SPECIAL EXAMINATION • REPORT NUMBER 25-07 • DECEMBER 2025

Hospital Provider Fee

Requested information on administration and outcomes

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Lisa Kieffer | Executive Director

DOAA
Georgia Department
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Performance Audit Division
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Why we did this review

The House Appropriations Committee requested this special examination of the hospital provider fee. Based on this request, we reviewed (1) how much hospitals pay in provider fees; (2) how much hospitals paying the provider fee receive in add-on payments made in recognition of the fee; (3) impacts to the state as a result of reductions in federal support for the provider fee program; and (4) the benefits the state provides to hospitals receiving add-on payments made in recognition of the fee.

About the hospital provider fee

Under the provider fee program, the Department of Community Health (DCH) assesses a 1.45% or 1.40% fee on the net patient revenue of all hospitals in the state except psychiatric, critical access, and state-owned hospitals (119 hospitals participated in fiscal year 2025). DCH uses provider fee revenues as a portion of the required non-federal funds states must contribute to support their Medicaid expenses. The fee was established in 2010.

In recognition of the fee, hospitals receive an 11.88% increase in Medicaid payments from DCH and the state's managed care organizations. Per federal regulations, these payments are not designed to return fees paid to participating hospitals directly.

What we found

In fiscal years 2020-2025, hospitals paid approximately $2.2 billion in provider fees and received $1.7 billion in Medicaid add-on payments made in recognition of the fee. DCH oversight of fee and add-on payment processes could be improved to ensure hospitals pay the entirety of fees owed and add-on payments are paid to appropriate providers. Recent federal changes to Medicaid are not currently expected to impact the fee.

DCH oversight related to fees and add-on payments could be improved.

In fiscal years 2020-2025, hospitals paid $2.2 billion (94%) of the $2.4 billion in hospital provider fees owed. Total fees paid were less than total fees owed in all six years reviewed, with the greatest difference ($58 million) in fiscal year 2022. DCH does not currently impose penalties for late or underpayments, and communication regarding fee balances across agency staff and to hospitals is limited.

Additionally, our review of managed care add-on payments identified that the state's Medicaid managed care organizations distributed nearly $5 million to providers that did not participate in the provider fee program in fiscal years 2022-2025. While DCH receives a third-party report containing managed care add-on payment information, it does not review the report. Managed care data also lacks the detail needed to verify the add-on payment was applied to the original payment amount; as such, we were unable to verify the add-on payments were calculated appropriately.

In all years reviewed, hospitals received less in total add-on payments than the amount of fees owed or paid.

Hospitals received $1.7 billion in add-on payments during the period reviewed—$539 million less than total fees paid. In all years, the total amount of fees assessed or paid was greater than total add-on payments received. In accordance with federal requirements, individual hospitals should not

expect add-on payments to equal fees paid; however, DCH rules indicate that total fees paid should be substantially equivalent to total add-on payments.

Most hospitals participating in the provider fee program receive state income tax exemptions, and some receive other financial benefits.

Hospitals participating in the provider fee program receive various financial benefits from the state, including income, sales and use, and property tax exemptions. In fiscal years 2020-2023, total state income tax exemptions for these hospitals were estimated to be between $889.5 million and $936.3 million. Total exemptions for fiscal years 2024-2028 are forecasted to be between $1.45 billion and $1.53 billion. Hospitals also received exemptions for state sales and use, local sales and use, and local property taxes during the period.

In addition to tax exemptions, hospitals received benefits from various state programs. These include Rural Hospital Tax Credit donations, Rural Hospital Stabilization Grant funds, Disproportionate Share Hospital payments, and Graduate Medical Education payments. It should be noted that these benefits are not directly tied to provider fee participation and support other purposes.

Recent federal changes to Medicaid do not currently impact the provider fee program.

U.S. House Resolution 1, which became law on July 4, 2025, introduced new federal requirements for programs like the hospital provider fee. Because the changes primarily affect states that expanded Medicaid eligibility, the legislation does not currently impact Georgia's hospital provider fee program or the revenues it raises for state Medicaid expenses. The legislation's moratorium on increasing existing rates could limit DCH's ability to raise provider fee revenues in the future; however, this has not been proposed since the program's inception.

