for discounts under the hospital's financial assistance policy.

Figure 2 below reflects the distribution of patients by payer types.

Patient Billing

Elements of a hospital bill are universal; however, the format may vary. A hospital bill will begin with the amounts the hospital charges for the services that were rendered. **Hospitals are required to charge the same amount for any service regardless of the patient's payment source.**

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

Bad Debt Cost Analysis

According to the 2022 Georgia Department of Community Health's Hospital Financial Survey, Georgia hospitals reported \$727 million in bad debt cost, or about 2.3% of their total expenditures. Average bad debt decreased 14% from 2021 to 2022.

Subsidizing Uncompensated Care

To make up for deficits from Medicare, Medicaid and the uninsured, hospitals must make up that lost money from other payers. Together, Medicare, Medicaid and uninsured patients account for 59% of all Georgia's hospital encounters.¹⁰

As shown in Figure 3, PPS hospitals need to make a 16% profit on the remaining encounters from other payers to offset their uncompensated care.¹¹

Hospital Expense

In 2021, 46% of Georgia hospitals' expenses covered payroll and employee benefit payments for 156,680 full-time employees. Hospitals spent an additional \$2.2 billion on contract labor. The average cost of a 2022 hospital inpatient admission in Georgia was around \$15,500; however, costs varied widely depending on the services provided during the admission.¹²

Figure 3

Subsidizing Uncompensated Care from Government Payers and Self-Pay 2021

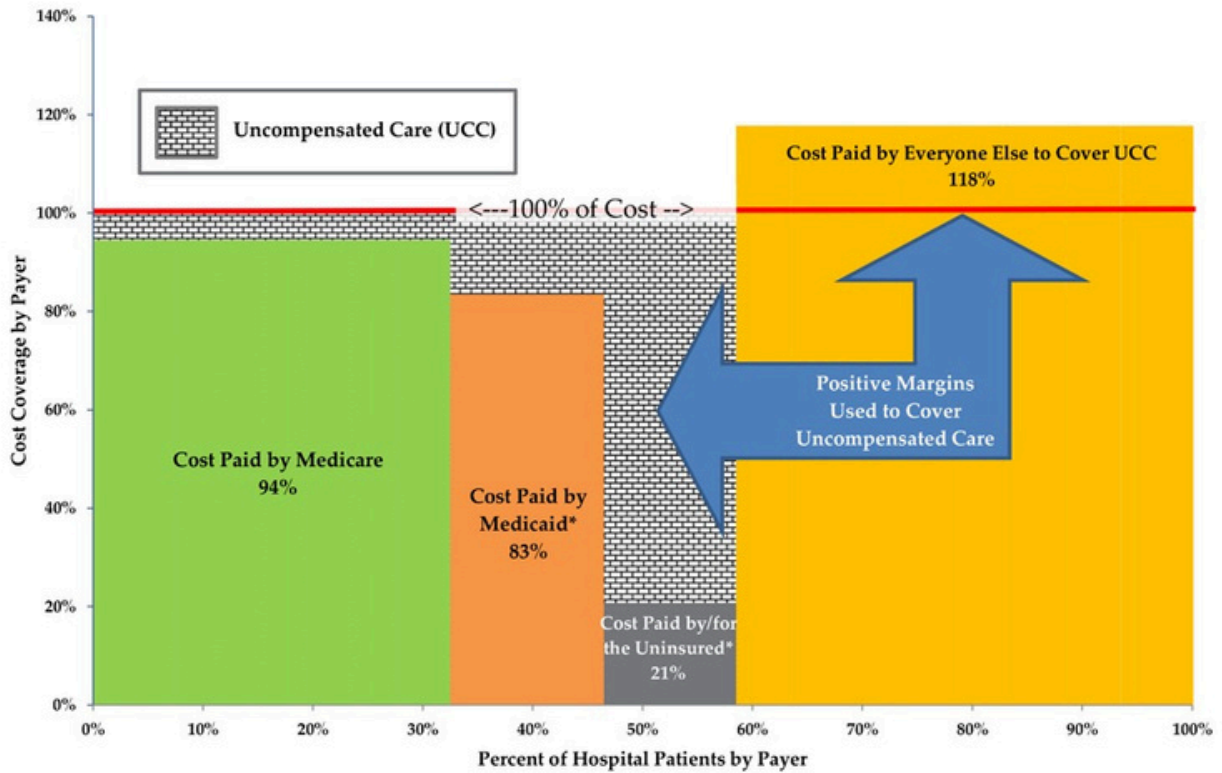
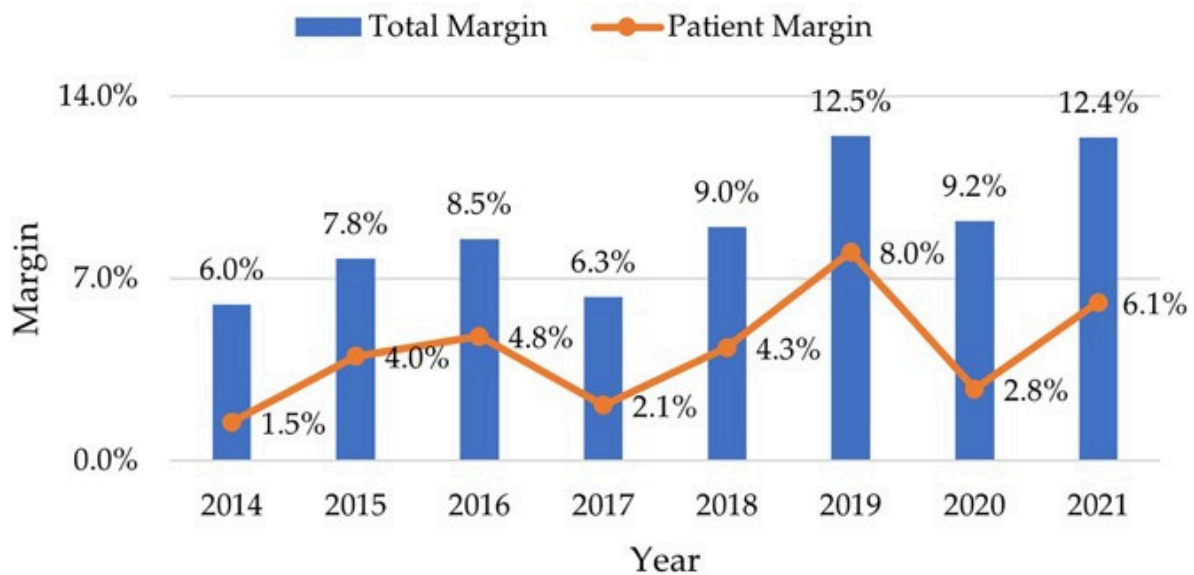


Figure 4

Trends in Hospital Margins



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

Hospital Fiscal Health

Like any business, hospitals incur costs to provide health care services but, unlike other businesses, hospitals don't always get fully reimbursed. 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). These situations present challenges to hospitals' fiscal health.

Hospitals measure their fiscal health by the amount of funding they have in "reserve," which is typically reported as "days cash on hand." This number tells how many days a hospital could continue to operate without any revenue. To run efficiently, the hospital must have money left over after accounting for all other costs (positive operating margin). To do this efficiently, the hospital must have a positive operating margin. Hospitals are then 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.

On average, Georgia's hospital industry is achieving modest margins. Almost one-third, or 29%, of Georgia's hospitals lost money in 2021 and 44% of rural hospitals had negative total margins. Hospitals can cope with negative operating margins in the short term by:

- Carefully controlling cash flow.
- Using revenue from other lines of business the hospital may own (e.g., a nursing home).
- Delaying capital improvements.
- Reducing expenses.

These are only short-term solutions, and hospitals that are unable to maintain positive operating margins will likely face closure sooner or later. Unfortunately, 16 Georgia hospitals have closed since 2013.

See Figure 4 on page 15 for more details on trends in hospital margins. Hospitals must rely on other sources of revenue to achieve modest margins.

Inside the H

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

In 2022, the patient care margin (i.e., revenue and expenses from patient care) for all hospitals in Georgia was 5.2%, with 54% of them losing money based on the payments they received for taking care of patients. Revenue from supplemental governmental payments, investment income and other non-patient sources added 4.2% to the average margin in 2022.¹³

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.

Reserves

Hospitals must maintain financial reserves to ensure their long-term financial viability. Hospitals must have reserves if they want to be able to borrow money from financial institutions for capital improvements, 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.

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

Captives

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. Like all businesses, hospitals purchase insurance to protect themselves. Captives are licensed insurance companies used by hospitals as financial safety nets to be able to face unexpected events, including legal challenges. Having this protection allows hospitals to focus their efforts on treating patients and providing important community services. Captives may also provide more coverage than traditional commercial insurance carriers.

Captives also help protect hospital organizations from the risk of potentially frivolous lawsuits. Current tort laws in Georgia have encouraged extremely high jury awards and incentivized lawsuits in cases where mediation may have been a viable option. Frivolous lawsuits lead to increased cost of care for all Georgia's patients and impact hospitals' ability to provide high-quality care to all, including Georgians in need of high-risk services. Hospitals take on this financial risk and must have a way to insure themselves so they can continue providing care to their communities.

Who Pays Your Bill?

Most Georgia hospitals depend heavily on payments for services provided to patients insured by governmental programs. For example, the Medicare and Medicaid programs account for almost half of the typical hospital's net patient revenue.¹⁴

1. Medicare

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 1.38 million Georgians were enrolled in Medicare coverage in 2022.¹⁵

Traditional Medicare pays predetermined, non-negotiable fixed amounts for hospital services based on the patient's diagnosis and treatment, whereas the Medicare Advantage program requires hospitals to negotiate payment rates with private Medicare managed care plans. Medicare payments reflect local wage rates and Southern states like Georgia receive lower payment rates from Medicare compared to their northern peers, generally due to higher wages in that region of the country.

Medicare payments have been less than Medicare costs since 2002 and continue to remain below break-even, **as shown in Figure 5 on page 19.**

Several pieces of federal legislation over the past several years have reduced Medicare reimbursement to Georgia's hospitals and these reductions are expected to continue. **See Figure 6 on page 19.**

Inside the H

Medicare serves most people aged 65 or older regardless of income.

Overall, Medicare pays less than cost to most hospitals. In FY 2021, Medicare paid 92% of cost to PPS hospitals for inpatient and outpatient services.¹⁶

Almost 1.4 million Georgians were enrolled in Medicare coverage in 2022.²⁰ Medicare is made up of:

- Part A, inpatient hospital benefits.
- Part B, outpatient and physician services.
- Part C, an option to receive benefits through private insurance plans known as "Medicare Advantage" plans.
- Part D, Medicare's prescription drug plan.

