Georgia Department of Audits and Accounts
Performance Audit Division
Greg S. Griffin, State Auditor
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Department of Community Health

Requested Information on the Indigent Care Trust Fund

Why we did this review

This special examination of the Indigent Care Trust Fund was conducted at the request of the House Appropriations Committee.

The Committee noted that annual fund revenue has grown significantly since the last review conducted by our office. Our review of fiscal year 2000 activity showed that the fund had revenue of $483 million, compared to nearly $1.8 billion in fiscal year 2016. The Committee requested that we review the fund's growth and examine how the Department of Community Health manages the fund's assets and any balance held from year to year.

About the ICTF

The General Assembly established the Indigent Care Trust Fund (ICTF) to expand Medicaid eligibility and services; support rural and other care providers who serve the medically indigent; and to support primary health care programs for medically indigent citizens. The Department of Community Health is responsible for administering the ICTF.

What we found

Indigent Care Trust Fund (ICTF) revenue was approximately $1.8 billion during fiscal year 2016. The majority of revenue is derived from two revenue programs—the Hospital Medicaid Financing Program ($835 million) and the Nursing Home Provider Fee Program ($502 million), while a significant amount also comes from the Disproportionate Share Hospital (DSH) Program ($430 million). Smaller amounts are obtained from ambulance licensing fees, Certificate of Need penalties, and breast cancer license plate sales.

The revenue categories above consist of funds from various payers. A majority of ICTF funds (68%) are provided by the federal government, while fees generally paid by healthcare providers are 25% of total funding. Intergovernmental transfers from hospital authorities and other governmental entities are 7% of total funding. Less than 1% of ICTF revenue was state general funds. Most of the fee revenue, intergovernmental transfers, and state funds serve as the match allowing the Department of Community Health (DCH) to obtain additional federal funds.

The ICTF currently supports indigent care in several ways. The trust funds' hospital and nursing home provider fees provide methods for the state to obtain additional federal funds for the state's Medicaid program. The DSH Program provides funding to eligible hospitals to either pay or reduce the bills of uninsured individuals who are deemed medically indigent. The ICTF also provides limited funding for breast cancer screenings and education.

The primary role of the ICTF has changed in the last 15 years. The ICTF initially served as the state's method for funding the DSH

Program, which previously required hospitals to fund certain primary care activities. Since 2001, DCH has eliminated the primary care requirement and the General Assembly has added revenue sources to the ICTF. The ICTF's total revenue increased from $483 million in fiscal year 2000 to approximately $1.8 billion in fiscal year 2016, an increase of 270%. Most of the ICTF's additional revenue is derived from the Nursing Home Provider Fee Program and the Hospital Medicaid Financing Program, which were added to the ICTF in 2003 and 2010, respectively. These programs, which accounted for 75% ($1.3 billion) of the ICTF's total revenue in fiscal year 2016, provide funds for Medicaid instead of the uninsured.

As a result of federal and state law, additional changes to the ICTF could occur over the next year.

- **Federal Reduction in DSH Allotment** – Anticipating fewer uninsured individuals and less uncompensated care, the Affordable Care Act requires the federal government to reduce DSH payments nationwide. The reductions were scheduled to begin in fiscal year 2014 but were delayed. While the reduction methodology has not been finalized, Georgia's DSH Program would face a $95 million (22%) reduction in fiscal year 2018 based on the US Centers for Medicare and Medicaid Services' initial methodology. This would reduce Georgia's total DSH allotment (including state funds) for fiscal year 2018 to approximately $339 million, down from an estimated $434 million in fiscal year 2017. The precise impact on individual hospitals cannot be determined because the amount of uncompensated care and the distribution across hospitals varies each year.

- **Repeal of Georgia's Hospital Medicaid Financing Program** – The ICTF's revenue could also be reduced in fiscal year 2018 if the state law authorizing the Hospital Medicaid Financing Program sunsets on June 30, 2017 as scheduled. In fiscal year 2017, hospitals are expected to pay approximately $284 million in fees, which will generate an additional $600 million in federal funds to support other Medicaid services. Approximately $271 million will be returned to hospitals through a combination of Medicaid add-on payments (estimated $242 million) and private hospital upper payment limit payments (estimated $29 million). The remainder, approximately $613 million, will be used to support other Medicaid services. The $613 million represents approximately 6% of Georgia's $9.7 billion Medicaid budget. During the 2017 legislative session, the General Assembly can decide whether to extend this provision. If the fee is eliminated, the state would have to utilize an alternate revenue source, reduce Medicaid rates, or reduce Medicaid services.

What we recommend

This report is intended to provide answers to questions posed by the House Appropriations Committee. We hope that this report provides pertinent information to help inform policy decisions.

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Purpose of the Special Examination

This review of the Indigent Care Trust Fund (ICTF) was conducted at the request of the House Appropriations Committee. This report will answer the following questions:

1. What are the sources of revenue for the Indigent Care Trust Fund?
2. How is ICTF revenue allocated?
3. How has the role of the ICTF changed over time?
4. How would reductions in ICTF revenue impact the state's ability to provide care for the medically indigent?

A description of the objectives, scope, and methodology used in this review is included in Appendix A. A draft of the report was provided to the Department of Community Health for its review, and pertinent responses were incorporated into the report.

Background

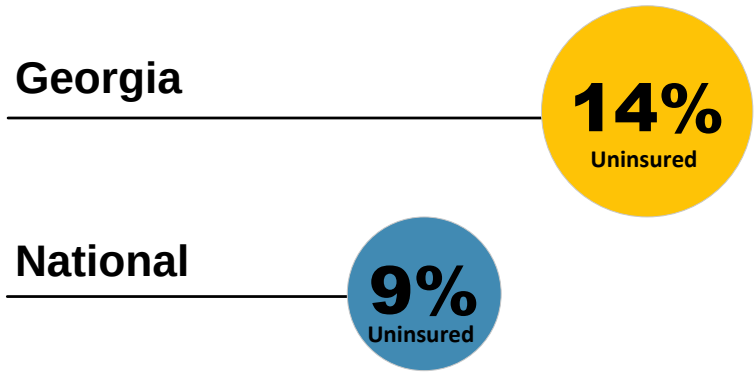
Indigent Care

Insurance coverage affects the ability of individuals to access healthcare services and the ability of healthcare providers to obtain payment when services are provided. Because uninsured individuals are frequently indigent, many rely on the state's healthcare safety net of hospitals, community health clinics, and charity clinics for services. Conversely, individuals covered by employer or other private health insurance plans have a wider range of providers from which to obtain services, and the patients and insurers generally reimburse providers at a level exceeding cost. Medicaid provides a narrower range of providers than many private plans, and the reimbursement rates are often below provider costs.

A relatively large portion of Georgia's population is either uninsured or on Medicaid, leading to large uncompensated care costs[1] for healthcare providers. As shown in **Exhibit 1** on the following page, 13.9% of Georgians (1.4 million) were uninsured in 2015, exceeding the national average by nearly five percentage points. Another 18% (1.8 million) were on Medicaid in the same year. According to the Georgia Hospital Association (GHA), hospitals provided $1 billion in uncompensated care to individuals who qualified for hospitals' indigent (reduced) or charity (free) care programs in 2014. GHA also estimated that payments for Medicaid claims covered approximately 84% of hospital costs. To varying degrees, other types of healthcare providers also serve the uninsured and Medicaid populations and are likely to have uncompensated care costs as a result.

[1] Uncompensated care is an overall measure of the amount of care provided for which no payment was received from the patient or insurer.

Exhibit 1
Georgia's Uninsured Rate Exceeds the National Average, Fiscal Year 2015



Source: U.S. Census Bureau

Indigent Care Trust Fund

Individuals are medically indigent if their income is no greater than 200 percent of the federal poverty level guidelines published by the US Department of Health & Human Services.

The Indigent Care Trust Fund (ICTF) was created in 1990 to: 1) expand Medicaid eligibility and services; 2) support rural and other care providers, primarily hospitals, who serve the medically indigent; and, 3) support primary health care programs for medically indigent citizens and children in Georgia. The trust fund consists of a primary account, as well as two segregated accounts added in the last 15 years to hold funds from specific revenue sources. The Georgia Constitution (Article III, Section IX, Paragraph VI) was amended to authorize the ICTF, and it was formally created by state law (O.C.G.A 31-8-152) in 1990.

The Georgia Department of Community Health's Division of Financial Management administers the ICTF, but the fund is not the responsibility of a single program office. Other units within the department, such as the Office of Health Planning and the State Office of Rural Health, support revenue collection and provide oversight for specific activities related to the ICTF. The Departments of Public Health and Revenue also collect and transfer revenue to DCH for deposit into the ICTF.

It must be noted that the ICTF is not only a state treasury fund created by state law. The appropriations act also contains an ICTF Program to which the General Assembly appropriates only a portion of the revenue that passes through the ICTF account.

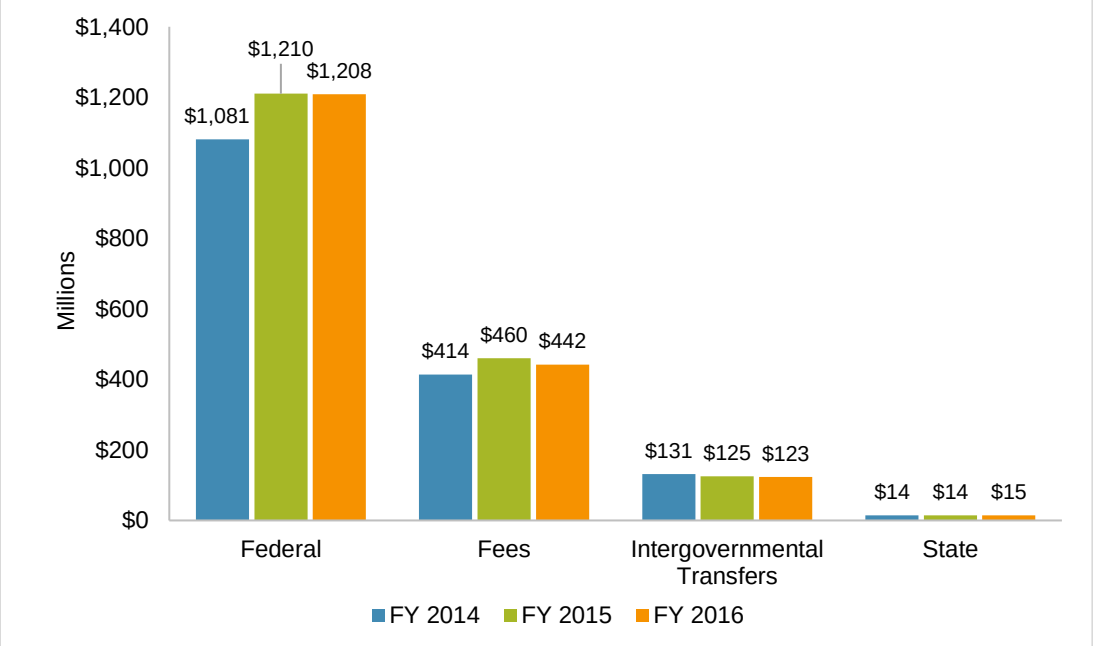
Requested Information

What are the sources of revenue for the Indigent Care Trust fund and how is revenue allocated?