What we recommend

We recommend DCH strengthen its oversight processes related to the provider fee payment. This would include assigning oversight functions to a single DCH position and implementing penalties or other corrective actions for hospitals that fail to pay the entire amount or fail to pay in a timely manner. To ensure total add-on payments are substantially equivalent to total fees paid, we also recommend DCH review whether the 11.88% add-on payment percentage should be increased. Finally, we recommend DCH implement oversight processes for add-on payments paid by managed care organizations (CMOs). This includes establishing a routine procedure to ensure the add-on payment is appropriately calculated and paid, as well as reviewing an existing report that contains information about providers receiving add-on payments from CMOs.

See **Appendix A** for a detailed listing of recommendations.

Agency Response: *DCH agreed or partially agreed with the findings and recommendations. DCH agreed it must ensure fee payments are made in full and on time but also noted the need to minimize financial strain on hospitals. Agency responses are included at the end of each finding.*

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Purpose of the Special Examination

This review of the hospital provider fee was conducted at the request of the House Appropriations Committee. Our review focuses on the following questions:

- How much do hospitals pay in provider fees?
- How much do hospitals paying the provider fee receive in add-on payments made in recognition of the fee?
- What impacts will the state experience as a result of reductions in federal support for the provider fee program?
- What benefits, including state income tax benefits, does the state currently provide to hospitals receiving add-on payments made in recognition of the fee?

A description of the objectives, scope, and methodology used in this review is included in **Appendix B**. 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

Hospital Provider Fee

The General Assembly established the hospital provider fee[1] with the passage of the Provider Payment Agreement Act in 2010. Prior to its scheduled repeal on July 1, 2013, the General Assembly reauthorized the fee with the Hospital Medicaid Financing Program Act, which was reauthorized in 2017, 2019, and 2024 and is scheduled to be repealed in 2030. The Act authorizes the Board of Community Health to assess a fee on all hospitals in the state except psychiatric, critical access, and state-owned facilities. In fiscal year 2025, 119 of 179 hospitals in Georgia were assessed the fee. The Georgia Department of Community Health (DCH) administers the fee and uses fee revenues to support Medicaid costs.

Medicaid is a joint federal and state program that provides health coverage for low-income individuals. In Georgia, DCH administers Medicaid. For an overview of Georgia's Medicaid program, see **Appendix D**.

Since its inception, DCH has assessed a fee equal to 1.45% of hospital net patient revenue[2] (1.40% for trauma hospitals), which is reported in the Hospital Financial Survey (HFS) hospitals must annually submit to DCH. The HFS used to determine fee amounts is generally dated three years prior to the relevant state fiscal year.[3] For example, fiscal year 2025 fees were determined using net patient revenue reported in the 2022 HFS. (See **Appendix C** for an overview of hospitals' net patient revenues in fiscal years 2017-2023.)

[1] The hospital provider fee is also called the "bed tax" or the "Tier 1 fee." We refer to it as the hospital provider fee in this report.
[2] Net patient revenue represents gross patient revenue less certain deductions, which include contractual adjustments and costs associated with bad debt, charity care, and indigent care. Hospitals are also instructed to deduct an estimate of total add-on payments received; staff from the audit firm that reviews Hospital Financial Survey data indicated this is intended to prevent hospitals from paying a fee on add-on revenues received in recognition of the fee.
[3] Hospitals are instructed to report financial information from their fiscal year ending in the calendar year corresponding to the HFS year. For example, a hospital with a July 1-June 30 fiscal year would report information from the year ending June 30, 2025 in the 2025 HFS. If a hospital does not submit an HFS for the year used to calculate fee amounts, DCH staff use HFS data submitted the year prior. Staff indicated this is rare.

While a total fee is assessed for the fiscal year, hospitals pay the amount in quarterly installments. Most hospitals pay online; however, they may also pay through an automated clearing house, a wire transfer, or a mailed check. DCH deposits fee revenues in a segregated account within the Indigent Care Trust Fund,[4] as required by law. **Exhibit 1** on page 4 portrays DCH's fee assessment and collection processes.

State law permits DCH to impose a penalty of up to 6% for any hospital that fails to remit the quarterly fee payment within the time required or for each month (or fraction of a month) the payment is overdue. Additionally, if a hospital fails to pay on time, state law requires DCH to withhold an amount equal to the fee and late penalties from any payments it owes the hospital for Medicaid claims.