Figure 5

Georgia PPS Hospital Medicare Margins 2011-2020

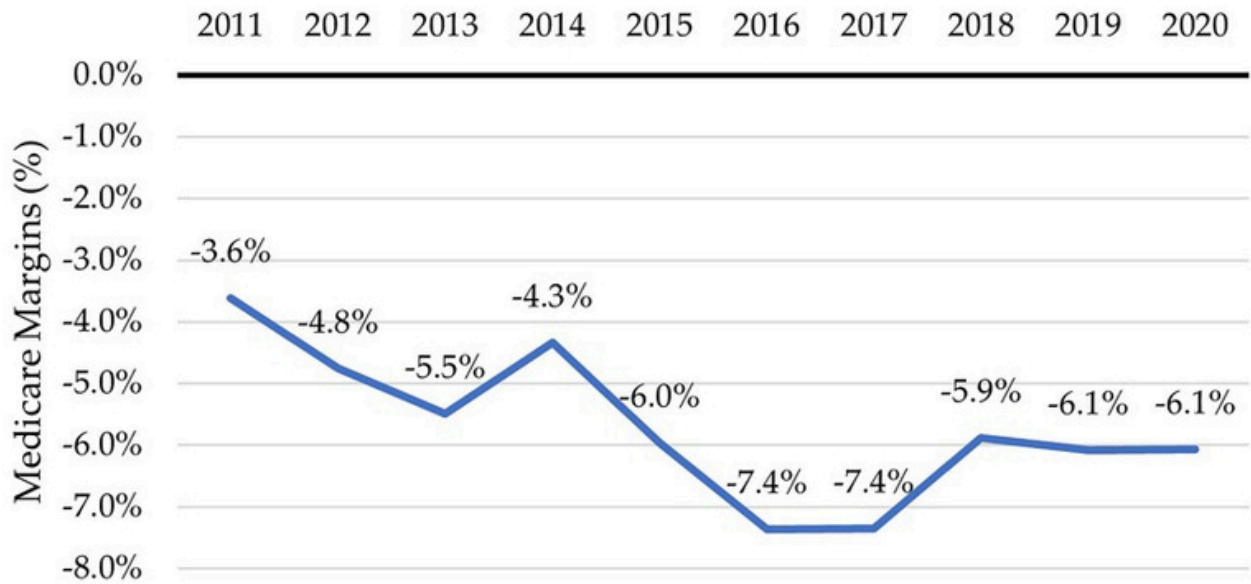
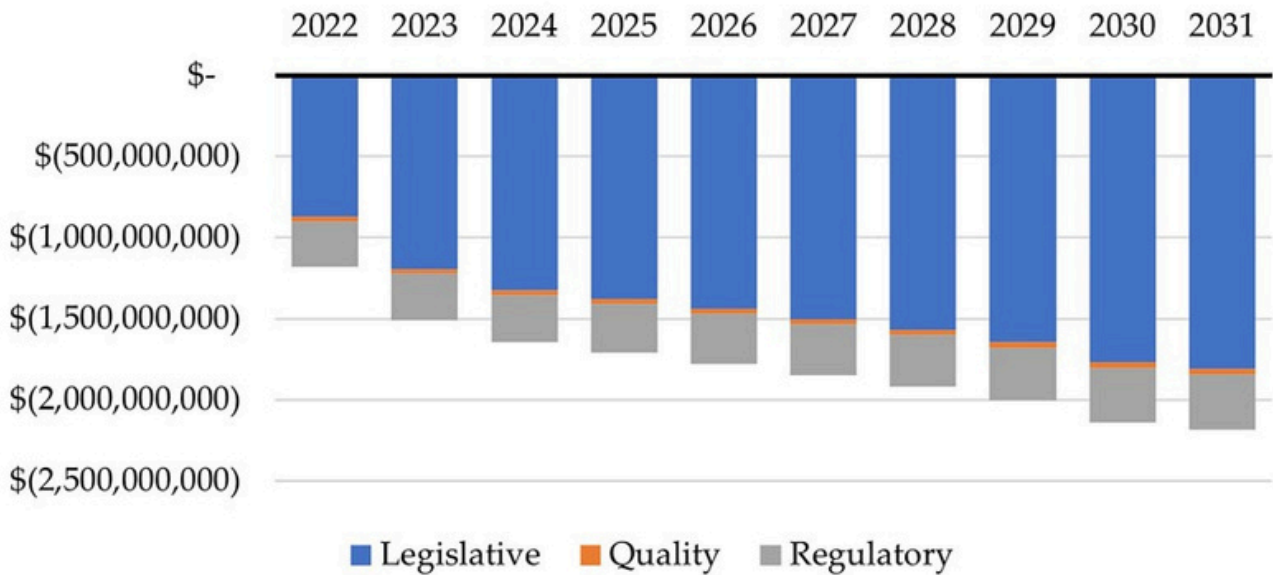


Figure 6

Medicare Cuts by Type of Federal Action Cumulative Impact on Georgia Hospitals



2. Medicaid

Medicaid is available to low-income individuals, pregnant women, and the aged, blind or disabled. Jointly funded by the federal and state governments, the program is operated by the states and overseen at the federal level by the Centers for Medicare & Medicaid Services (CMS). Georgia's Medicaid program is administered by the Georgia Department of Community Health.

Georgia Medicaid covered an average of 2.25 million beneficiaries each month during FY 2021.¹⁸

The federal government sets minimum standards, but states can choose to cover people at higher income levels and define additional eligible populations. **See Figure 7 on page 21 for an overview of the populations to whom Medicaid is available in Georgia.**

Medicaid Coverage Gap and the Uninsured

Georgia has the third-highest percentage of uninsured residents, at 11.7%. Many in this category are also in the Medicaid coverage gap: They cannot afford private insurance yet make too much to qualify for Medicaid. As of mid-2023, Georgia had 252,000 adults in the coverage gap.¹⁹ Compared to other states, Georgia historically ranks low in terms of the percentage of state spending that is allocated to Medicaid. Only 23% of Georgia's state spending goes to Medicaid, ranking it 32nd in the nation. The most recent data shows that Georgia spent about \$5,953 per full benefit enrollee compared to the United States average of \$9,303.²⁰

In 2022, Georgia expanded post-partum coverage for Medicaid beneficiaries to one year and in July 2023 implemented Georgia Pathways to Coverage, a limited Medicaid expansion for adults up to 100% of the federal poverty level who meet certain work, community service, or educational activities.

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Who is Eligible for Medicaid?

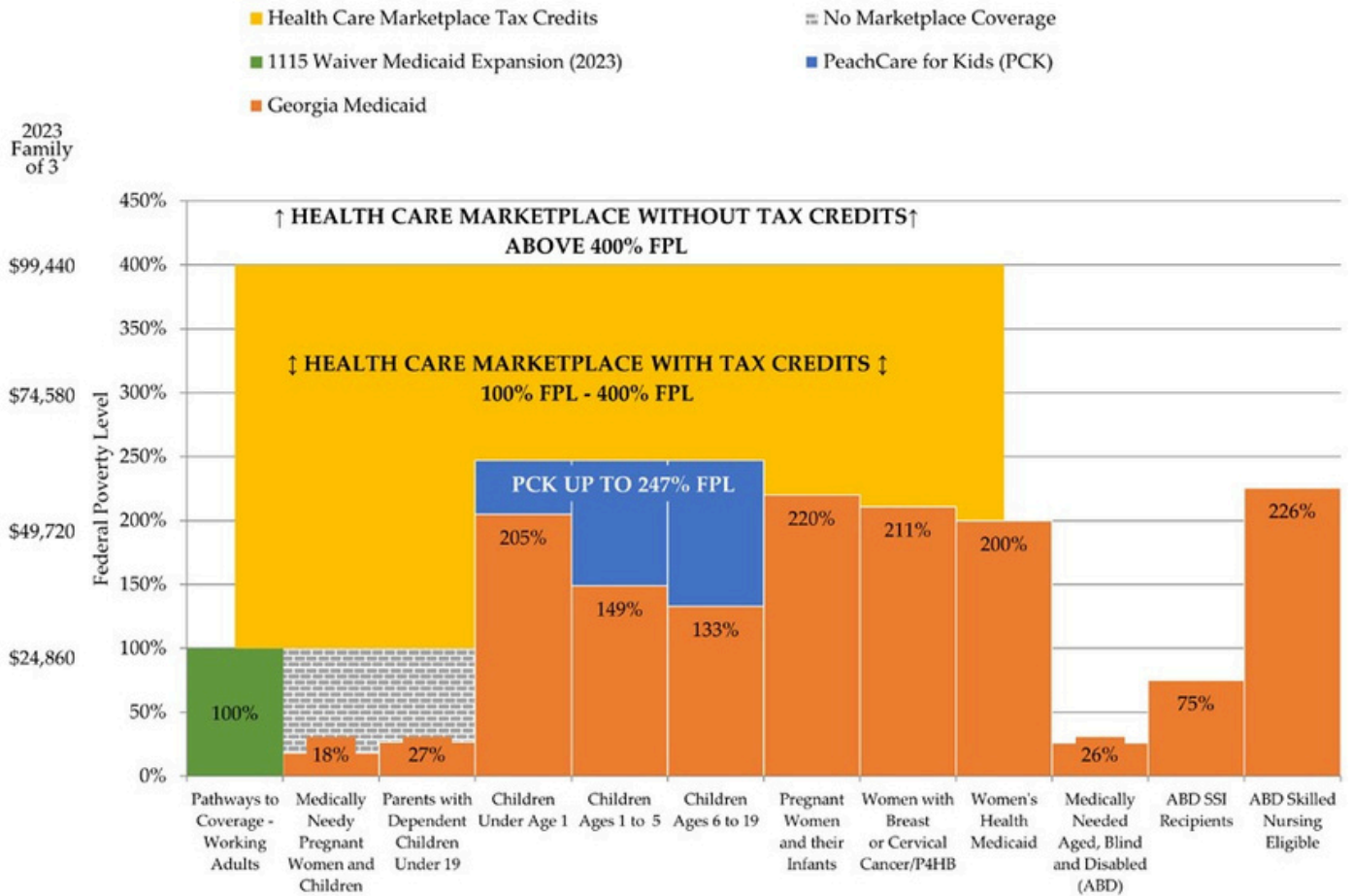
Contrary to popular belief, Medicaid does not provide coverage to all low-income people.

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;¹⁷
- State residency requirements.



Figure 7



Inside the H

The **Patients First Act** authorized the Georgia Department of Community Health to submit a Section 1115 Medicaid Waiver request to CMS. It also authorized Gov. Kemp to submit a Section 1332 State Innovation Waiver to pursue health insurance coverage solutions for the commercial health insurance marketplace.

The first, **Georgia Pathways (1115 Waiver)**, provides health coverage to Georgians who meet certain work, community service, or educational requirements, either by enrolling them in Medicaid or covering a portion of an employer-based health plan.