Since the establishment of the Indigent Care Trust Fund, the General Assembly has created several additional sources of revenue for the fund. The General Assembly then appropriates ICTF funds to several programs: the ICTF Program, Low-Income Medicaid, and Aged, Blind, Disabled Medicaid. The funds are generally paid to healthcare providers serving uninsured or Medicaid patients.

Fiscal year 2016 ICTF revenue totaled approximately $1.8 billion, up $150 million since fiscal year 2014. Most of the increased funds came from the federal government. As shown in **Exhibit 2**, approximately two-thirds of ICTF revenue are federal funds and one-third are fees and intergovernmental transfers. State funds and interest make up a small portion of the ICTF revenue.

Exhibit 2
Federal Funds Represent Majority of ICTF Revenue, Fiscal Years 2014-2016



Source: TeamWorks Financials data

Revenue from multiple programs is required by state law to be deposited into the ICTF. Appropriations of funds from the ICTF do not lapse to the general fund at the end of the fiscal year. As shown in **Exhibit 3**, the ICTF has a primary account and two segregated accounts. The ICTF's primary account consists of revenue collected from four programs: Disproportionate Share Hospital (DSH), Ambulance Services Licensing, Certificate of Need, and the Breast Cancer Awareness License Plate. The vast majority of revenue and expenditures in the primary account is associated with the DSH Program. Revenue collected from the Hospital Medicaid Financing Program and the Nursing Home Provider Fee Program is deposited into two segregated accounts. Each of the ICTF's programs is discussed in the following bullets.

Exhibit 3
ICTF Revenue and Expenditures were $1.8 Billion in Fiscal Year 2016

Program	Beginning Balance	Revenue	Expenditures	Ending Balance
Primary Account				
Disproportionate Share Hospital Program	$298,314	$430,059,282	$430,059,282	$298,314
Ambulance Services Licensing Program	2,331,098	17,529,168	19,860,266	
Certificate of Need Program	38,248	3,621,956	2,321,703	1,338,500
Breast Cancer Awareness License Plate Program	2,102,780	313,359	750,000	1,666,139
Total	$4,770,440	$451,523,765	$452,991,251	$3,302,953
Segregated Accounts				
Hospital Medicaid Financing Program	$0	$834,985,117	$834,985,117	$0
Nursing Home Provider Fee Program	0	502,191,689	502,191,689	0
Total	**$4,770,440**	**$1,788,700,571**	**$1,790,168,057**	**$3,302,953**

Source: TeamWorks Financials data

- **Disproportionate Share Hospital Program** was the primary source of revenue for the ICTF when the fund was established in 1990. The program receives intergovernmental transfers from hospital authorities and other governmental entities as well as state appropriations and uses these funds as a match for federal DSH funds. The General Assembly appropriates the combined funds to the ICTF Program to make payments to hospitals that serve a large number of Medicaid and uninsured patients. Hospitals must use DSH funds to deliver services to individuals with incomes up to 125% and 200% of the federal poverty limit at no charge and at reduced rates, respectively. DSH contributed $430 million to the ICTF and expended the same amount in fiscal year 2016. See **Appendix B** for more information.

- **Ambulance Services Licensing Program** was included as a source of revenue for the ICTF when the fund was established in 1990. The program was established in 1973 to license ambulance services and inspect vehicles. Revenue from license fees charged to ambulance services, which include ground, air, and neonatal transport services, is used to obtain federal Medicaid funds. The combined total of these funds are part of the ICTF and are used to reduce state funding requirements for the Aged, Blind, and Disabled Medicaid program. Ambulance licensing-related funds contributed $17.5 million to the ICTF in fiscal year 2016, though this fiscal year contained an unusual amount of federal funding. See **Appendix C** for more information.

- **Certificate of Need Program** was established in 1979 to control the addition and duplication of healthcare facilities and services. Providers granted a certificate of need to establish or expand facilities or services must agree to provide a minimum amount of indigent and charity care and DCH assesses penalties against facilities that do not meet this requirement. In 2001, state law authorized DCH to deposit revenue collected from these types of CON penalties into the ICTF. DCH uses revenue collected from CON penalties as part of the state match for the Disproportionate Share Hospital Program. The

program contributed $3.6 million to the ICTF in fiscal year 2016. **Appendix D** provides more information.

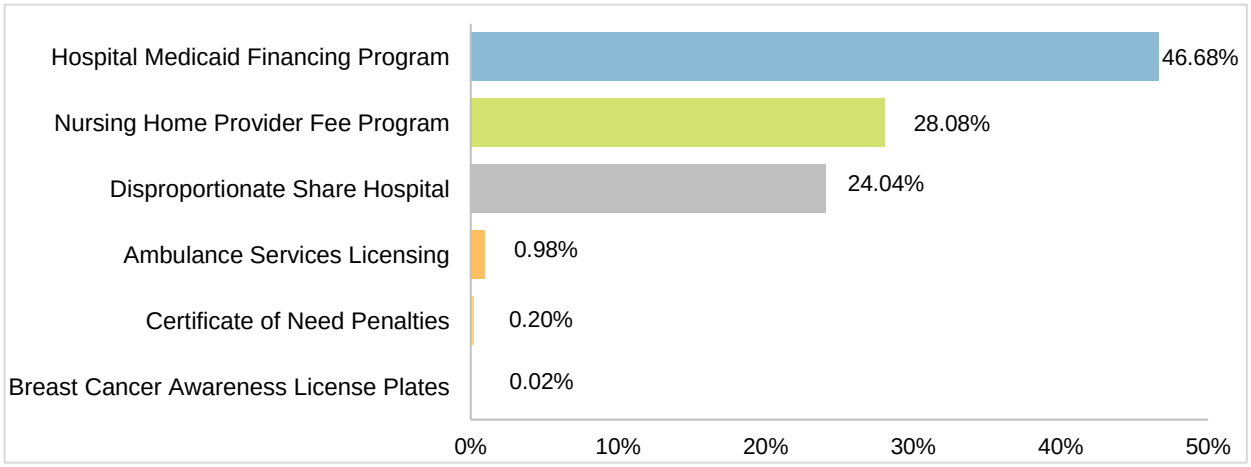
- **Breast Cancer Awareness License Plate Program** was created by the General Assembly in 2002 to support breast cancer screening and treatment programs for indigent women. State law requires $22.05 of the special license plate fee collected from the sale of breast cancer awareness license plates to be deposited into the ICTF. During fiscal year 2016, this program contributed approximately $313,000 to the ICTF. **Appendix E** provides additional information.

- **Hospital Medicaid Financing Program** was established in fiscal year 2011 as a segregated account within the ICTF. DCH charges fees to hospitals to obtain federal funds for Medicaid and deposits the combined revenue into the ICTF. The General Assembly appropriates these funds to the Low-Income and Aged, Blind, and Disabled Medicaid programs. The Hospital Medicaid Financing Program contributed $835 million to the ICTF during fiscal year 2016. See **Appendix F** for more information.

- **Nursing Home Provider Fee Program** was created as a segregated account within the ICTF in 2003. The program generates revenue from fees charged to nursing homes to obtain federal matching funds. The General Assembly appropriates the combined funds to the Aged, Blind, and Disabled Medicaid Program. During fiscal year 2016, the Nursing Home Provider Fee Program contributed approximately $502 million to the ICTF. See **Appendix G** for more information.

As shown in **Exhibit 4,** the Hospital Medicaid Financing Program is the largest source of revenue, accounting for 47% of the ICTF's total revenue in fiscal year 2016. The Nursing Home Provider Fee and DSH programs also significantly contribute to the total annual funding. The remaining three programs account for less than 2% of ICTF revenue.

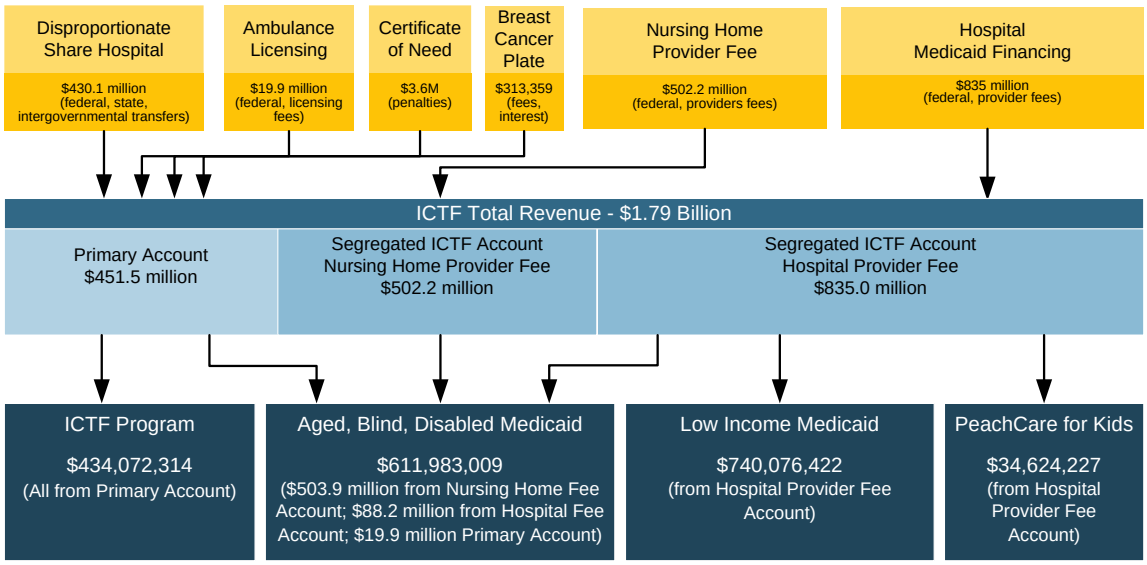
Exhibit 4
Hospital Medicaid Financing Program Responsible for Nearly Half of ICTF Revenue, Fiscal Year 2016



Source: TeamWorks Financials data

As shown in **Exhibit 5,** in fiscal year 2016 the General Assembly appropriated ICTF funds to the Low Income Medicaid Program, Aged, Blind, and Disabled Medicaid Program, PeachCare for Kids[2] , and the ICTF Program. Funds for the PeachCare and Medicaid programs pay for claims submitted by Medicaid providers. Most of the funds appropriated to the ICTF Program do not pay claims but instead fund DSH payments to hospitals to mitigate the uncompensated care costs resulting from a significant number of uninsured and Medicaid patients.

Exhibit 5
Majority of ICTF Funds are Appropriated to Medicaid Programs, Fiscal Year 2016



Note: The program amounts listed on the bottom row are expenditures as reported in the Fiscal Year 2016 Budgetary Compliance Report. These amounts include adjustments made after the fiscal year, which may result in differences with other figures in this special examination.

Source: TeamWorks Financials data

How has the role of the Indigent Care Trust Fund changed over time?