Federal Guidelines

The hospital provider fee is a form of a "provider tax," which states began using in the 1980s to support their Medicaid programs. Provider taxes—referred to as "health care-related taxes" in federal regulations and approved by the Centers for Medicare and Medicaid Services (CMS)—allow states to tax healthcare providers in the form of a licensing fee, assessment, or other payment. States then use the tax revenues as a portion of the non-federal dollars they are federally required to contribute for Medicaid costs (see text box for further discussion).

In Georgia, the General Assembly appropriates provider fee funds to two of the state's three Medicaid programs—Low-Income Medicaid (LIM) receives nearly 90% of appropriations, while Aged, Blind, and Disabled (ABD) receives the remaining 10%.[5] These appropriations fulfill a portion of the state's non-federal funding requirement.

Determining the federal government's share of a state's Medicaid expenditures

Federal law requires the U.S. Department of Health and Human Services to provide the federal medical assistance percentage (FMAP) to all states with approved Medicaid plans. The FMAP represents the percentage of total Medicaid expenditures the federal government will support and is annually calculated using a formula that incorporates the state's per capita income. The remaining costs are supported by permissible non-federal sources of funding, including state general funds, local government funds, and provider taxes; federal regulations require that at least 40% of non-federal funds come from state general funds.

For federal fiscal year 2026 (October 1, 2025-September 30, 2026), Georgia's FMAP is 66.40%. This means approximately $0.66 of every dollar spent for Georgia Medicaid is supported by the federal government (with some exceptions). The remaining $0.34 is funded by state general funds, hospital provider fees, and other provider payments.

[4] *Established in 1990, the Indigent Care Trust Fund was created to expand Medicaid eligibility and services and support providers and primary care programs that serve the medically indigent. The Fund, which is administered by DCH, is a dedicated fund within the state treasury but also serves as a program to which funds are appropriated in the annual appropriations act.*

[5] *The third program is PeachCare for Kids, which provides health coverage for low-income children. ABD and LIM primarily provide coverage for low-income adults.*

A provider tax must meet the following requirements to be approved by CMS:

- The tax must be **broad-based**, meaning it is imposed uniformly on an entire class of healthcare items, services, or providers;
- The tax must be **uniformly imposed** throughout a jurisdiction, (i.e., imposed at the same rate per taxable unit); and
- The tax must not have **hold-harmless** provisions, meaning it must not guarantee—directly or indirectly—that the provider will receive all or a portion of its tax payment back via Medicaid payments. This requirement also dictates that Medicaid payments must not vary based on tax amount.

  CMS uses two tests to determine whether a tax holds providers harmless indirectly. First, prior to the passage of the most recent federal budget reconciliation bill, providers in all states must not have been taxed at a rate greater than 6% of total patient revenues (referred to as the "safe harbor threshold"). If the tax passes this test, it does not indirectly hold taxpayers harmless. If the tax exceeds the safe harbor threshold, it must pass the second test, which checks whether 75% or more of taxed entities receive 75% or more of total tax costs back in enhanced Medicaid payments.

As discussed on pages 1 and 23, DCH assesses a 1.45% fee (1.40% for trauma hospitals) on net patient revenues through the hospital provider fee. DCH estimates its overall provider tax rate for hospitals (including the provider fee) was 1.9% in fiscal year 2024.

States may receive waivers for either the broad basis or uniform imposition requirement provided certain conditions are met, including a requirement that the state show the impact of the tax is generally redistributive. DCH received waivers for these two requirements when CMS approved the provider fee. The fee program has not changed since it was approved.