The second, **Georgia Access (1332 Waiver)**, allows the state to operate its own insurance exchange or marketplace for consumers to shop for or purchase health insurance plans and creates a state reinsurance program in which Georgia uses the money to help insurance companies cover the cost of their sickest patients.

How Does Medicaid Pay?

Georgia Medicaid covers inpatient and outpatient hospital services under two different payment arrangements:

1. Fee-for-service (FFS)

Under FFS, a hospital bills the state for each covered service provided to a Medicaid patient. The hospital is paid a standard and predetermined amount per service based on Medicaid payment policies.

2. Care Management Organizations (CMOs).

Under the CMOs, Georgia Medicaid pays a fixed monthly payment to a CMO based on how many Medicaid members are enrolled in the CMO's plan. The CMO is then responsible for paying hospitals (providers) for covered services provided to enrolled members. The hospital bills the CMO for services that have been negotiated between the hospital and the CMOs for the hospital to participate in the CMO's provider network.

In FY 2021, Georgia Medicaid, under both payment arrangements, paid 24% less than cost for Medicaid inpatient and outpatient hospital services.²¹ **See Figure 8A and 8B for more details.**

Figure 8A Cost Covered by Medicaid Payment* 2021

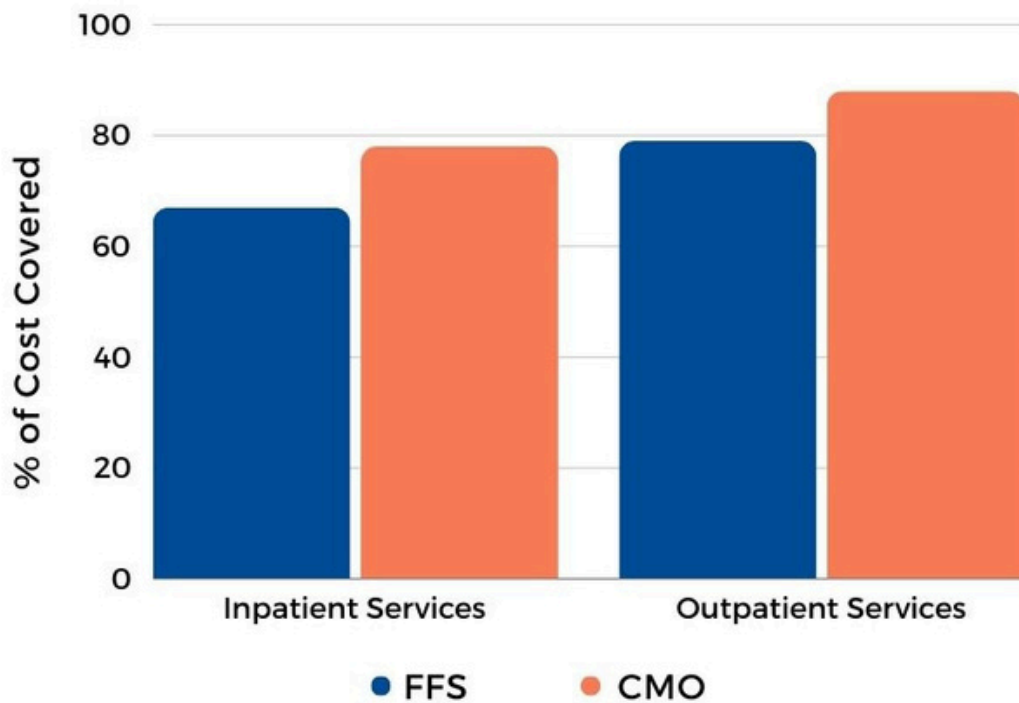
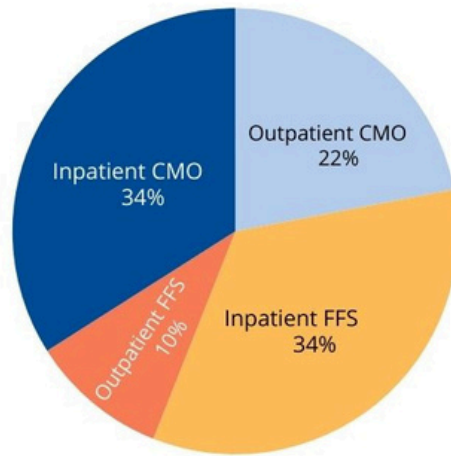


Figure 8B

Hospital Medicaid Payments 2021



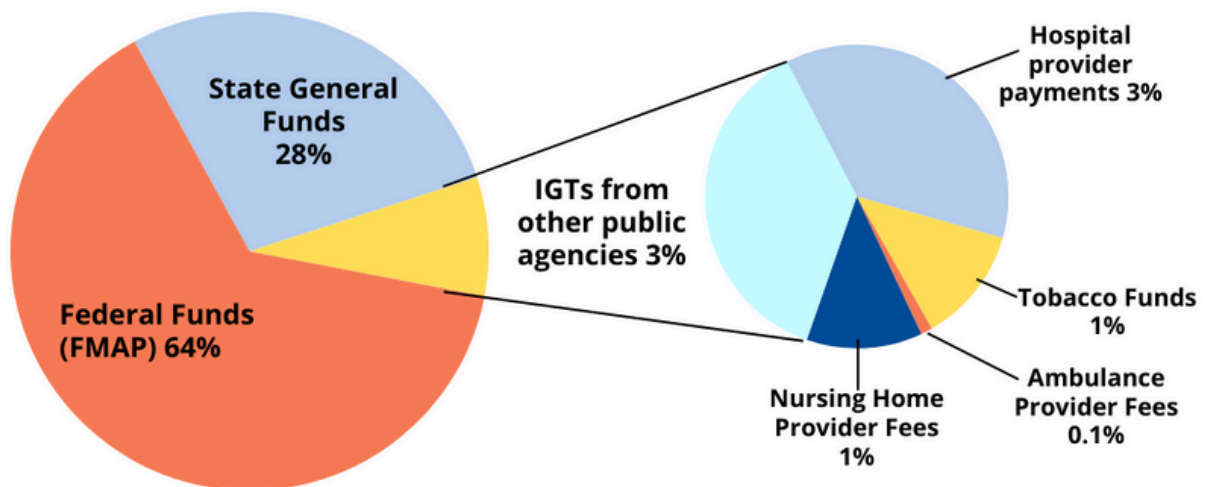
How is Medicaid Funded?

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

Figure 9 details the sources of Medicaid funding.²²

Figure 9

FY 2024 Appropriated Fund Sources for Medicaid \$13.2 Billion



3. Special Supplemental Payments

The federal Disproportionate Share Hospital (DSH) program provides hospitals payment toward the cost of care for the uninsured and any remaining uncompensated Medicaid costs.

Federal legislation delayed planned DSH cuts required by the Affordable Care Act until at least March 2024 and extended them through 2028.²³ The cuts will occur regardless of a state's decision to expand Medicaid. Nationally, available DSH funds will decrease by \$32 billion beginning no earlier than March 8, 2024. Georgia's annual federal DSH allotment is projected to be reduced by 48%, going from \$339 million to \$176 million.²⁴

The Medicaid Upper Payment Limit (UPL) program and the Directed Payment Program (DPP) help fund regular Medicaid payments that are less than cost and are paid in addition to regular Medicaid payments. Payments from UPL and DPP help qualifying hospitals offset the cost of serving Medicaid and uninsured patients.

Figure 10 on page 26 provides more detail about these programs. In 2022, almost one-third of Georgians were either uninsured (11.7%) or enrolled in Medicaid (18%).²⁵

Inside the H

The Uninsured in Georgia

- About 1 in 8 Georgians, or 11.7% (1,290,400), is uninsured.
- Georgia ranks third-highest in the nation for the percentage of its citizens uninsured.
- About 1 in 16 children in Georgia, or 6.1% (172,100) is uninsured.

SOURCE: Kaiser Commission on Medicaid and the Uninsured, 2021

After considering all payment sources for Medicaid and the uninsured, hospitals were paid 84% of cost for Medicaid and 21% for the uninsured in FY 2021. ³⁰ offset these remaining cost deficits, hospitals need to receive payments from other payers in excess of cost to break even.

Directed Payment Program Payments

In 2021, the Department of Community Health implemented the Directed Payment Program (DPP) mentioned above. DPP is a supplemental payment program designed to increase payments for hospital services provided to Medicaid managed care patients. The DPP requires Medicaid managed care plans to pay hospitals up to the Medicare equivalent. A separate DPP requires Medicaid managed care plans to pay teaching hospitals up to the equivalent of the average commercial insurance payment for hospital services. These directed payments fund investments in hospital initiatives designed to improve the health of the Medicaid population as well as strengthen Georgia's health care workforce.

In state fiscal year 2023, the directed payment program increased net payments to participating hospitals by \$1 billion. *While these new payments are an unprecedented and welcome increase in funding for the hospital industry, they do not eliminate the annual amount of uncompensated care provided to the Medicaid and uninsured patients, as shown in Figure 11 on page 26.*

Inside the H

In FY 2023, Upper Payment Limit payments to all hospitals totaled \$349 million, with \$80 million made for targeted payments and \$269 million made in residual payments to public and certain private hospitals.²⁶

UPL payments are funded with a combination of federal and state matching funds based on the Federal Medical Assistance Percentage (FMAP) for each state, which the Medicaid program uses to determine the federal government's share of the cost of covered services in state Medicaid programs.

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. IGTs is a method in which public hospitals can transfer funds to the Agency for Health Care Administration to help fund the Medicaid program.

For targeted UPL payments and residual payments to critical access hospitals, the state matching funds are available through state appropriations. State matching funds for the residual payments to other private hospitals come from provider payments made by hospitals participating in the Hospital Medicaid Financing Program.