While the statutory purpose of the ICTF has not changed since its creation in 1990, its revenue sources and funded activities have expanded. In 2000, the primary use of the ICTF was to pay a portion of the uncompensated care provided by hospitals to the medically indigent. The primary use of the ICTF has shifted, primarily as a result of its revenue growth. Most ICTF revenue is now used as a state funding match for additional federal Medicaid funds. Supporting hospitals' uncompensated care costs remains at similar levels, though the required support for primary care programs has been eliminated.

As previously noted, the ICTF has three purposes listed in the Georgia Constitution and state law:

1. expand Medicaid eligibility and services;

[2] As of fiscal year 2017, PeachCare for Kids is 100% federally funded and no ICTF revenue is appropriated to the program.

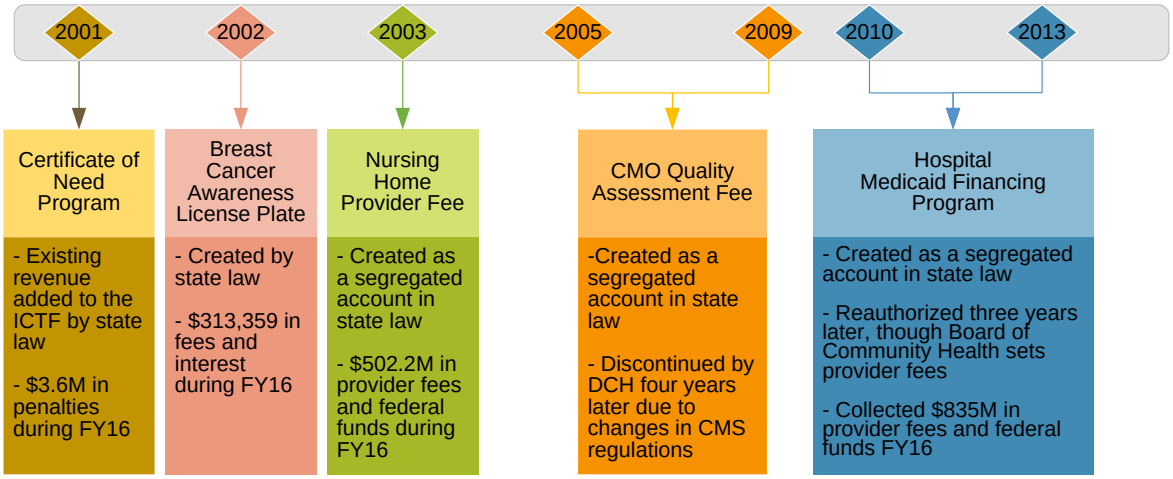
2. support rural and other care providers, primarily hospitals, who serve the medically indigent; and
3. support primary health care programs for medically indigent citizens and children in Georgia.

In fiscal year 2000, approximately 81% of the ICTF's revenue was directed at the second and third purposes. The ICTF was the state's method for funding the DSH Program, and DSH hospitals were required to spend a portion of their payments on primary care services. In fiscal year 2016, the primary care requirement has been dropped and significant fund sources that serve as a state match for Medicaid funds were added. For fiscal year 2016, 76% of ICTF funding was directed to expanding Medicaid eligibility and services.

Additional Revenue Generating Programs

Since 2001, the General Assembly has authorized DCH to deposit revenue collected for five new programs into the ICTF (see **Exhibit 6**). During fiscal year 2016, revenue from two of these programs accounted for $1.3 billion of the ICTF's $1.8 billion in total revenue.[3]

Exhibit 6
Five New Programs Have Been Added to the ICTF since Fiscal Year 2000



Source: State law and TeamWorks Financials data

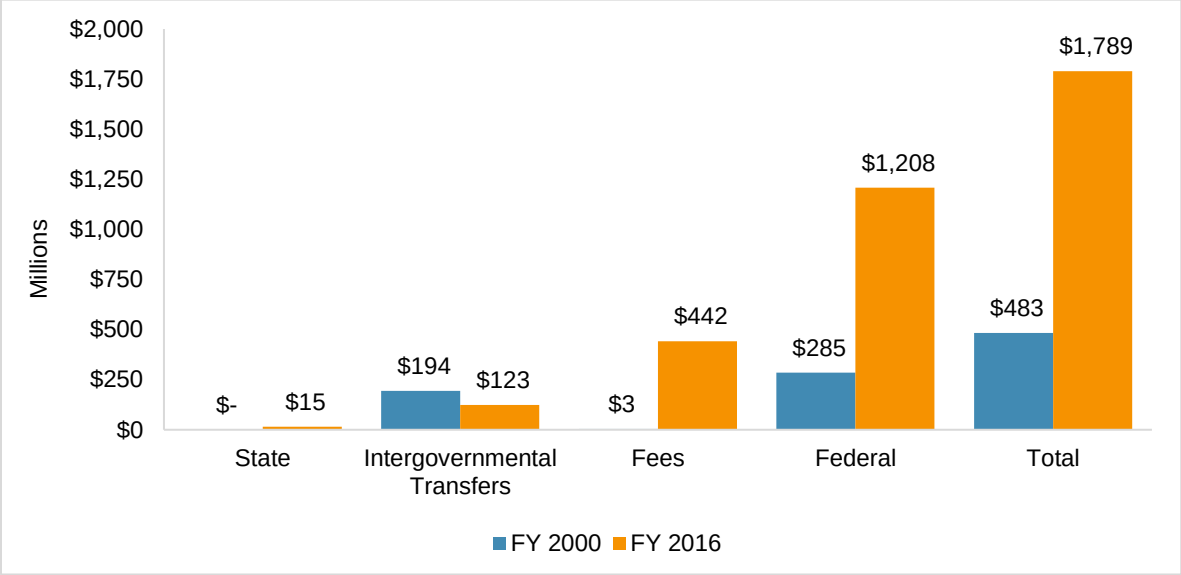
The increase in the ICTF's revenue is primarily due to funds obtained from the Nursing Home Provider Fee Program and the Hospital Medicaid Financing Program, which were added to the ICTF in 2003 and 2010, respectively. These programs, which are funded with a combination of provider fees and federal revenue, accounted for 75% ($1.3 billion) of the ICTF's total revenue in fiscal year 2016. During fiscal year 2016, these programs' funds totaled more than $903 million in federal funds and $434 million in fees. Revenue from Certificate of Need penalties and Breast Cancer Awareness license plates accounted for approximately $4 million.

The expansion of revenue sources increased total ICTF revenue from $483 million in fiscal year 2000 to approximately $1.8 billion in fiscal year 2016, an increase of 270%.

[3] While still in state law, collection of the CMO Quality Assessment fee was discontinued in October 2009 due to changes in the US Centers for Medicare and Medicaid Services' regulations.

Revenue from federal, fees, and state funds all increased over the time period (see **Exhibit 7**), with federal funds increasing by more than $900 million. In fiscal year 2000, about 59% of the ICTF's total revenue was from federal funds, 40% was from intergovernmental transfers paid by public hospitals, and slightly less than one percent was from fees. In fiscal year 2016, federal funds accounted for 68% of ICTF revenue, fee revenue was 25%, and intergovernmental transfers 7%.

Exhibit 7
ICTF Revenue Increased $1.3 Billion between Fiscal Years 2000 and 2016[1]



[1] Fees also include revenue from interest.

Source: TeamWorks Financials data and DOAA report on ICTF released in 2000

Intergovernmental transfers decreased from $194 million in fiscal year 2000 to approximately $123 million in fiscal year 2016. These transfers are made by public hospital authorities to fund the state's share of the DSH Program for public hospitals. Prior to fiscal year 2006, DCH collected intergovernmental transfers at a level high enough to fund the state's share of the DSH Program for payments to both public and private hospitals. DCH discontinued this practice when the Centers for Medicare and Medicaid Services required state funds to be used. Changes in the Federal Medical Assistance Percentage (FMAP), which determines the amount of state matching funds required for the DSH Program, contributed to the decrease in intergovernmental transfers. Between fiscal years 2000 and 2016, the FMAP increased from 59.88% to 67.55%, reducing the state matching funds required.

While no state funds were appropriated to the ICTF in fiscal year 2000, $15 million was appropriated to the ICTF in fiscal year 2016. State funds are appropriated to the ICTF to serve as the primary source of the state match for DSH payments made to private hospitals.[4] The state began appropriating funds to the ICTF for this purpose in fiscal year 2006.

[4] DCH also uses revenue from Certificate of Need penalties to fund the state's portion of DSH payments to private hospitals.

Primary Care Services

DCH eliminated the primary care services requirement for hospitals receiving DSH funds during fiscal year 2006. Prior to the rule change, hospitals receiving DSH payments were required to use at least 15% to provide or expand primary care services that addressed community health needs. DCH annually selected priorities for primary care spending, and hospitals developed plans in collaboration with local partners. In 2004, the Georgia Health Policy Center found that the program achieved its primary goal to improve access to primary care services for Georgia's medically indigent residents. The study reported that the primary care services program was a vital part of the state's health care safety net.

Given the time that has lapsed, DCH staff was unable to provide a reliable explanation for the elimination of the provision. According to a 2004 Georgia Health Policy Center report, Georgia was the only state requiring hospitals to spend 15% of their total DSH payment on community-based primary care services. After DCH eliminated the primary care requirement, some hospitals reduced spending on those services and the media documented cutbacks in grants to primary care organizations. However, the landscape for health care has changed significantly in the last ten years. The current impact on primary care caused by the requirement's elimination is unknown.

How would reductions in ICTF revenue impact the state's ability to provide care for the medically indigent?

ICTF revenue may be reduced in the near future due to scheduled changes at the federal and state levels. The federal government is scheduled to reduce DSH allocations to each state beginning in fiscal year 2018, while the state law authorizing the Hospital Medicaid Financing Program is scheduled to sunset on June 30, 2017.

Federal DSH Funding

As part of the Affordable Care Act, Congress established a schedule to reduce federal Medicaid DSH payments to account for the anticipated decrease in uninsured individuals and uncompensated care provided by hospitals. These reductions were originally set to take effect in fiscal year 2014 but have been repeatedly delayed. They are currently expected to take effect in fiscal year 2018. The scheduled reduction will start at 16% in fiscal year 2018 and reach 55% in fiscal year 2025. The reduction percentage will vary by state.

Georgia may be subjected to larger than average reductions due to its DSH payment allocation method. The Centers for Medicare and Medicaid Services (CMS) is statutorily required to develop a reduction methodology that applies greater reductions to states with lower uninsured rates and states that do not target their DSH payments to high-need hospitals. While Georgia has one of the highest rates of uninsured residents in the country, it also provides DSH payments to a higher proportion of hospitals than most other states. In state plan reporting year 2011, Georgia made DSH payments to a higher proportion of hospitals than 78% (38 of 49) of other states.

While the reduction methodology has not been finalized, Georgia's DSH program would face a $95 million reduction in fiscal year 2018 if the methodology developed by

CMS for the scheduled 2014 reductions is used. CMS was in the process of finalizing its reduction methodology for 2018 in September 2016, but the statutory factors that must be considered have not changed since 2014. Using the 2014 methodology, the Medicaid and CHIP Payment Access Commission (MACPAC) estimated that the DSH reductions for fiscal year 2018 will have widely varying effects on individual states. Reductions will range from 1.5% to 37.1%, with Georgia's allotment estimated to decrease 22%. If the estimate is accurate, Georgia's total DSH allotment (including state funds) for fiscal year 2018 would be approximately $339 million, down from an estimated $434 million in fiscal year 2017 (see **Exhibit 8**).