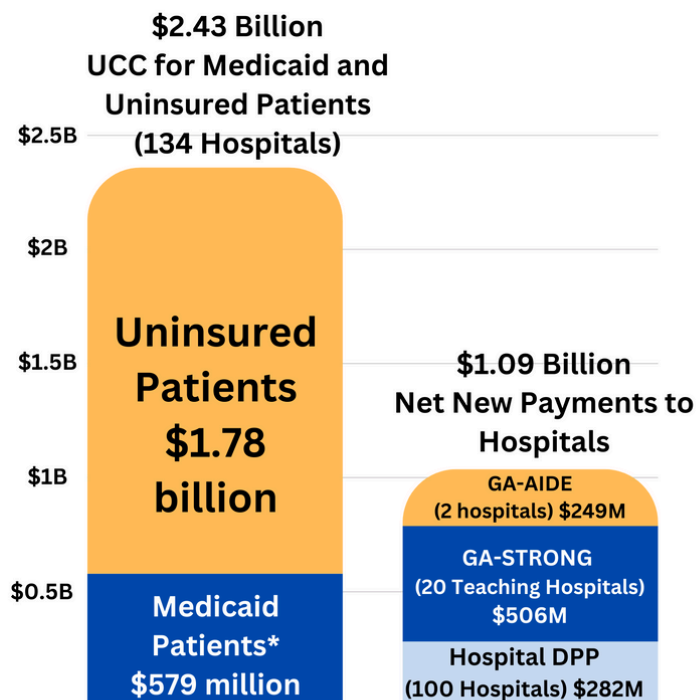
Figure 10

Supplemental Payment Programs

	Medicaid Disproportionate Share Hospital Program	Upper Payment Limit (UPL) Program	UPL - Medicaid Financing Program	Directed Payment Program
Effective Date	1981	April 2000	July 2013	July 2022
Participating Hospitals	Hospitals meeting federal criteria	Public PPS Hospitals and Critical Access Hospitals	Private PPS and LTAC Hospitals	PPS Hospitals
Payment Basis	Up to uncompensated cost for Medicaid and Uninsured Patients	Inpatient - Medicare Equivalent Outpatient - Cost		Teaching (Commercial Equivalent) Non-teaching (Medicare Equivalent)
Applies to		Fee-for-Service Claims		Managed Care Claims
Financing Mechanism	Intergovernmental Transfers (IGTs) State Funds (Private)	Intergovernmental Transfers (Public PPS) State Funds (CAH)	Medicaid Hospital Financing Program	IGTs (Public) and Hospital Directed Payment Program

Figure 11

Estimated Statewide Impact: Hospital Directed Payment Programs (DPP) on Uncompensated Care (UCC) for Medicaid & Uninsured Patients



*considers UPL payments

4. PeachCare for Kids

Federal law allows states to create State Children’s Health Insurance (SCHIP) programs to cover additional children in families with incomes too high to qualify for Medicaid. Georgia’s SCHIP is PeachCare for Kids (PCK) and covers children not eligible for Medicaid in families with annual incomes up to 247% of the federal poverty level (about \$63,775 for a family of three in 2024.²⁷ In FY 2021, Georgia covered an average of almost 141,000 children each month.²⁸ Monthly payments are required for children ages 6 and over and are based on a sliding scale based on a family’s income as a percentage of the federal poverty level. For FY 2023, premiums range from a maximum of \$36 for one child up to a maximum of \$72 per family.²⁹

For FY 2024, Georgia’s FMAP is 65.89 and will increase to 66.04% in FY 2025%.³⁰

5. State Health Benefit Plan

The State Health Benefit Plan (SHBP) is self-insured by the state and provides health care coverage for Georgia’s active and retired state employees, teachers and other school personnel.

In FY 2022, the SHBP provided coverage for a monthly average of 664,000 members statewide at a cost of nearly \$5.7 billion.³¹ The Plan is financed by members’ monthly payments and employer contributions (set annually by the Board of Community Health).

The SHBP offers:³²

- Health Reimbursement Arrangement (HRA) - HRA plans are offered exclusively by Anthem. 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 ranging from \$100 (Bronze) to \$800 (Gold) in an HRA account funded by the plan. Members can earn additional HRA funds by participating in well-being activities.
- 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 or United HealthCare), while members in the Atlanta region have a third option with Kaiser Permanente.³³
- High Deductible Health Plan (HDHP) - Members who use the HDHP option are required to pay coinsurance and have higher deductibles in exchange for lower premiums. Enrollment in an HDHP also allows a member to use a Health Savings Account. The HDHP option is offered exclusively by United HealthCare.

Who Regulates Your Health Plans?

1. Fully Insured Accident and Health Insurance Plans

Accident and health insurance plans are regulated by state and federal law.

An insurance company in the United States must be licensed by the state in which it issues coverage. An insurer may also issue coverage in one state that covers members who live in another.

The Georgia Office of the Commissioners of Insurance and Fire Safety (OCI) is responsible for the licensing of companies to transact business in Georgia and for ensuring that those companies remain solvent and comply with Georgia laws and regulations.

Self-insured plans, Medicare Advantage plans, and the plans for veterans and their dependents are subject to federal law and are not under the authority of the OCI.

Payer	Regulating Entity
Medicaid - Traditional	Department of Community Health
	Centers for Medicare & Medicaid Services
Medicaid - Managed Care	Department of Community Health
	Office of the Insurance Commissioner
	Centers for Medicare & Medicaid Services
Medicare - Traditional	Centers for Medicare & Medicaid Services
Medicare - Managed Care (Medicare Advantage Plans)	Centers for Medicare & Medicaid Services
	Office of the Insurance Commissioner
Commercial Plans - Marketplace (Exchange Plans)	Office of the Insurance Commissioner
	Centers for Medicare & Medicaid Services
Commercial Plans - Fully Insured	Office of the Insurance Commissioner
Commercial Plans - Self-Insured	Department of Labor

Similarly, plans that are licensed by a different state are under the authority of that state’s law, not Georgia law, even when the patient resides in Georgia. This can be confusing to hospitals as they attempt to determine which set of laws apply to a particular type of coverage for a patient.

Most health insurance offered in the United States today is considered “managed care.” This term generally means a system for financing and, sometimes, delivery, of health care that is intended to control cost, utilization, and quality of care. For plans licensed in Georgia, state regulations address how they do business, including claim payment deadlines, late payment interest and rules related to authorizations for services and appeals.

In recent years, patient cost share amounts for both in- and out-of-network care have increased significantly to where many patients cannot afford the cost of their care, which contributes to higher hospital bad debt. To try to address this issue, the federal government issued transparency requirements for hospitals where they must publish their charge and contract rates in a way that is accessible to consumers. There have also been regulatory efforts to reduce consumer debt related to health care, including surprise billing legislation and limitations on collections and credit reporting of medical debt.

Plan Billing and Payment

Billing and payment of claims for health plan members is determined by contract terms, benefit plan design, and federal and state law. There are varying degrees to which hospitals and other providers can negotiate rates in a managed care contract. Efforts to find new ways to reduce medical costs have led insurers to sometimes use “narrow networks,” which have a limited choice of in-network providers even though other providers have contracts with the same insurance company. To ensure full benefits will be available, a provider must verify eligibility and benefits before providing non-emergent services to a patient.

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

When a provider is not in the plan’s network, there is no contract to dictate the amount that the plan must pay or the amount that can be billed to the patient. However, both aspects of the claim may be addressed by federal or state law. Many insurers will set the allowed amount at what they consider to be a reasonable fee for the service and then pay a portion of that at the lower out-of-network percentage. “Balance billing” is when an in-network provider bills the patient for the discount agreed to in the contract or when an out-of-network provider bills the patient for the difference between the allowed amount and the provider’s charges. In some cases, patients are unaware of the network status of hospitals and providers and balance billing comes as a surprise to them, which is known as “surprise billing”.

Georgia’s “Surprise Billing Consumer Protection Act” requires insurers to pay hospitals and providers for certain out-of-network services at the greater of 1) the median in-network rate, 2) any previous contract rate between the parties, or 3) another rate set by the insurer. The act also prohibits hospitals and providers from billing the patient more than their in-network cost share for those services.

If either the hospital/provider or the insurer believes the payment amount is too high or too low, they have 30 days from the date of initial payment or denial of payment to notify the other party that they want to negotiate, after which both parties may begin a 30-day open negotiation period to determine the payment amount. If this is unsuccessful, the Act allows for a third-party entity, known as a certified independent dispute resolution entity, to review the case and determine the final payment amount.

Services covered by the Act are emergency services and non-emergency services provided at an in-network hospital by an out-of-network provider.

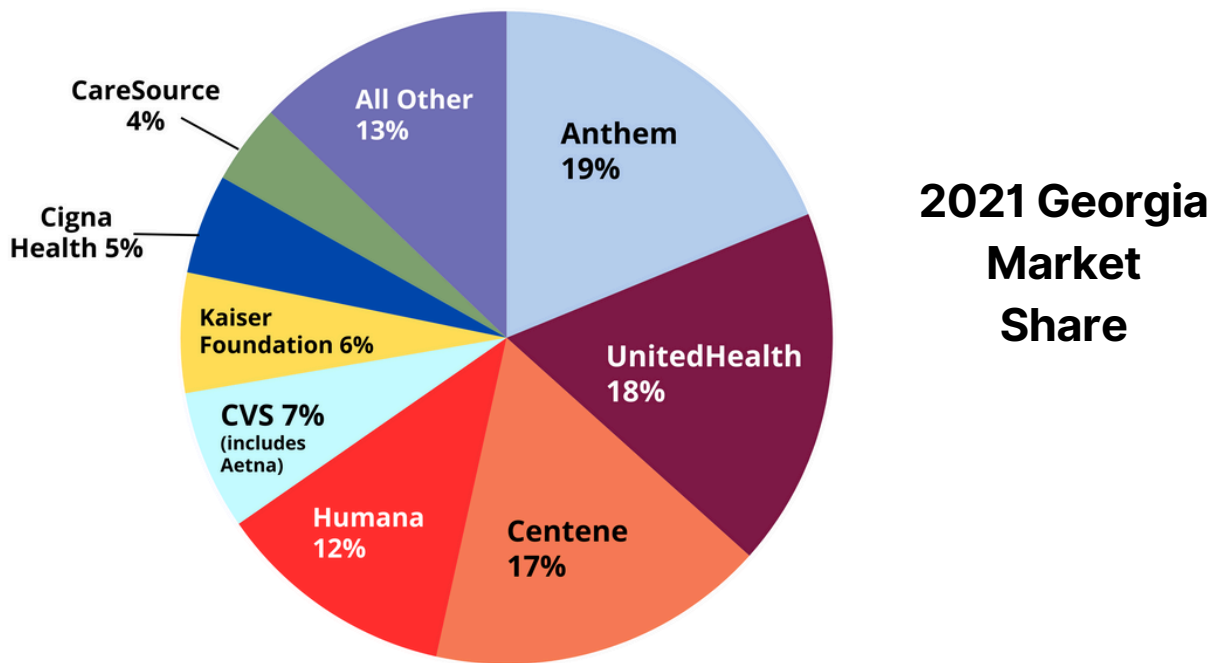
The federal No Surprises Act applies to non-governmental health coverage that is not under the authority of the applicable state law, some additional services, and rights of uninsured or non-covered patients. It also includes a dispute resolution process.

Insurance Industry Evolution

The US Department of Justice (DOJ) blocked large consolidation efforts by the insurance industry in 2016. The industry has moved toward more vertical integration with a focus on reducing cost. An example of vertical integration would be when an insurer buys a company that comes before or after it in the supply chain process, for example, insurers that purchase pharmacy benefit management organizations.

The most current market share information published by the National Association of Insurance Commissioners for Georgia health insurers is **shown in Figure 12 below**.³⁴

Figure 12



Inside the H

The distinction between the different managed care plans has blurred over the past few years. Common characteristics include:

- Networks of contracted providers that agree to be paid less for services in exchange for being used by more patients or the ability to have coverage for patients in some plans.
- Requirements for prior approval 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.
- 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.
 - Federal law requires that specified preventive care be covered in full when provided by in-network providers.

2. Health Insurance Marketplace

In Georgia, residents can purchase insurance coverage through Georgia Access, a Health Insurance Marketplace operated jointly by the state and federal governments. Individuals or families with incomes between 138% and 400% of the federal poverty level who purchase coverage through the Georgia Access are eligible for subsidies, which help offset their premium costs and cost shares.

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

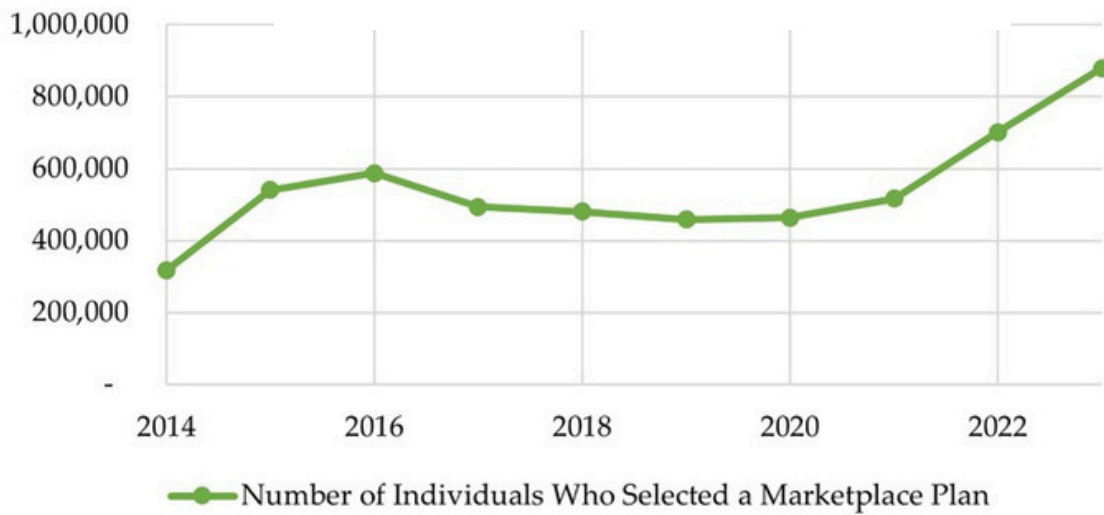
A consumer's share of the cost is paid through premiums, deductibles, and co-payments or coinsurance. In general, the more a consumer pays for a health care service, the lower the plan's premium. For example, premiums for Bronze plans are typically lower than the other plan types; however, the cost of accessing services is much higher.

Except for premiums, which are paid to the insurer on a monthly basis, providers must collect payment directly from the consumer when health care services are rendered. Consumers who cannot pay their share may be eligible for indigent or charity care where 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.

In December 2019, the State of Georgia requested approval of a federal Section 1332 Waiver³⁵ to implement a two-phased approach to address growing health care access and affordability challenges. The Section 1332 Waiver application was designed to reduce premiums, increase coverage, and promote a more competitive private insurance marketplace with the introduction of a state reinsurance program for Plan Years 2021 through 2025 and the Georgia Access Model (a state-operated marketplace in lieu of the federal Health Insurance Marketplace) for Plan Years 2022 through 2025.³⁶

Figure 13

Healthcare Exchange Marketplace Enrollment in Georgia 2014-2023



3. Self-Insured Employee Benefit Plans

In 2022 in the United States, about 49% of people received health care coverage through an employer’s benefit plan.⁴⁵ Employers that offer health benefits may purchase insurance from a licensed insurer or set up their own plans in accordance with state and federal law.⁴⁶

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that regulates self-funded employer-sponsored health plans under the U.S. Department of Labor.

4. Workers’ Compensation

In Georgia, state law requires that any employer with three or more regular employees have workers’ compensation coverage when employees are injured while on the job. Workers’ compensation covers the cost of medical treatment, helps replace lost wages, and helps employees get back to work as soon as possible.



Hospital Provider Payment Programs

The Hospital Provider Payment Program (HPPP) authorizes the Department of Community Health to assess one or more provider payments on hospitals for the purpose of obtaining federal financial participation for Medicaid. See Figure 14 for an overview of the hospital provider payment programs the Department has implemented.

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

Payments made by hospitals are deposited into the state's Indigent Care Trust Fund and, per state statute, used strictly for the Medicaid program. In FY 2023, approximately 18% of the payments were used to finance the state share of a hospital Medicaid payment add-on of 11.88% while the remaining 82% was used as one of the fund sources for the state's share of Medicaid payments to all providers. The hospital Medicaid payment add-on is intended to help offset the cost of the program payments for hospitals serving the Medicaid population. In FY 2024, hospitals will pay an aggregate of \$408 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 2023 program activity, 20 hospitals had a cumulative net positive impact of \$50 million, 98 had a cumulative net negative impact of \$181 million. The individual hospital net impact in FY 2023 ranged from a loss of \$11.1 million to a gain of \$19.2 million.³⁹

The Hospital Medicaid Financing Program

Participation in the Hospital Medicaid Financing Program (HMFP) is limited to a subset of private hospitals. Specialty hospitals, public hospitals, critical access hospitals and free-standing psychiatric hospitals are exempt from the HMFP. Participating hospitals make periodic contributions to the state based on the total number of days that non-Medicare patients spend in their facilities. These contributions are used to finance the state share of federally funded additional payments made to 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 additional payments available and the amount of state share needed.

HMFP hospital payment amounts are determined by 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.
- Are rural hospitals serving as a telemedicine presenting site.

In FY 2023, 47 participating private hospitals received a total of \$114 million after making \$31 million in contributions.⁴⁰ For the 40 HMFP -eligible hospitals with net negative losses in the HPPP in FY 2023, HMFP payments eliminated the losses for 22 hospitals and cumulatively reduced the losses of the remaining 18 hospitals by 53%.⁴¹

Figure 14 Hospital Provider Payment Programs Overview

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



Indigent Care Trust Fund

The Indigent Care Trust Fund (ICTF) was established by a state constitutional amendment in 1990. The ICTF helps the medically needy, or indigent, get the care they need, and the use of funds deposited in the ICTF are limited to:

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

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Contrary to popular belief, hospitals cannot simply 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 from the federal Medicaid Disproportionate Share Hospital program, hospital provider fees, breast cancer car license plate fees, ambulance licensing fees, and Certificate of Need (CON) penalties. Various state laws dictate how ICTF revenues are used, and they must follow the general provisions of the state constitutional amendment.

See Figure 15 on page 37 for the distribution of funds types in the ICTF in 2022.⁴²



Rural Health

While more Georgians live in urban areas (70%) than in rural areas (30%), the conditions in rural areas significantly affect the state's overall productivity, health, and health care costs.⁴³

Rural Hospital Tax Credit Program

Georgia provides tax credits for individuals and corporations that contribute to rural hospital organizations. Tax credits per individual rural hospital organization are limited to \$4 million annually. To qualify, hospitals must:

- Be a licensed acute care hospital.
- Provide inpatient services in a rural county with a population of less than 50,000 or be a designated critical access hospital.
- Participate in Medicare and Medicaid and provide health care services to indigent patients.
- Have at least 10% of its annual net revenue categorized as indigent care, charity care, or bad debt. Annually file IRS Form 990 or the equivalent with the Department of Community Health.
- Be operated by a local hospital authority or be designated as a 501(c)(3) organization by the IRS.
- Have a three-year average patient margin less than one standard deviation above the statewide three-year average of all rural hospital organizations. In other words, the hospital's profit margin from patient revenue is slightly below the statewide average for rural hospitals.

Individual taxpayers are allowed a tax credit equal to 100% of their contribution up to a maximum of \$5,000 (single filer) or \$10,000 (married couple filing jointly). Corporate taxpayers are allowed a tax credit up to 100% of their contribution or 75% of the corporation's tax income liability, whichever is less. The legislation limits the annual aggregate amount of tax credits for all rural hospitals to \$60 million. In 2022, the General Assembly passed House Bill (H.B.) 1041, which increased this limit to \$75 million annually, beginning in 2023. In 2024, the limit was raised to \$100 million annually as a provision in HB 1339.

In 2023, hospitals received \$73 million in donations.

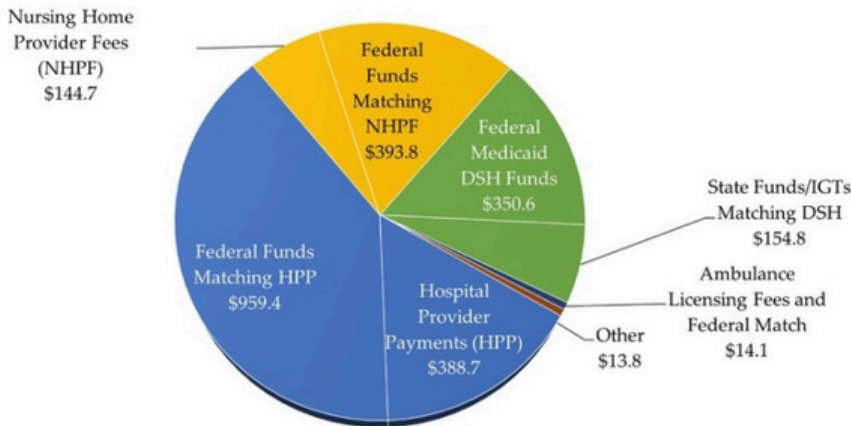
Tax-exempt hospitals are required to post financial-related information on the main page of their websites. If hospitals do not post this information, they are not allowed to receive any state funds, including Rural Hospital Tax Credit donations. (DCH is required to notify organizations before suspending any funds.)

The Rural Hospital Tax Credit program is slated to be repealed on Dec. 31, 2024 and GHA is working with stakeholders and legislators to extend the sunset date.