Exhibit 8
Federal DSH Allotment Estimated to Decrease by 22% in Fiscal Year 2018

	FY 2017 Preliminary	FY 2018 Estimate[1]	Difference
Federal Allotment	$294,702,018	$229,867,574	($64,834,444)
State Match Needed			
Transfers (Estimate)	$120,098,357	$93,493,375	($26,604,982)
State Funds (Estimate)	19,287,146	15,227,317	(4,059,829)
Total	**$434,087,521**	**$338,588,266**	**($95,449,255)**
Federal Funds by Pool			
Pool 1: Small-Rural	$62,557,586	$48,764,917	($13,762,668)
Pool 2: Other, Eligible	$232,144,432	$181,072,657	($51,071,775)

[1]Before the reduction is applied, the federal allotment will increase based on the consumer price index percent change from the previous year. This increase was less than 1% in fiscal years 2016 and 2017.

Source: DCH data and Medicaid and CHIP Payment and Access Commission (MACPAC) Report to Congress, February 2016

As discussed in **Appendix B**, Georgia divides its DSH allotment into two pools—small-rural hospitals and other eligible hospitals. A 22% reduction in fiscal year 2018 would equate to approximately $13.7 and $51.1 million less in federal funding for small-rural and other eligible hospitals, respectively. The precise impact on individual hospitals cannot be determined because the amount of uncompensated care and the distribution across hospitals varies each year. However, if these factors were to remain similar to fiscal year 2016 amounts, the decreases in DSH payments[5] would range from $5,500 at Hughston Hospital in Columbus, Georgia to $15.7 million at Grady Memorial in Atlanta.

DCH Response: *DCH noted that there is still uncertainty regarding how DSH reductions will be implemented. It also noted that "it is possible Georgia could mitigate the magnitude of the reduction by only allocating payments to high need hospitals. However, this would altogether eliminate DSH payments to a large number of hospitals. Additionally, the methodology for calculating each state's*

[5] DSH payment refers to the gross DSH payment less intergovernmental transfer amount, if applicable.

reduction has not been finalized, so there is no guarantee that a change in Georgia's methodology would have the desired impact on the DSH reduction amount."

DCH also stated that payments are targeted to high need hospitals, noting that "high need (or deemed) hospitals represented 22% of hospitals but received 49% of the 2016 DSH funds."

Hospital Medicaid Financing Program

The General Assembly created a hospital provider fee with passage of the Provider Payment Agreement Act during the 2010 session as a revenue match for Medicaid. Prior to the scheduled repeal of the law in July 1, 2013, the General Assembly passed the Hospital Medicaid Financing Act (O.C.G.A. 31-8-179) to provide the Board of Community Health the authority to assess provider payments on hospitals for the purpose of obtaining federal financial participation for Medicaid. The Board created two fees via rule—"Tier I" fee that is based on revenue that applies to most hospitals and a "Tier II" fee that applies to a subset of private hospitals. The law is scheduled to sunset again at the end of fiscal year 2017. According to DCH staff, the hospital provider fee allowed state general funds to be used for other purposes and for Medicaid services to be maintained.

For every $1 in state Medicaid funding, Georgia receives $2.10 in federal funds. In fiscal year 2017, hospitals are expected to pay approximately $284 million in fees, which will result in an additional $600 million in federal funds. Approximately $271 million will be returned to hospitals through a combination of Medicaid add-on payments (estimated $242 million) and private hospital UPL payments (estimated $29 million). The remainder, approximately $613 million, will be used to support other Medicaid services. The $613 million represents approximately 6% of Georgia's $9.7 billion Medicaid budget. If the fee is eliminated, the state would be required to address the $613 million shortfall using one, or a combination, of the following:

- **Utilize an alternative revenue source** – Federally recognized sources of funding for the state's share of Medicaid payments include legislative appropriations, inter-governmental transfers (IGT), certified public expenditures (CPE), and permissible taxes and provider donations; at least 40% must be financed by the state and up to 60% may come from local governments through IGT or CPE.

- **Reduce Medicaid rates** – States establish their own Medicaid provider payment rates within federal regulations. Federal regulation requires that states "assure that payments are consistent with efficiency, economy, and quality of care, and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

- **Reduce Medicaid services** – Federal law requires states to provide certain "mandatory" Medicaid benefits and allows states the choice of covering other "optional" benefits. Optional benefits covered in Georgia include adult dental, vision, podiatry, and psychological services. DCH officials noted that while there may be potential to reduce Medicaid expenditures by eliminating certain optional services, there are also significant policy implications with

New Limits on Pass-Through Payments

The Centers for Medicare and Medicaid Services (CMS) issued regulations in 2016 that will limit states' ability to direct managed care organization expenditures. Although these revisions do not have an impact on ICTF revenue, they could impact how funds are distributed to providers. Under Tier I of the Hospital Medicaid Financing Program, DCH offsets providers' expense in paying the Tier I fee by adding 11.88% to those providers' inpatient and outpatient rates. DCH has directed the state's CMOs to pass on these rate increases to providers. CMS considers these to be pass-through payments that will be restricted by the new regulations.

Pass-through payments must be phased out over the next 10 years unless CMS approves the state practice as an exception to the rule. DCH officials stated that the add-on payment may be allowed if DCH can demonstrate that it is linked to an effort to improve quality. DCH would likely apply for this exception if the Hospital Medicaid Financing Program is reauthorized during the 2017 session. If the exception is not approved, DCH estimates that it will have until 2020 (if current structure is unchanged) to develop a plan to link the payment to quality or begin the phase out process.

each optional service Georgia provides. For example, some optional services serve as preventative measures intended to reduce expenditures in other areas (e.g., adult dental and family planning) while others provide a lower-cost alternative to mandatory services (e.g., community-based services for the elderly and disabled).

- **Restrict Medicaid eligibility** – Federal law requires states to provide Medicaid coverage for certain groups of individuals and allows states to expand eligibility to cover other groups. Georgia has expanded eligibility in some cases. For example, federal law requires that pregnant women with incomes up to 185% of the federal poverty limit be covered, and Georgia has expanded eligibility to pregnant women up to 200% of the federal poverty limit. Georgia has also expanded coverage to breast and cervical cancer patients, the medically needy[6] , and various waiver program participants.

In addition to providing funds for Medicaid, the Act provides the funding mechanism by which private hospitals are able to obtain upper payment limit payments. This program allows approximately 45 private hospitals to collect supplement payments for Medicaid patients based on what the hospital would have received using Medicare payment principles. Under authority of the Act, the Board of Community Health established a Tier II fee for these hospitals, with the fee revenue used to obtain the federal funds. All fee revenue and federal funds are returned to the hospitals. See **Appendix F** on page 27 for more details.

If the Act sunsets and the fees eliminated, DCH would likely see a slight increase in Certificate of Need (CON) penalty collections. CON holders are required to provide uncompensated charity and indigent care that meets or exceeds 3% of adjusted gross revenue. Providers that do not meet this commitment are required to pay a penalty in the amount of the difference. DCH waived this requirement for hospitals when the

[6] The Medically Needy program allows a person whose income exceeds the established eligibility threshold to use incurred/unpaid medical bills to "spend down" the difference between their income and the income limit to become eligible.

hospital provider fee was enacted, and officials noted that penalty collections went down as a result.

If the fees are continued, DCH should evaluate the current fee schedules to ensure that that the fees collected are "substantially" equivalent to the amount returned to providers. If changes result in a reduction in fee collections, less federal funds will be available for other Medicaid services.

Appendix A: Objectives, Scope, and Methodology

Objectives

This report examines the Indigent Care Trust Fund administered by the Department of Community Health. Specifically, our examination set out to determine the following:

1. What are the sources of revenue for the Indigent Care Trust Fund?
2. How does DCH allocate ICTF revenue to providers?
3. How has the role of the ICTF changed over time?
4. What potential impact would reductions in ICTF revenue have on the state's ability to provide care for the medically indigent?

Scope

This special examination generally covered activity related to the Indigent Care Trust Fund that occurred from fiscal year 2014 through fiscal year 2016 with consideration of earlier or later periods when relevant. Information used in this report was obtained by reviewing relevant state laws, rules, and regulations, and interviewing agency officials and staff from the Department of Community Health. We also reviewed Georgia's state plan for Medicaid, DCH annual reports, forms and instructions for facility surveys, and other agency documents. We also reviewed information from DOAA's 2000 and 2003 reports examining the ICTF, interviewed hospital and other healthcare industry stakeholders, and reviewed relevant healthcare studies and reports. Revenue and expenditure data from the state's accounting system was used to inform multiple objectives.

Methodology

To determine the sources of revenue for the ICTF, we analyzed revenue data and interviewed DCH staff about the collection and management of funds for each program. We obtained and reviewed activity data from the Department of Revenue regarding the breast cancer awareness license plate. We also reviewed applicable federal regulations and DOAA's 2010 performance audit and follow up review on Special License Plates. We interviewed staff at the Department of Public Health regarding the collection of revenue for the ambulance services licensing program. We obtained and analyzed revenue data for fiscal years 2014 through 2016 for the program. We assessed DPH's controls over the collections data for ambulance services licensing that we used for this examination and determined that the data used were sufficiently reliable for our analyses. While we concluded that the information was sufficiently reliable for the purposes of our review, we did not independently verify the data.

To obtain information on how DCH allocates ICTF revenue, we interviewed DCH staff about its process for distributing payments to health providers. We also obtained and analyzed expenditure data from the Medicaid Management Information System and reviewed information from the Georgia Cancer for Oncology Research and Education. We also reviewed DCH's Medicaid State Plan and allocation data files. To determine how many patients are served with DSH funds, we reviewed DCH's Hospital Financial Survey (HFS) data. We assessed DCH's controls over the HFS data related to patient counts and determined that the data was not entirely reliable. We adjusted the patient count data to remove obvious errors and believe the amended data represents a reasonable estimate.

To determine how the role of the ICTF has changed over time, we reviewed historical reports and other information from DCH's website about ICTF related programs. We also interviewed staff and examined literature published by the Georgia Health Policy Center and other organizations regarding primary care services in Georgia.

To determine the potential impact reductions in ICTF revenue would have on the state's ability to provide care for the medically indigent, we examined federal regulations governing the DSH Program. We interviewed representatives of the Centers for Medicare and Medicaid Services, the Governor's Office of Planning and Budget, and hospital associations. We also reviewed a February 2016 Medicaid and CHIP Payment Access Commission (MACPAC)[7] report to Congress, which discusses the anticipated DSH reductions, and other literature that assessed the potential impact of DSH reductions and the elimination of the hospital provider fee.

This special examination was not conducted in accordance with generally accepted government auditing standards (GAGAS) given the timeframe in which the report was needed. However, it was conducted in accordance with Performance Audit Division policies and procedures for non-GAGAS engagements. These policies and procedures require that we plan and perform the engagement to obtain sufficient, appropriate evidence to provide a reasonable basis for the information reported and that data limitations be identified for the reader.