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 connects small rural communities with state and federal resources to help develop long-term solutions to rural health problems. The SORH administers four primary programs: Primary Care Office Programs; Hospital Services Program; Migrant Health, Homeless and Special Projects; and the Breast Cancer License Plate Program.⁴⁴

Figure 15 FY 2022 Indigent Care Trust Fund Revenues Total of \$2.4 Billion



Figures in millions

Inside the H

Rural Hospital Stabilization Committee

The Rural Hospital Stabilization Program works to identify the needs of the rural hospital community and provide potential solutions. The program aims to increase communication between rural hospitals and the state and improve Georgia's citizens' access to health care.⁴⁵

The Rural Hospital Stabilization Grant Program provides funding to rural hospitals to increase the use of new and existing technology and infrastructure in smaller critical access hospitals, Wi-Fi and telemedicine equipped ambulances, telemedicine equipped school clinics, federally qualified health centers, public health departments and local physician offices.⁴⁶

Emergency and Trauma Care

Emergency Care

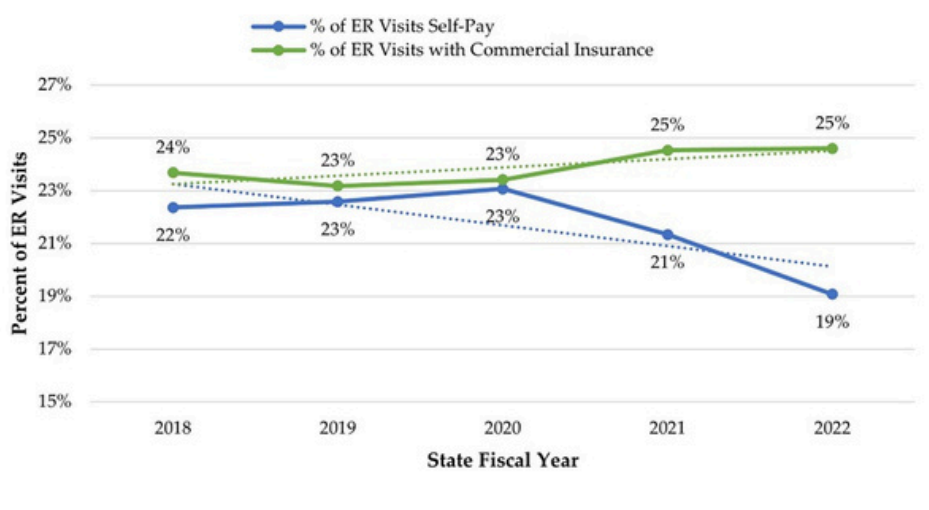
A hospital is typically the first place medical emergency assistance is sought. The federal **Emergency Medical Treatment and Active Labor Act (EMTALA)** ensures that hospitals provide care to anyone needing emergency treatment, regardless of citizenship, legal status, or ability to pay. EMTALA requires that anyone who comes to the hospital requesting emergency care must be screened to determine whether an emergency medical condition exists.

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

The number of emergency room visits by patients without insurance continues to decrease since new commercial health insurance coverage is available through the Health Insurance Marketplace; however, these self-pay visits still account for almost 17% of all visits to the ER.⁴⁷

Figure 16

**Trends in Emergency Room Use
Commercial Coverage vs. Self Pay
2018 - 2022**



Trauma Care

Most hospitals provide some level of trauma care; however, only 34 of the state's 105 acute care hospitals are designated trauma centers. This small number is likely due to the significant ongoing financial investment it takes to be a designated trauma center and not enough funding to offset the cost.

See page 40 for a map and list of trauma centers.

Georgia's Super Speeder law increases fines for dangerous drivers to discourage trauma-causing behavior. The law adds an additional \$200 fine for driving faster than 85 mph anywhere in the state and for driving 75 mph or more on a two-lane road. It also increases driver's license reinstatement fees for drivers committing a second and third offense for violations that result in a suspended license and for other negligent behaviors. The Georgia Trauma Commission received a total of \$22.1 million in state funds in the FY 2024 Appropriations Act.⁴⁸ The Super Speeder law has generated \$273 million in revenue since its inception in 2009. This is an average of approximately \$22 million per year after the full implementation.⁴⁹

In 2016, Georgia voters overwhelmingly approved a constitutional amendment to dedicate funds from the excise tax for the sale of fireworks to the Georgia Trauma Commission, fire services and local public safety services. Excise tax collections totaled \$2.7 million in FY 2023.⁵⁰

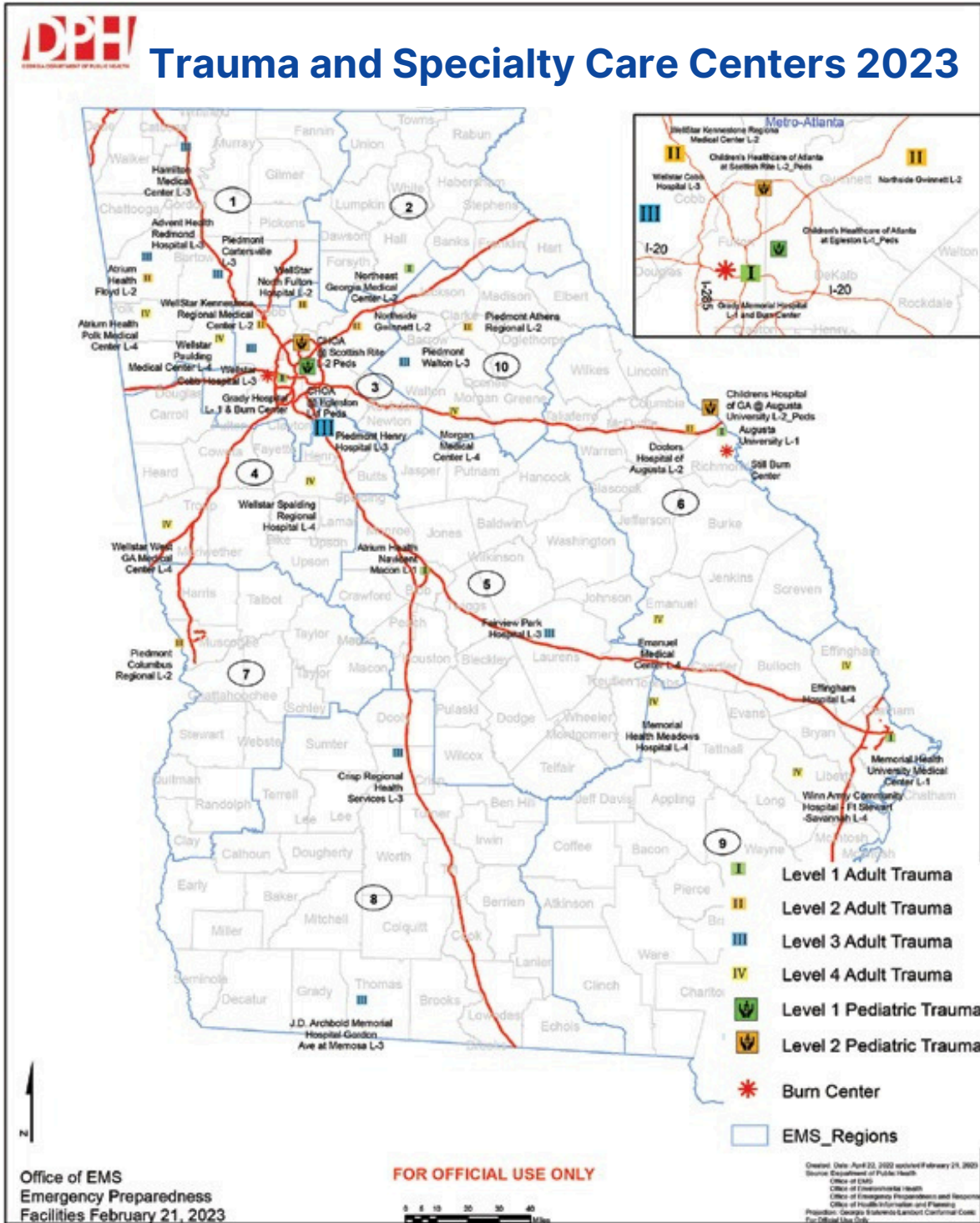
Trauma Commission

The Georgia Trauma Commission is tasked with creating and maintaining a trauma system for the State of Georgia and handling the distribution of trauma system funds that the Georgia legislature sets aside each year for trauma centers.⁵¹ Members of the Commission include hospital, physician, and EMS representatives who are involved in trauma care throughout the state.

The Trauma Commission's FY 2024 budget is \$22.1 million.⁵² The Commission uses its funding to pay trauma providers for their readiness costs, provide grants for new trauma provider start-ups, and help offset uncompensated costs of providing trauma care.



Trauma and Specialty Care Centers 2023



Level I

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

Level II

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

Level III

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

Designated Burn Centers

- Grady Burn Center
- Joseph M. Still Burn Center

Level IV

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

Specialty Care Centers Pediatric Trauma Centers

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



Health Care Workforce

Health Care Workforce in Georgia

Like many other states, Georgia struggles with a health care workforce shortage, especially in rural areas. Thanks to the growth of the health care industry, the unemployment rate in Georgia has remained low. Health care and health care support occupations are expected to drive the job growth in Georgia. Total employment in Georgia is projected to grow to more than 5 million jobs by 2028, an 11.8% increase in jobs since 2018.⁵³ By 2028, health care and social assistance will account for over one-fifth of new jobs created in Georgia.⁵⁴

The total number of registered nurses (RNs) in the state will grow to 87,000 by 2026 and is expected to be 98,800 by 2030. This same year, there is a projected demand for 101,000 RNs, resulting in a shortage of 2,200.⁵⁵ Additionally, the need for RNs is projected to grow 6% from 2022 to 2032.⁵⁶ With the RN turnover rate for the Southeast ranging from 18.4% to 27.1%⁵⁷, health care organizations are ramping up recruitment and retention efforts, as well as establishing programs to train students as health care workers to help establish a pipeline of skilled talent. To do this, Georgia is investing in increased residency program capacity. One example is the Georgia Board of Health Care Workforce, which operates loan repayment programs designed to incentivize providers to practice in rural communities. There is also a focus on filling health care support occupations, including technicians. Due to demand, openings for these positions will grow at a rapid pace, creating a supply gap. These roles also have high turnover rates and are impacted by increased competition from other industries.

Access to health care varies across the state. Many counties face severe provider shortages, with 43% of Georgia's 159 counties falling below the statewide average number for each category of nurses, physician assistants, total doctors and primary care doctors per 100,000 residents. Compared to the statewide average rate per 100,000 residents, 89% of Georgia's counties have fewer doctors, 87% have fewer physician assistants, and 46% have fewer nurses. More than three quarters or 78% of Georgia counties are recognized as being shortage areas for dental care, mental health, and/or primary care.⁵⁸

Preceptor Tax Incentive Program

Georgia provides state income tax credits for uncompensated community-based faculty physicians and other providers who provide training to medical, physician assistant, and nurse practitioner students.

Students must be enrolled in one of the state's public or private medical/osteopathic, physician assistant, or nurse practitioner programs.

Hospitals' Financial Support of Health Care Education

Georgia hospitals have contributed millions of dollars to support health care education. In 2021, not-for-profit hospitals reported more than \$618 million in community support of health professions education.⁶¹

Areas of support include:

- Scholarships and tuition reimbursement.
- 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.
- Funding the expansion of classrooms, laboratory space, or equipment and supplies needed for student education and training.
- Funding simulation equipment.
- Providing student housing.