[7] MACPAC is a non-partition legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on issues affecting Medicaid and the state Children's Health Insurance Program.

Appendix B: Disproportionate Share Hospital Program

The Disproportionate Share Hospital (DSH) Program was established by federal legislation in 1981 to increase health care access for the medically indigent by making additional payments to hospitals that serve a large number of Medicaid and uninsured patients. Hospitals use DSH funds to provide services at no charge to individuals with income up to 125% of the federal poverty limit and at reduced rates for those with income between 125% and 200% of the poverty limit. In recent years, hospitals have reported serving more than 800,000 annually, in whole or in part, with DSH funds.

Federal Medical Assistance Percentages (FMAP) are the percentage rates used to determine the federal matching funds allocated annually to certain medical and social service programs.

A part of the ICTF since the fund's creation in 1990, DSH is a federal grant for which states must provide matching funds based on the state's Federal Medical Assistance Percentage (FMAP). Both federal and matching funds are a part of the ICTF. Under the Affordable Care Act (ACA), Congress established a schedule to reduce federal DSH allotments to states to account for an anticipated decrease in uninsured individuals and in hospitals' uncompensated care costs. See page 9 for more detail.

Intergovernmental Transfer Assessment

Most of the state's share of the DSH Program is generated through intergovernmental transfers from public hospital authorities. The transfer is equal to the state share of the DSH payment that the associated public hospital will receive. Federal regulation prohibits private hospitals from remitting the state's share; therefore, the General Assembly appropriates funds to serve as the state match for private hospital payments.

Revenue and Expenditures

As shown in **Exhibit B-1**, DSH funding and expenditures have remained relatively stable in recent years. Federal funds and the FMAP increased slightly between fiscal years 2014 and 2016, requiring a decreased amount of matching funds (combination of intergovernmental transfers and state funds). Intergovernmental transfers decreased slightly between fiscal years 2014 and 2016, while state funds increased slightly.[8] Total expenditures and DSH payments to hospitals (total expended less intergovernmental transfers) had minor changes over the three-year period.

[8] Additional state general funds are required for DSH if the FMAP decreases or the proportion of uncompensated care delivered in private hospitals increases. In fiscal year 2016, a public hospital converted to private, requiring an additional $2.08 million in state funds.

Exhibit B-1
ICTF's Revenue from DSH Has Remained Stable, Fiscal Years 2014-2016

Source	FY 2014	FY 2015	FY 2016	% Change FY 2014-16
Prior Year Carry Over	$1,831,380	$298,314	$298,314	(83.7%)
Revenue				
Federal Funds	$286,613,961	$291,518,844	$292,019,777	1.9%
State Funds	14,445,532	14,133,296	14,668,976	1.5%
CON Penalties[1]	696,968	4,702,893	2,321,703	233.1%
Intergovernmental Transfers[2]	131,435,116	125,137,713	123,370,529	(6.1%)
Total Revenue	**$433,191,577**	**$435,492,746**	**$432,380,985**	**(0.2%)**
Total Available	$435,022,957	$435,791,060	$432,679,299	(0.5%)
Total Expended	**$434,724,643**	**$435,492,746**	**$432,380,985**	**(0.5%)**
Balance Remaining	$298,314	$298,314	$298,314	0.0%
DSH Payment[3]	**$303,289,527**	**$310,355,033**	**$309,010,456**	**1.9%**

[1] CON penalties are collected in the Certificate of Need Program. As needed, CON penalty revenue is used as state match for the DSH Program. CON penalties are discussed on page 23.

[2] For fiscal year 2015, intergovernmental transfers includes funds from the Children's Health Insurance Program Reauthorization Act.

[3] DSH Payment refers to the total amount expended less intergovernmental transfers.

Source: TeamWorks Financials and DCH data

Eligibility and Allocation

Deemed Hospitals

Federal designation for hospitals with low-income utilization of at least 25% or a Medicaid inpatient utilization rate at least one standard deviation above the mean for hospitals receiving Medicaid payments in the state.

DSH payments can only be made to hospitals that apply for funds and meet federal and state guidelines. To receive a DSH payment, federal regulations require that a hospital have a Medicaid utilization inpatient rate of at least 1% and—with limited exceptions—at least two obstetricians with staff privileges that treat Medicaid patients. Payments are limited to a hospital's loss incurred for services provided to Medicaid and uninsured patients (referred to as the "DSH Limit"). Regulations also require that DSH payments be made to hospitals that serve a large portion of low-income or Medicaid recipients ("deemed" hospitals). Beyond these requirements, states have flexibility to develop a DSH allocation method and institute additional conditions. Georgia allocates DSH funds to all hospitals that meet the minimum federal requirements.

Under Georgia's DSH allocation method, three factors determine the DSH payment made to a hospital: hospital pool (small-rural or other eligible), the amount of uncompensated care delivered, and uncompensated care costs in relation to the hospital's total cost of services to Medicaid and uninsured individuals. The hospital ownership type only affects the gross DSH payment.[9] The three factors that affect the DSH payment are discussed below.

[9] Hospital authorities and other governmental entities remit intergovernmental transfers that serve as the state match for their associated public hospital(s). If the other three factors are equal, a public hospital will receive a larger DSH payment to account for the transfer. However, the final DSH payment, gross DSH payment less the transfer amount, for two identical hospitals would be equal.

- **Hospital Pool** – The state's total DSH allotment is divided into two pools, one for small-rural hospitals and another for all other eligible hospitals. Small-rural hospitals are those with less than 100 beds and not located in a metropolitan statistical area as defined by the U.S. Office of Management and Budget. When DCH eliminated a multiplier for small-rural hospitals in the 2008 revision of its allocation method, it implemented the two pool system to mitigate the impact. Small-rural hospitals receive approximately 13.4% of the total DSH allotment, the same portion they received in 2008.
- **Uncompensated Care Costs** (DSH Limit) – Each hospital has a designated maximum allotment that is limited by federal requirements to its uncompensated care costs (UCC) for services provided to Medicaid and uninsured patients.
- **UCC as a Percentage of Uninsured/Medicaid Costs** (Hospital-Specific Percentage) – The UCC as a percentage of the costs for services provided to the Medicaid and uninsured populations can vary across hospitals.

These factors affect the DSH payment[10] a hospital will receive. When other factors are equal, higher UCC will lead to a higher payment. When other factors are equal, a higher percentage will lead to a higher payment. While the hospital pool affects payments, it is not reasonable to compare small-rural and other eligible hospitals. The median DSH limit for small-rural hospitals in fiscal year 2016 was $1.7 million, compared to $12.4 million for all other eligible hospitals.

Distribution of Revenue

DSH payments offset a portion of eligible hospitals' uncompensated care costs. In fiscal year 2016, DSH hospitals reported uncompensated care costs of $1.5 billion[11] , while DSH payments totaled $309 million. Of the 163 Georgia hospitals that served Medicaid patients in fiscal year 2016, 130 applied for and received DSH funds.[12] DSH payments ranged from $26,128 (Jefferson Hospital in Louisville, Georgia) to $74.5 million (Grady Memorial in Atlanta). These payments offset approximately 20% of UCC for the 130 hospitals, though the offset ranged from 2% for Doctor's Hospital (Augusta, Georgia) to 51% for Phoebe Worth Medical Center (Sylvester, Georgia).

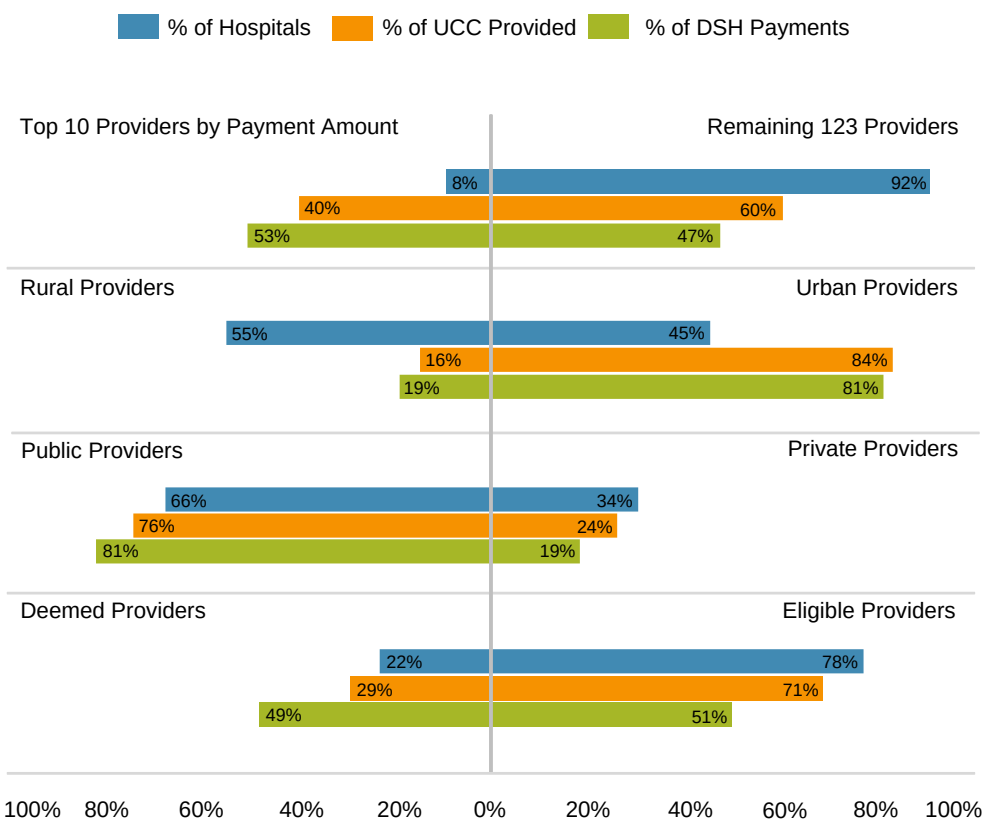
Exhibit B-2 shows the distribution of hospitals, uncompensated care costs, and DSH payments across four hospital characteristics: ranking of DSH payment amount, location, ownership, and DSH status designation. These categories are discussed below. Percentages in the exhibit and within the discussion below relate to the 133 hospitals determined eligible for DSH in fiscal year 2016, unless otherwise noted.

[10] For the purpose of this discussion, DSH payment refers to the gross payment amount less its associated intergovernmental transfer, if applicable.

[11] Approximately 81% of the fiscal year 2016 figure were for services provided to the uninsured and the remaining 19% were for services provided to Medicaid patients.

[12] Participation in DSH is voluntary. According to DCH, some hospitals do not apply because they do not meet the minimum federal requirements.

Exhibit B-2
Uncompensated Care Costs and DSH Payment Amounts Vary by Provider Type[1], Fiscal Year 2016



[1] Provider types are not exclusive (e.g., one provider may be deemed, rural, and public).