Many hospitals 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 HOSA – Future Health Professionals (formerly Health Occupations Students of America) organizations and offer volunteer programs that provide health care experience to interested individuals.

Inside the H

Georgia Board of Health Care Workforce

The Georgia Board of Health Care Workforce (GBHCW) is a state agency responsible for advising the Governor and the General Assembly on physician workforce and medical education policy and issues. GBHCW works to identify the physician workforce needs of Georgia communities and to meet those needs through the support and development of medical education programs.⁵⁹

The Board's responsibilities include:⁶⁰

- Provide funding for medical education programming (schools and residencies)
- Produce data reports on the state's health care workforce
- Administer service-cancelable loan repayment programs
- Conduct programming to assist residents/physicians with finding a place to practice in Georgia



Health Information


HIPAA and the HITECH Act

The federal **Health Insurance Portability and Accountability Act (HIPAA)** requires hospitals to keep personal health care information confidential unless medically necessary. For example, hospitals may use or disclose a patient's health information to enable providers to treat the patient, obtain payment for services, and for certain hospital operations such as quality initiatives. The law protects protected health information (PHI) such as name, age, gender, diagnoses, health insurance information, and any data that can be used to identify a person's health status. that requires hospitals to use and disclose only the minimum amount of health information necessary to accomplish the intended purpose of the disclosure and to safeguard the privacy and security of protected health information (PHI). Under HIPAA, patients have the right to place a limit on how their health information is used and shared. They also have the right to receive an account of certain types of disclosures of their health information.

The federal Health Information Technology for Economic and Clinical Health (HITECH) Act expanded the HIPAA privacy and security requirements. The HITECH Act more directly regulates subcontractors that handle PHI and requires hospitals to inform patients when there is a security breach involving their unsecured health information. Efforts to safeguard PHI have become increasingly vital, as health care cybersecurity attacks are more common. According to an analysis of breach data from the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR), from 2019 to 2023, there has been a 239% increase in large breaches involving hacking and a 278% increase in ransomware.⁶² In 2023, hacking accounted for 77% of the large breaches.⁶³

Secure Sharing of PHI Across the State

Electronic health information exchange (HIE) allows doctors, nurses, pharmacists, and certain qualified health care professionals to securely share a patient's electronic health record. In Georgia, the Georgia Health Information Network (GaHIN). GaHIN facilitates the use and secure exchange of patient health information so providers have what they need at the point of care, resulting in improved quality of care, better health outcomes, and reductions in cost. GaHIN interconnects regional area HIEs with large health systems, payers, wellness partners, state agencies, and other health care organizations.



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



Patient Safety and Quality

Ensuring quality and patient- and family-centered safe care is a priority of all Georgia hospitals, who spend significant resources on monitoring the quality and safety of care provided to patients.

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

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

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

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

Figure 17 on page 59 depicts the significant number of entities that are involved in this process.

Accreditation Program

Many hospitals seek voluntary accreditation from national entities as a way to display commitment to high-quality, comprehensive patient care. Two examples are The Joint Commission and DNV Healthcare.

Provider Credentialing

Credentialing is used by hospitals to ensure the qualifications of licensed physicians or other health care providers and is the basis for appointing them to the hospital's medical staff. Credentialing includes an evaluation of the provider's education, training, experience, competence, and judgment, as well as 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. To simplify the process of adding providers to a hospital's plan network, many hospitals and health systems with a large number of employed providers prefer to have the plan verify the credentials of the added providers. This 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.

Inside the H

Accreditation Programs

The Joint Commission and DNV Healthcare are Centers for Medicare and Medicaid Services (CMS)-approved accrediting organizations for hospitals.⁷⁶

Hospitals utilize accreditation organizations like these to show that:

- (1) They have passed a rigorous external inspection.
- (2) The care they provide meets the highest and most current quality and patient safety standards.

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



State Regulatory Requirements

Certificate of Need

Certificate of Need (CON) is a health planning law administered by the Department of Community Health (DCH). The CON law 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. In other words, the new facility must prove that there is a need for its existence. CON helps the state ensure access to quality health care services to all Georgians. It also supports the continued availability of unprofitable, but essential, services provided by hospitals 24/7. These include emergency services, trauma services, intensive care services, neonatal intensive care services, and the most complex inpatient surgical services.

The CON law often requires an applicant to commit to providing a specified amount of indigent and charity care 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 range of services unavailable elsewhere and providing care to anyone who comes to the emergency department, regardless of ability to pay.

Health Care Facility Licensure and Regulation

DCH is the state agency responsible for licensing many of Georgia’s health care facilities, including hospitals. Annual licensure fees for hospitals and other licensed facilities help 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 follow the state licensure requirements and Medicare’s COPs. However, DCH conducts periodic validation surveys of such hospitals to ensure compliance.

Practitioner Licensure

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

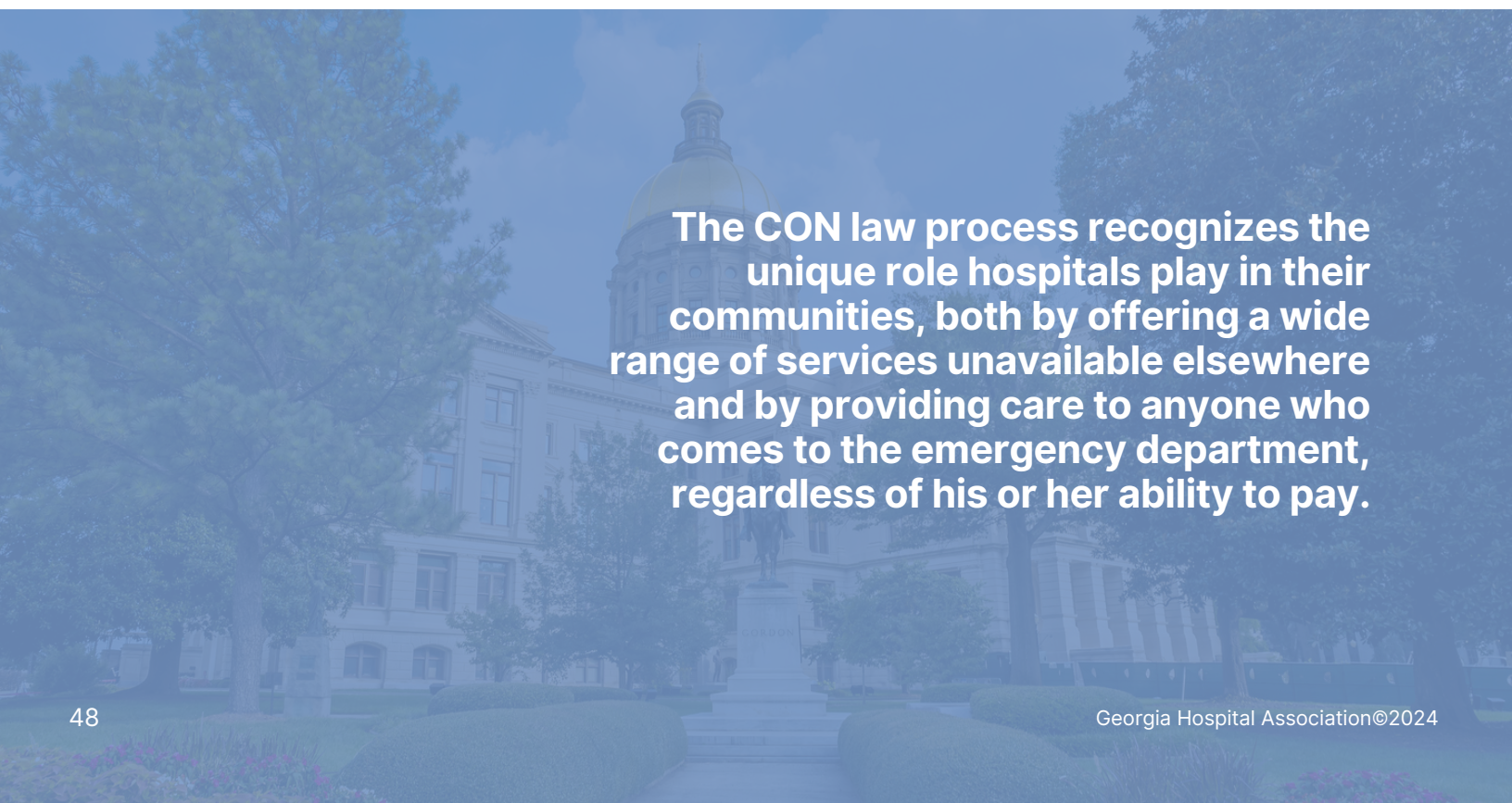
For More Information

Composite Medical Board
www.medicalboard.georgia.gov/

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

Board of Pharmacy www.gbp.georgia.gov

Board of Dentistry www.gbd.georgia.gov



The CON law 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.

Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Endnotes

¹ Prepared to Care – The 24/7 Standby Role of America’s Hospitals. American Hospital Association. November 2012.

² Bureau of Economic Analysis. Regional Economic Accounts: 2022 Total Full Time and Part Time Employment by NAICS Industry for the Health Care and Social Assistance Industry. www.bea.gov.

³ Bureau of Economic Analysis. Regional Economic Accounts: 2022 Total Full Time and Part Time Employment by NAICS Industry for the Health Care and Social Assistance Industry. www.bea.gov.

⁴ Bureau of Economic Analysis. Regional Economic Accounts: 2020 Total Full Time and Part Time Employment by NAICS Industry for the Health care and Social Assistance Industry. www.bea.gov.

⁵ The Accreditation Council for Graduate Medical Education (ACGME) is responsible for the Accreditation of post-MD medical training programs within the United States. Accreditation is accomplished through a peer review process and is based upon established standards and guidelines. Source: www.acgme.org.

⁶ Derived from hospital data reported on FY 2019 IRS Form 990 Schedule H.

⁷ Derived from the 2022 Department of Community Health Hospital Financial Survey.

⁸ Hospitals participating in the Disproportionate Share Hospital program are already required to do this per state rules and regulations.

⁹ Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. <https://health.gov/healthypeople/priority-areas/social-determinants-health>

¹⁰ Source: Georgia Discharge Data System. State FY 2023 patient encounters for inpatient admissions and outpatient visits by payer category.

¹¹ Based on average cost per case type for each payment source. Calculated using 2021 patient counts and cost coverage. FY 2021 cost coverages for Medicaid and self-pay patients from FY 2021 Medicaid Disproportionate Share Hospital calculations. 2021 Medicare cost coverages from DataGen 4Q2022 Medicare Margins Analysis for PPS Hospitals in Georgia. Cost coverage for all other payers extrapolated to break even.

¹² Derived from the 2022 Department of Community Health Annual Hospital Questionnaire and Hospital Financial Survey. <https://dch.georgia.gov/health-planning-databases>.