Source: DCH data

- **Top Ten Providers by Payment Amount** – In fiscal year 2016, the ten providers with the highest payment amounts received approximately 53% of DSH payments ($163 million of $309 million) and accounted for approximately 40% of all UCC provided by DSH hospitals. Grady Memorial received 24% of DSH funding ($74.5 million). The hospital reported the highest amount of UCC in the state ($160 million), approximately 10% of the total reported by all DSH hospitals. A factor in Grady Memorial's payment was UCC representing 26% of the hospital's total cost for services provided to the Medicaid and uninsured populations, one of the highest rates in the state.

- **Location (Rural or Urban)** – In fiscal year 2016, approximately 55% (73 of 133) of DSH hospitals were designated as rural. Rural hospitals provided 16% of the UCC reported by DSH hospitals and received 19% ($57.6 million) of DSH payments. Urban hospitals provided a large majority of the uncompensated care and received most of the DSH payments. DSH payments offset a slightly higher percentage of rural hospitals' UCC (23.7%) than urban hospitals' (19.5%).

- **Ownership (Public or Private)** – In fiscal year 2016, 66% (88 of 133) of DSH hospitals were public, but these hospitals provided 76% of UCC and received 81% of DSH payments.

  Although the number of private DSH hospitals has remained relatively stable, the amount of DSH funds allocated to them increased from $48.9 million in fiscal year 2014 to $58.5 million in fiscal year 2016. Because the state's share of payments to private hospitals is provided by state funds, higher allocations to these hospitals increase the need for state general funds to serve as the state match.

- **Status (Deemed or Eligible)** – In fiscal year 2016, 83% of hospitals (136 of 163) that received Medicaid payments applied for a DSH payment. Of these, approximately 76% were designated eligible (104 of 136), 21% (29 of 136) were deemed, and 2% (3 of 136) were ineligible. Only 130 of the hospitals received a DSH payment—three deemed hospitals had no uncompensated care costs and three were ineligible because they did not meet the federal obstetrician requirement.

  Of the 133 DSH-eligible hospitals, 29 (22%) were designated as deemed. These hospitals reported 29% of uncompensated care costs and received nearly half of DSH payments. The number of deemed hospitals decreased from 32 in fiscal year 2014 to 29 in fiscal year 2016. The decline is primarily the result of changes in hospitals' Medicaid and low-income utilization rates. For example, Children's Healthcare of Atlanta at Hughes Spalding was a deemed hospital in fiscal years 2014 and 2015 but not in fiscal year 2016 after reporting significantly lower Medicaid and low-income utilization.

  In Georgia's DSH allocation method, a hospital's status does not impact its DSH payment. However, as discussed on page 9, CMS may consider whether a state's allocation method favors deemed hospitals when determining DSH reductions.

Appendix C: Ambulance Services Licensing Program

Ambulance Services Licensing was established in 1973 to license ambulance services and inspect emergency vehicles. The program is housed in the Department of Public Health's Office of Emergency Medical Services and Trauma; however, revenue from its licensing of ambulance services are deposited into the ICTF and used to obtain federal funds. The combined total of these funds are used to support the Aged, Blind, and Disabled Medicaid program.

Licensing Process

The Department of Public Health (DPH) licenses air ambulance services, ground ambulance services, and neonatal transport services (see **Exhibit C-1**). To obtain an ambulance services license, applicants must submit an application and pay the license fee established by the Board of Public Health. The license fee for all ambulance services for fiscal year 2017 is $2,500 plus $1,400 for each vehicle or aircraft. DPH requires ambulance services licenses to be renewed annually and uses an electronic licensing system to monitor licenses and payments. During fiscal year 2016, DPH licensed 251 ambulance services. DPH transfers fees collected for ambulance services licenses to DCH monthly for deposit into the Indigent Care Trust Fund.

Exhibit C-1
Ground Ambulances Represent the Majority of Licensees, Fiscal Years 2014-2016

	FY 2014	FY 2015	FY 2016
Ground Ambulance	216	212	243
Air Ambulance	2	4	4
Neonatal Transport	3	3	4
Total	**221**	**219**	**251**

Source: Department of Public Health data

Revenue and Expenditures

As shown in **Exhibit C-2**, the ambulance licensing program fee revenue transferred to the ICTF has gradually increased over the last three years, growing from $3.3 million in fiscal year 2014 to $4.1 million in fiscal year 2016. Given the Federal Medical Assistance Percentage for fiscal year 2016, the expenditure of all fee revenue for fiscal year 2016 would have generated approximately $8.3 million in federal funds for a total of $12.4 million in revenue and expenditures. The actual federal fund revenue and expenditures are exceptions due to DCH not spending all fee revenue collected in fiscal year 2015 in that year. Because $2.3 million in fee revenue was not spent until fiscal year 2016, when combined with the expenditure of 2016 collections, the fee-related expenditures generated an unusually high amount of federal funds in fiscal year 2016. Fees, which reduce the amount of general funds needed for the program, and the corresponding federal matching funds from this program are used to support the Aged, Blind, and Disabled Medicaid program.

Exhibit C-2
Ambulance Services Licensing Fee Revenue to the ICTF Has Increased, Fiscal Years 2014-2016

Source	FY 2014	FY 2015	FY 2016	% Change FY 2014-16
Prior Year Carry Over	$0	$0	$2,331,098	
Revenue				
Federal	$6,433,102	$2,518,299	$13,392,608	108%
Fees	3,329,351	3,574,823	4,136,560	24%
Total Revenue	**$9,762,453**	**$6,093,122**	**$17,529,168**	**80%**
Total Available	$9,762,453	$6,093,122	$19,860,266	103%
Total Expended	**$9,762,453**	**$3,762,024**	**$19,860,266**	**103%**
Balance Remaining	$0	$2,331,098	$0	0%

Source: TeamWorks Financials data

Appendix D: Certificate of Need Program

The Certificate of Need Program was established in 1979 to control the addition and duplication of healthcare facilities and services. It is intended to ensure equal access to quality health care at a reasonable cost. Providers that do not provide a minimum level of uncompensated care to the medically indigent must pay a monetary penalty, all of which is deposited into the ICTF. DCH uses revenue collected from CON penalties as part of the state match for the Disproportionate Share Hospital Program.

Penalty Assessment

Georgia law (O.C.G.A. 31-6-40) requires institutional health services to apply for a Certificate of Need (CON) before establishing or expanding health care services or facilities. DCH's Office of Health Planning (OHP) evaluates proposals to assess whether to grant a certificate of need. Facilities granted a certificate of need are required to devote a certain percentage of their adjusted gross revenue to uncompensated charity and indigent care.[13]

OHP conducts annual surveys of health providers to compile financial and other information for regulatory, planning and reimbursement purposes. OHP uses the Hospital Financial Survey and the Indigent Care Trust Fund Addendum to identify providers with a shortfall in their indigent and charity care commitment. Those with a shortfall receive a notification letter as part of the annual compliance notification process. The letter specifies the amount of the shortfall and imposes a monetary penalty for noncompliance that is the difference between the commitment and actual amount of indigent and charity care provided. Unless the provider requests an administrative hearing within 30 days to dispute the shortfall, payment of the monetary penalty is due. State law requires proceeds to be deposited into the ICTF.

OHP reported that facilities do not always comply with annual survey requirements. In June 2016, OHP initiated a survey compliance project to allow facilities with delinquent surveys to complete those surveys prior to OHP initiating enforcement actions. DCH sent a Notification of Deficiencies letter to 339 facilities, specifying the year(s) for which an annual survey is outstanding. DCH granted facilities until September 15, 2016 to complete delinquent surveys, after which applicable fines will begin accruing for non-compliant facilities. DCH intends to use the information collected from delinquent surveys to identify facilities that have not reported, collect penalties for shortfalls, and update its database.

Penalty Revenue and Expenditures

For fiscal year 2016, the ICTF had $3.6 million from Certificate of Need revenue, primarily penalties collected for shortfalls in indigent and charity care commitments (see **Exhibit D-1**). Total revenue also includes approximately $51,000 from interest. Revenue from Certificate of Need penalties fluctuated between fiscal years 2014 and 2016 because penalties are assessed only to providers that are determined to be non-compliant. Revenue may also vary based on OHP's efforts to enforce indigent care commitment requirements.

[13] Certain facilities, such as home health facilities, may be subject to providing less indigent or charity care.

Exhibit D-1
Certificate of Need Penalty Revenue to the ICTF Has Fluctuated, Fiscal Years 2014-2016

Source	FY 2014	FY 2015	FY 2016	% Change FY 2014-16
Prior Year Carry Over	$1,466,352	$3,271,754	$38,248	(97%)
Revenue				
Fees	$2,486,334	$1,443,995	$3,570,687	44%
Interest	16,036	25,393	51,268	220%
Total Revenue	**$2,502,370**	**$1,469,388**	**$3,621,956**	**45%**
Total Available	$3,968,722	$4,741,141	$3,660,204	(8%)
Total Expended	**$696,968**	**$4,702,893**	**$2,321,703**	**233%**
Balance Remaining	$3,271,754	$38,248	$1,338,500	(59%)

Source: TeamWorks Financials data

Expenditures of CON penalty revenue fluctuated between fiscal year 2014 and fiscal year 2016. CON penalties are used as part of the state match for the DSH Program. Changes in expenditures indicate variances in the amount of penalty revenue that DCH used as the state match for the DSH Program.

Appendix E: Breast Cancer Awareness License Plates

The General Assembly created the Breast Cancer Awareness License Plates in 2002 to support breast cancer screening and treatment related programs for the medically indigent. A portion of revenue collected from the sale of breast cancer awareness license plates is transferred to the ICTF. Through contracts, the funds are used for breast cancer screenings, outreach, education, and treatment programs that target minority indigent women.

Fee Collection

State law requires $22.05 of the $35 Breast Cancer Awareness License Plate fee collected for each plate issued and renewed to be deposited into the ICTF.[14] The Department of Revenue remits funds collected for the plate to DCH on a monthly basis.

Revenue and Expenditures

The ICTF's revenue for fiscal year 2016 included $311,000 from Breast Cancer Awareness License Plates (see **Exhibit E-1**). Revenue has declined since fiscal year 2014, which is the result of a decline in the sale of the license plates. According to program officials, this may be the result of the increase in the number of special license plates made available to vehicle owners since 2002 when the breast cancer license plate was created or the increase in plate fees implemented in 2011.

Exhibit E-1
Breast Cancer Awareness License Plate Revenue to the ICTF Has Declined, Fiscal Years 2014-2016

Source	FY 2014	FY 2015	FY 2016	% Change FY 2014-16
Prior Year Carry Over	$2,795,392	$2,475,267	$2,102,780	(25%)
Revenue				
Fees	$428,035	$375,600	$311,236	(27%)
Interest	1,840	1,913	2,123	15%
Total Revenue	**$429,875**	**$377,513**	**$313,359**	**(27%)**
Total Available	$3,225,267	$2,852,780	$2,416,139	(25%)
Total Expended	**$750,000**	**$750,000**	**$750,000**	**0%**
Balance Remaining	$2,475,267	$2,102,780	$1,666,139	(33%)

Source: TeamWorks Financials data

Expenditures of Breast Cancer Awareness License Plate revenue has remained steady. Total expenditures for fiscal years 2014 through fiscal year 2016 were $750,000 annually and exceeded the program's total revenue. During this period, the program also maintained a fund balance that exceeded total revenue. However, because expenditures were greater than revenue each year, the fund balance has declined.

[14] The $22.05 represents the portion of special license plate revenue that may go to benefit designated organizations.

Distribution of Revenue

DCH expends plate revenue through a contract with the Georgia Center for Oncology Research and Education (CORE). The current contract began in September 2015 and provides $750,000 for breast cancer screening and treatment programs. CORE uses a competitive request for proposal process to identify treatment service projects or education and preventive service projects. Health entities can request up to $100,000 for treatment service projects and up to $50,000 for education and preventive service projects. They must agree to provide matching funds or in-kind support that equals or exceeds the amount of the grant request.

CORE allocates contract funds to grants awarded to public and private health organizations and the Department of Public Health, genetic counseling and testing program, breast cancer license plate marketing, and administrative costs. As shown in **Exhibit E-2**, the funds support breast cancer screening, treatment and education related services.

Exhibit E-2
Breast Cancer Awareness License Plate Revenue Supports Breast Cancer Screening and Treatment Services

Public and Private Health Organizations (February 2016 to June 2016)	
Activities & Services	**Total**
Clinical Breast Exams	268
Screening Mammograms	520
Diagnostic Mammograms	125
Biopsies	24
Ultrasounds	44
Genetic Risk Assessment	2
Genetic Testing	3
Genetic Counseling	3
Radiation Services	4
Chemotherapy	4
Surgery	4
DPH Breast & Cervical Cancer Program (December 2015 to June 2016)	
Activities & Services	**Total**
Clients Assisted With Getting Clinical Breast Exams	137
Clients Assisted With Getting Mammograms	137
Women Educated Through Health Fairs and Other Events	931

Source: Georgia Center for Oncology Research and Education

Appendix F: Hospital Medicaid Financing Program

The General Assembly created a hospital provider fee to be deposited into the Indigent Care Trust Fund with the passage of the Provider Payment Agreement Act during the 2010 legislative session. The Act specified the rate and hospitals subject to the fee. Prior to the scheduled repeal of the law on July 1, 2013, the General Assembly passed the Hospital Medicaid Financing Act (O.C.G.A. 3-8-179) to provide the Board of Community Health with the authority to assess provider payments on hospitals for the purpose of obtaining federal financial participation for Medicaid. The Act will sunset on June 30, 2017 unless reauthorized during the 2017 legislative session.

Fee Assessment

The Board of Community Health assesses two provider fees under the Act: the Hospital Provider Payment Program fee (commonly referred to as "Tier I") and the Hospital Medicaid Financing Program fee ("Tier II"). Tier I fees are paid by a majority of hospitals and make up the vast majority of revenue obtained under the Act, while Tier II fees are paid by significantly fewer private hospitals.

- **Tier I** – The Tier I fee was enacted by state law in fiscal year 2011 and reauthorized by DCH board rule (Rule 111-3-9) in fiscal year 2014 to generate a portion of the state's share of Medicaid funding. According to DCH officials, the fee methodology (e.g., hospitals that are subject to the fee and the fee amounts) was determined by DCH, legislators, and the hospital community.

  Approximately 67% of hospitals (125 of 187) are required to pay the Tier I provider fee, with psychiatric, critical access, and state- and federal-owned or operated hospitals exempt. Non-exempt hospitals are assessed a fee on the net patient revenue reported on their annual DCH hospital financial survey.[15] Most hospitals pay a fee of 1.45%, though trauma hospitals pay 1.40%. DCH rules require providers to make quarterly payments, with failure to make timely payments resulting in a 6% penalty.

- **Tier II** – The Tier II fee was enacted by DCH board rule (Rule 111-3-10) in fiscal year 2014. The fee revenue is matched with additional federal funds to make upper payment limit (UPL) payments[16] to a subset of private hospitals that did not already receive UPL payments. The fee methodology was developed by an advisory committee created by an executive order from the Governor.

  Approximately 24% (44 of 187) of hospitals are required to pay the Tier II provider fee. Private hospitals pay the fee, but specialty, critical access, and psychiatric hospitals are exempt. To determine the Tier II fee amount, DCH must first determine the amount of UPL payments that will be made to the

[15] Hospital revenue from their fiscal year that ended in calendar year 2015 is captured on the 2015 hospital financial survey (HFS). The 2015 HFS was due in July 2016. Provider fees are based on the most recent HFS available. For example, fiscal year 2017 hospital provider fees are based on the 2014 HFS.

[16] The Center for Medicare and Medicaid Services (CMS) allows states to reimburse Medicaid providers up to the amount Medicare would have paid. The UPL payments supplement regular Medicaid payments that may be below provider cost. States must provide matching funds at the state's FMAP to draw down the federal UPL allotment. It should be noted that other healthcare providers, including public hospitals and nursing homes, also receive UPL payments; however, those payments do not flow through the ICTF.

hospitals. DCH compares the amount paid for services to Medicaid patients to the estimated amount that would have been paid based on Medicare payment principles. The difference becomes the Tier II allotment available for disbursement, and the state's share, based on the current FMAP, becomes the amount needed from the Tier II provider fee. This amount is converted to a per non-Medicare bed day rate ($10.90 in fiscal year 2016) and assessed annually.

Revenue and Expenditures

As shown in **Exhibit F-1**, the combined revenue from both tiers increased by 19.5% from approximately $699 million in fiscal year 2014 to $835 million in fiscal year 2016. The increase in revenue is driven primarily by higher Tier I fees, which increased by 9.5% between fiscal years 2014 and 2016 due to increased net patient revenue. The Tier I fee and its associated federal matching funds represent approximately 97% of hospital provider fee revenue. During the same time, Tier II fees decreased by 45%, as a result of lower Medicare payment rates imposed under the Affordable Care Act. Lower Medicare rates reduce the upper payment limit and the associated payments.

Hospital provider fee revenue is also impacted by the timing of Tier II payments. Tier II payments cross years due to the timing of DCH's submission and CMS' approval of Tier II allocation. For example, 85% and 69% of fiscal year 2014 and 2015 Tier II payments were made in fiscal year 2015. All fiscal year 2016 Tier II payments were made in fiscal year 2017.

All hospital provider fees are expended in the year collected. In fiscal year 2016, hospitals' provider fee expenditures, including federal funds, were approximately $835 million.

Exhibit F-1
ICTF Revenue from Hospital Medicaid Financing Program Revenue Has Increased, Fiscal Years 2014-2016

Source	FY 2014	FY 2015	FY 2016	% Change FY 2014-16
Prior Year Carry Over	$0	$0	$0	0.0%
Revenue				
Federal	$460,742,952	$564,022,898	$564,382,950	22.5%
State	0	0	0	0.0%
Fees	237,978,451	278,958,076	270,602,167	13.7%
Total Revenue	**$698,721,403**	**$842,980,974**	**$834,985,117**	19.5%
Total Available	$698,721,403	$842,980,974	$834,985,117	19.5%
Total Expended	**$698,721,403**	**$842,980,974**	**$834,985,117**	19.5%
Balance Remaining	$0	$0	$0	0.0%

Source: TeamWorks Financials data

Distribution of Revenue

The majority of hospital provider fee revenue, 68% in fiscal year 2016 (approximately $564 million of $835 million), is used for Medicaid payments to all providers. The remaining 32% is returned to participating hospital providers. As discussed below, a

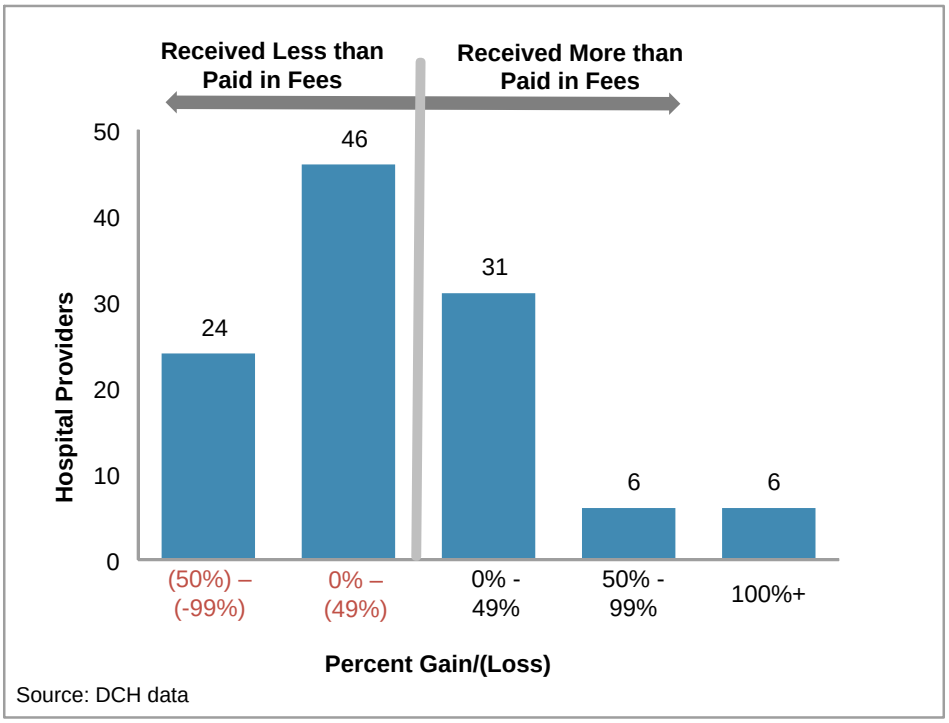
portion of Tier I revenue is allocated to hospital providers through a Medicaid add-on, while all Tier II revenue is allocated to hospital providers through UPL payments.

When provider fees are used as state matching funds for Medicaid, federal regulations require there to be a difference between the fee payment made by a provider and the subsequent payment made to the provider. As a result, some hospitals benefit more from the distribution of revenue than others. Hospitals that do not serve as many Medicaid patients may contribute more than they receive. The distribution of revenue in each tier is discussed below.

- **Tier I** – DCH offsets hospital providers' expense in paying the Tier I fee by adding 11.88% to those providers' inpatient and outpatient rates. DCH board rules authorize the Department to conduct an annual review to ensure the total add-on payments is substantially equivalent to the total provider fees assessed.