¹³ These figures reflect only hospital expenses and revenues. They do not consider other hospital-owned health care providers (e.g., the revenue and expense of a hospital-based nursing home). In 2018, GHA changed the methodology for calculating margins to more accurately reflect contractual adjustments.

¹⁴ American Hospital Association (AHA), 2022 Annual Survey of Hospitals.

¹⁵ Health Insurance Coverage of the Total Population. 2021. Kaiser Family Foundation. <http://kff.org/other/state-indicator/total-population/>

- ¹⁶ Data Gen. Medicare Margin Analysis for 96 Georgia PPS Hospitals from 2020 Medicare cost reports on file with CMS as of July 2022.
- ¹⁷ For individuals who do not meet immigration criteria, Medicaid provides coverage only for emergency medical services so long as the individual meets all other Medicaid eligibility requirements.
- ¹⁸ Department of Community Health. Annual Report FY 2021.
- ¹⁹ Kaiser Family Foundation, June 2023. <https://files.kff.org/attachment/fact-sheet-medicaid-state-GA>
- ²⁰ Georgia Budget and Policy Institute. <https://gbpi.org/georgia-health-budget-primer-for-state-fiscal-year-2023/>
- ²¹ Source: www.dch.georgia.gov - FY 2023 Disproportionate Share Hospital (DSH) calculations from the Department of Community Health. Figures do not consider the impact of supplemental Medicaid payments or Medicaid payments paid to Georgia hospitals by out-of-state Medicaid programs.
- ²² HB 911, FY 2023 Appropriations Act. 2022 General Assembly.
- ²³ The Budget Control Act of 2012 and the American Taxpayer Relief Act of 2013 extended the ACA cuts through 2022. In December 2013, Congress passed the Bipartisan Budget Act of 2013, which eliminated Medicaid DSH reductions in 2014 and delayed 2015 scheduled reductions until 2016. The DSH cuts were also extended one more year to 2023. The Protecting Access to Medicare Act of 2014 delayed DSH scheduled reductions to 2017 and extended them through 2024. The Medicare Access and CHIP Reauthorization Act of 2015 delayed DSH reductions to 2018, extended them through 2025, and restructured the level of annual reductions from 2018 through 2025. A series of delays to the Oct. 1, 2019 scheduled reduction were passed in the fall of 2019, moving the implementation date to Nov. 21, 2019 and then to Dec. 20, 2019. Next, the Further Consolidated Appropriations Act, 2020 delayed the FFY 2020 DSH cuts until May 23, 2020.
- ²⁴ MACPAC, Annual Analysis of Disproportionate Share Hospital Allotments to States, March 2021.
- ²⁵ <http://kff.org/other/state-indicator/total-population/?state=GA>.
- ²⁶ Department of Community Health and www.dch.georgia.gov – FY 2022 UPL payments.
- ²⁷ 2023 Poverty Guidelines for the 48 Contiguous States and the District of Columbia. <https://aspe.hhs.gov/poverty-guidelines>
- ²⁸ Department of Community Health. Annual Report FY 2021.
- ²⁹ Department of Community Health. <https://dch.georgia.gov/programs/peachcare-kids/program-benefits-and-cost>
- ³⁰ Enhanced Federal Medical Assistance (FMAP) for CHIP. 2023. Kaiser Family Foundation. <https://www.kff.org/other/state-indicator/enhanced-federal-matching-rate-chip>
- ³¹ Department of Community Health Annual Report 2021
- ³² State Health Benefit Plan. <https://shbp.georgia.gov>
- ³³ United Healthcare and Kaiser Permanente offer credits toward cost sharing when members complete certain wellness activities.
- ³⁴ National Association of Insurance Commissioners Accident & Health Insurance 2021 Market Share Report
- ³⁵ Section 1332 of the Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver (now also referred to as a State Relief and Empowerment Waiver) to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA

- ³⁶ Public Notice. Reinsurance and Georgia Access Model – State Relief and Empowerment Waiver (Section 1332 Waiver.) Georgia Department of Community Health. November 4, 2019.
- ³⁷ <http://kff.org/other/state-indicator/total-population/>
- ³⁸ <https://www.kff.org/health-costs/report/2022-employer-health-benefits-survey/>
- ³⁹ Georgia Hospital Association analysis of the Department of Community Health Hospital Provider Payment Program Tracking Report, November 2022. Provider Payments made to the state available on <https://dch.georgia.gov/hospital-providers>.
- ⁴⁰ Department of Community Health, Hospital Medicaid Financing Program Payment Model, SFY 2022.
- ⁴¹ Georgia Hospital Association analysis of the Department of Community Health Hospital Provider Payment Program Tracking Report, November 2022. Provider Payments made to the state available on <https://dch.georgia.gov/hospital-providers>.
- ⁴² FY 2022 ICTF Financial – Revenue and Expenditure Activities (Unaudited). Department of Community Health.
- ⁴³ State of Georgia Rural Health Plan. Georgia State Office of Rural Health. Department of Community Health.
- ⁴⁴ <https://dch.georgia.gov/divisionsoffices/state-office-rural-health>
- ⁴⁵ <https://dch.georgia.gov/divisionsoffices/state-office-rural-health/rural-hospital-stabilization-program>
- ⁴⁶ <https://dch.georgia.gov/divisionsoffices/state-office-rural-health/rural-hospital-stabilization-program>
- ⁴⁷ Georgia Discharge Data System. January 2023 Query of Emergency Room Patients by Primary Payer Category.
- ⁴⁸ House Bill 19, 2023 General Assembly.
- ⁴⁹ Source: Department of Driver Services, HB 160 Notice and Revenue Tracking, September 2018.
- ⁵⁰ AFY 2023-FY 2024
- ⁵¹ Georgia Trauma Care Network Commission. <https://trauma.georgia.gov/about-us/governance>.
- ⁵² House Bill 19, 2023 General Assembly
- ⁵³ GEORGIA Workforce Trends An Analysis of Long-term Employment Projections to 2028. Georgia Department of Labor; Commissioner Mark Butler Retrieved from <https://explorer.gdol.ga.gov/vosnet/mis/Current/gaworkforcecurrent.pdf>
- ⁵⁴ GEORGIA Workforce Trends An Analysis of Long-term Employment Projections to 2028. Georgia Department of Labor; Commissioner Mark Butler Retrieved from <https://explorer.gdol.ga.gov/vosnet/mis/Current/gaworkforcecurrent.pdf>
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- ⁵⁶ NSI Nursing Solutions. (2024). National Healthcare Retention & RN Staffing Report. Retrieved from https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf
- ⁵⁷ NSI Nursing Solutions. (2024). National Healthcare Retention & RN Staffing Report. Retrieved from https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf
- ⁵⁸ Prescribing Remedies for Georgia’s Medical Provider Shortage. Timothy Sweeney <https://gbpi.org/prescribing-remedies-for-georgias-medical-provider-shortage/>
- ⁵⁹ Prescribing Remedies for Georgia’s Medical Provider Shortage. Timothy Sweeney <https://gbpi.org/prescribing-remedies-for-georgias-medical-provider-shortage/>

⁶⁰ <https://healthcareworkforce.georgia.gov/>

⁶¹ Source: 2019 IRS Form 990, Schedule H for 84 not-for-profit hospitals and health systems.

⁶² Critical Insight Healthcare Breach Report 2021.

⁶³ Critical Insight Healthcare Breach Report January -June 2022



Figure 17

Healthcare Oversight

DNV - DNV Healthcare
 HACRP - Hospital-Acquired Condition Reduction Program
 QIN-QIO - Quality Innovation Network - Quality Improvement Organization
 BFCC-QIO - Beneficiary and Family Centered Care - Quality Improvement Organization
 HRRP - Hospital Readmission Reduction Program
 IQR - Hospital Inpatient Quality Reporting Organization/Program
 TJC - The Joint Commission
 VBP - Hospital Value-Based Purchasing Program

AG - Georgia Office of the Attorney General
 CON - Certificate of Need
 DEA - U.S. Drug Enforcement Agency
 DOJ - U.S. Department of Justice
 FBI - Federal Bureau of Investigation
 OCR - U.S. Office of Civil Rights
 USPTO - U.S. Patent and Trade Office

BOP - Georgia Board of Pharmacy
 DOL - U.S. Department of Labor
 GCMB - Georgia Composite Medical Board
 GBHCW - Georgia Board of Health Care Workforce
 Georgia Office of Emergency Medical Services
 OCR - Office of Civil Rights
 OFCCP - Office of Federal Contract Compliance Programs
 OSHA - Occupational Safety & Health Administration
 NIOSH - National Institute for Occupational Safety & Health
 NLRB - National Labor Relations Board
 SOS - Georgia Secretary of State Professional Licensing Boards

DOT - U.S. Department of Transportation
 FAA - Federal Aviation Administration
 OEMS - Georgia Office of Emergency Medical Services

CMO - Medicaid Care Management Organizations
 DOR - Georgia Department of Revenue
 EBSC - U.S. Employee Benefits Security Administration
 GTC - Georgia Trauma Commission
 IRS - Internal Revenue Service
 MAC - Medicare Administrative Contractor

CDC - Centers for Disease Control and Prevention
 FDA - Food & Drug Administration
 HCAHPS - Hospital Consumer Assessment of Healthcare Providers and Systems
 HRSA - U.S. Health Resources & Services Administration
 ONC - Office of the National Coordinator for Health Information Technology
 UNOS - United Network for Organ Sharing

CERT - Comprehensive Error Rate Testing
 MFCU - Medicaid Fraud Control Unit
 MIC - Medicaid Integrity Contractor
 MIP - Medicare Integrity Program
 OIG - Offices of Inspector General (HHS and DCH)
 RAC - Recovery Audit Contractors (Medicare and Medicaid)
 SMRC - Supplemental Medical Review Contractor
 SUR - Medicaid Surveillance & Utilization Review
 ZPIC - Zoned Program Integrity Contractor

BOP - Georgia Board of Pharmacy
 CMS - Centers for Medicare & Medicaid Services
 DCH - Georgia Department of Community Health
 DPH - Georgia Department of Public Health
 DBHDD - Georgia Department of Behavioral Health and Developmental Disabilities
 EPA - U.S. Environmental Protection Agency
 EPD - Georgia Environmental Protection Division
 FCC - Federal Communications Commission
 FTC - Federal Trade Commission
 HFR - Georgia Healthcare Facility Regulation
 HHS - U.S. Department of Health and Human Services
 NRC - Nuclear Regulatory Commission

MAP - Medicare Advantage Plans
 OCI - Georgia Office of Insurance Commissioner
 OPB - Georgia Governor's Office of Planning and Budget
 PERM - Payment Error Rate Measurement
 PRRB - Payment Reimbursement Review Board
 SEC - Securities Exchange Commission
 SORH - Georgia State Office of Rural Health
 VA - U.S. Department of Veterans Affairs