  As a group, hospitals receive most of what they paid in Tier I fees through the add-on, but not all hospitals are net beneficiaries. In fiscal year 2016, at least 92% ($242 million of $264 million) of fees are expected[17] to be returned through the 11.88% Medicaid add-on. Although the majority of fees collected through the Tier I fee are returned through the add-on, most hospitals do not come out ahead (see **Exhibit F-2**). The percentage of hospitals that received more than they paid was approximately 48% (57 of 119) in fiscal year 2011 but

Exhibit F-2
Most Providers Experienced Losses in Tier I, Fiscal Year 2015



Source: DCH data

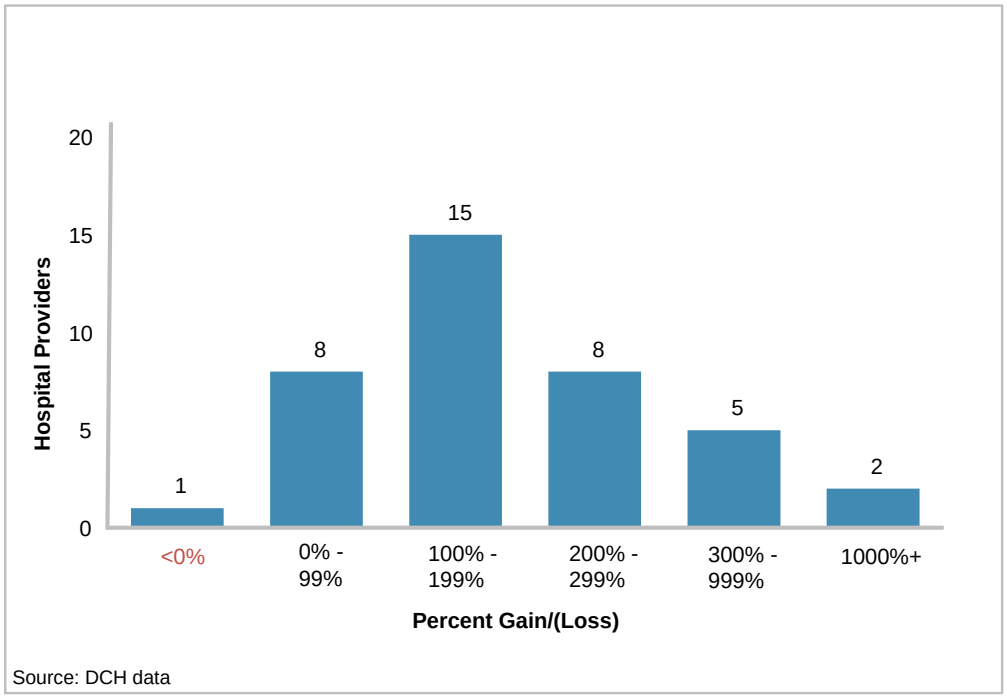
[17] As of September 30, 2016, approximately $225.5 million in Tier I add-on had been paid for services provided in fiscal year 2016. As claims are submitted over the next 12 months, this is expected to increase to between $242 and $255 million.

had declined to 38% (43 of 113) in fiscal year 2015.[18] The percentage of the fee recovered through add-on payments varied considerably by hospital. For example, in fiscal year 2015, six hospitals received less than 10% of what they paid in fees back through the add-on while six others received more than double what they paid.

- **Tier II** – All of the fees collected, as well as the federal funds drawn down in Tier II, are distributed back to eligible hospitals through UPL payments. Tier II funds are allocated to those that pay the fee as well as Long Term Acute Care hospitals (which are exempt from the fee but eligible to receive payments). UPL payment amounts are determined by each hospital's annual volume of Medicaid revenue. In fiscal year 2016, eligible providers received payments equal to .47% of their inpatient Medicaid revenue and 12.92% of their outpatient Medicaid revenue.

  Because the fee revenue and associated federal funds are allocated as UPL payments, the vast majority of hospitals (98% in fiscal year 2016) receive more than they pay (see **Exhibit F-3**). For those eligible to participate, Tier II offsets a portion of the losses experienced in Tier I. Approximately 46% of providers that had losses in Tier I (32 of 70) participated in Tier II. Tier II payments eliminated losses for 10 hospitals. It also reduced the losses of 21 hospitals from a cumulative $30.4 million to $19.6 million. One provider lost in both Tier I and Tier II, for a net loss of approximately $1 million.

Exhibit F-3
Most Providers Experienced Gains in Tier II, Fiscal Year 2015

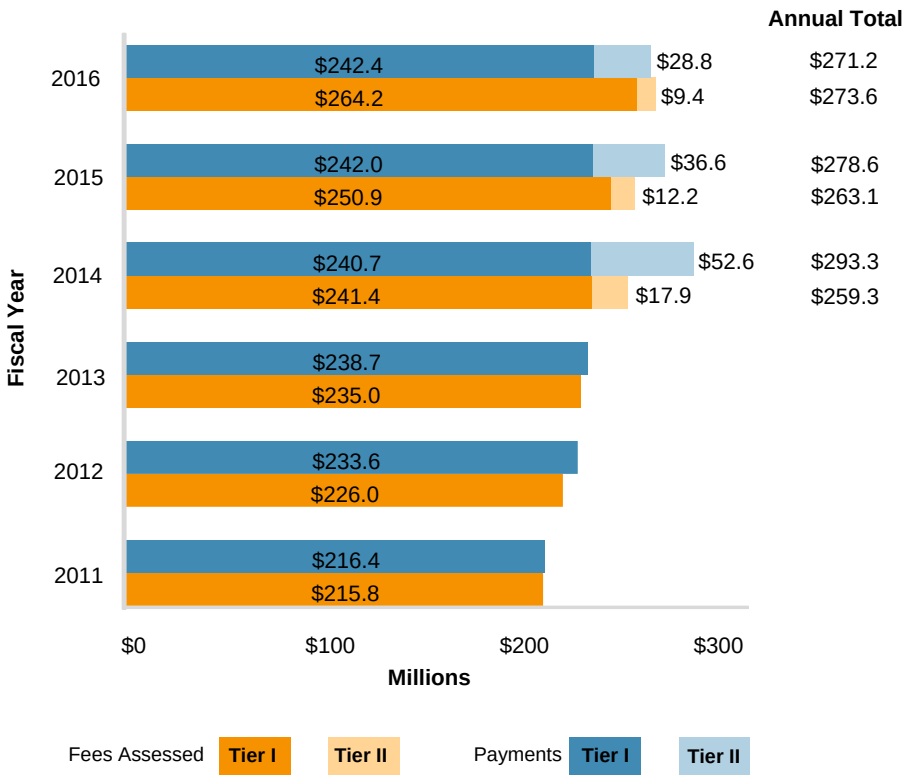


Source: DCH data

[18] Some hospital providers were excluded from this analysis (8 in fiscal year 2011 and 11 in fiscal year 2015). We excluded providers that showed no Medicaid add-on payments because they either (1) were not enrolled in Medicaid, (2) were part of a hospitals system and bill through another hospital, or (3) they serve dually eligible members under Medicare-Medicaid which effectively limits the Medicaid payment.

While net losses or gains vary by hospital and fee, the hospital community as a whole has experienced a net gain since the provider fee was instituted. As shown in **Exhibit F-4**, hospital providers received more in Tier 1 add-on payments and UPL payments than they paid in fees in fiscal years 2011-2015; in fiscal year 2016, the hospital community paid in more than it received. Considering all hospital provider fees and associated payments, participating hospitals netted approximately $59 million in fiscal years 2011 through 2016. The largest gain was approximately $34 million in fiscal year 2014. However, this appears to be trending downward in correlation with reduced Tier II payments (discussed previously on page 28).

Exhibit F-4
Hospitals Received More in Fee-Associated Payments Than They Paid in Hospital Provider Fees[1], Fiscal Years 2011-2016



[1]Fee and payment amounts are based on year assessed. Some fees and payments are collected or paid in the following fiscal year.

Source: DCH data

Appendix G: Nursing Home Provider Fee Program

The Nursing Home Provider Fee Act (O.C.G.A. 31-8-161), enacted in 2003, requires DCH to assess a fee on most nursing homes for the purpose of obtaining additional federal funding to supplement Medicaid payments made to nursing homes. All revenue collected is deposited into the Indigent Care Trust Fund.

Fee Assessment

Facilities assessed the nursing home provider fee pay $17.10 daily for each bed occupied by a non-Medicare patient (e.g., Medicaid patients, private insurance, private pay). The fee is designed to stay within federal guidelines that limit provider taxes to no more than 6% of provider revenue. Each year DCH estimates nursing homes' total annual revenue and total annual bed days based on cost reports to calculate a per day rate. However, the agency only adjusts the rate if it is above the federal threshold or if additional funds are needed. The rate has been adjusted nine times since the fee was enacted (six increases and three decreases).

In fiscal year 2015, approximately 96% (335 of 349) of nursing home providers in Georgia were required to pay the provider fee. The following categories of nursing homes are exempt in accordance with a waiver from the Centers for Medicare and Medicaid Services:

- Top ten nursing facilities that are public or not for profit, ranked by number of patient days;
- Continuing care retirement centers;
- State- or federally-operated nursing facilities;
- Nursing facilities that do not charge for services.

It should be noted that the current list of top ten providers by patient day is unchanged since fiscal year 2005. Our analysis of fiscal year 2015 data identified two providers that should be on the exempt list and two providers that should not. This does not have a significant impact on total Nursing Home Provider fee revenue provided for the ICTF, but it does have a financial impact on these providers. Two providers that have improperly remained on the exemption list had an estimated combined gain of approximately $454,000 in fiscal year 2016, while two providers that should be on the list had an estimated combined loss of approximately $413,000.

Revenue and Expenditures

As shown in **Exhibit G-1**, Nursing Home Provider Fee funding has remained relatively stable in recent years. In fiscal year 2016, the ICTF had approximately $502 million from federal funds and nursing home provider fees. Total fees collected increased by 3% ($5.9 million) between fiscal years 2014 and 2015, and decreased by 6.8% between fiscal years 2015 and 2016. All funds associated with the nursing home provider fee are expended in the year received. In fiscal year 2016, nursing home provider fee expenditures, including federal funds, represented approximately 31% ($502 million of $1.6 billion) of total Medicaid payments to nursing homes in Georgia.

Exhibit G-1
Nursing Home Provider Fee Revenue to the ICTF Relatively Stable, Fiscal Years 2014-2016

Source	FY 2014	FY 2015	FY 2016	% Change FY14-16
Prior Year Carry Over	$0	$0	$0	0.0%
Revenue				
Federal Funds	$327,091,485	$352,107,779	$338,668,007	3.5%
State Funds	$0	$0	$0	0.0%
Fees	169,521,312	175,413,852	163,523,682	(3.5%)
Total Revenue	**$496,612,797**	**$527,521,631**	**$502,191,689**	**1.1%**
Total Available	$496,612,797	$527,521,631	$502,191,689	1.1%
Total Expended	**$496,612,797**	**$527,521,631**	**$502,191,689**	**1.1%**
Balance Remaining	$0	$0	$0	0.0%

Source: TeamWorks Financials data

Distribution of Revenue

Nursing home provider fee revenue is returned to providers through both higher Medicaid rates and an add-on. In fiscal year 2016, an estimated 73% of the revenue (approximately $367 million of $502 million) was redistributed to nursing homes through a higher Medicaid rate. The remainder was returned to participating providers through an add-on payment equal to the daily fee rate paid by providers for onsite Medicaid bed days. While this add-on is intended to offset the fee paid on Medicaid bed days, it does not offset the total amount collected through the provider fee.

The provider fee and associated Medicaid add-on payment impact providers differently, depending on the extent to which a provider serves Medicaid patients. The Medicaid add-on returned approximately 82-83% of provider fees in fiscal years 2013 through 2015. Providers that serve a higher portion of Medicaid patients fared better than those that serve a small portion. In fiscal year 2015, one provider received 99.6% of provider fees paid back through the Medicaid add-on while another received 6.6%.

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