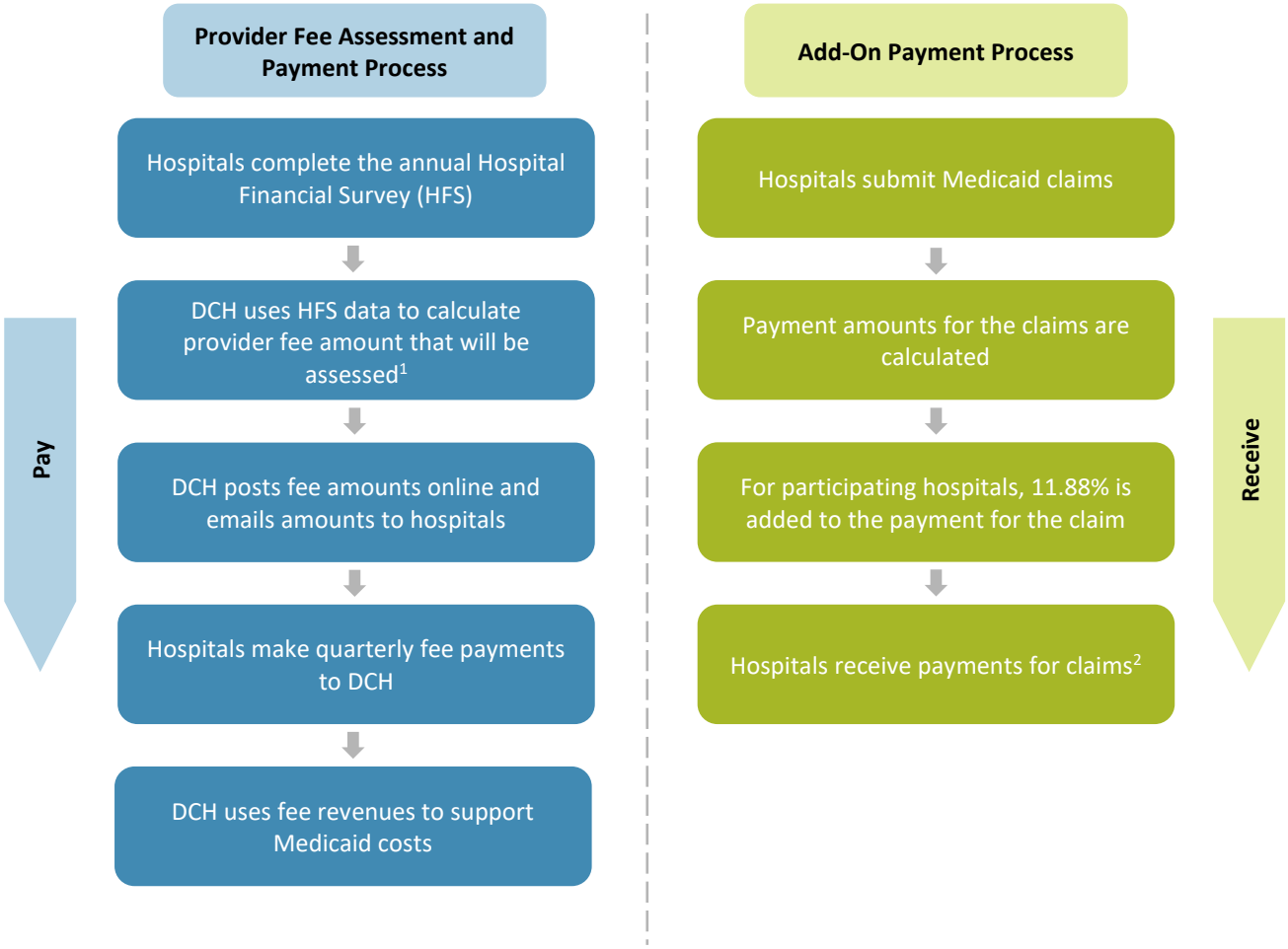
Add-On Payments

In recognition of the provider fee, DCH rules provide for an 11.88% increase in Medicaid reimbursement rates for inpatient and outpatient services provided by participating hospitals (see **Exhibit 1** on the next page). The add-on payment is applied to the final amount to be paid for the claim before the add-on is incorporated. For example, if the hospital will be paid $100, the add-on payment will be $11.88 (11.88% of $100), and the final paid amount will be $111.88 ($100 + $11.88). The add-on percentage is also applied to outpatient cost settlements[6] and graduate medical education payments,[7] which are supplemental payments hospitals receive from DCH separately from payments for claims. Hospitals receive the majority of add-on payments from claims.

[6] Outpatient cost settlement is a process in which DCH evaluates whether a hospital was appropriately reimbursed for an outpatient claim. If DCH finds it did not sufficiently pay the hospital for the cost, DCH pays the hospital the gap. Alternatively, if DCH identifies it overpaid for the claim, the hospital must pay DCH the overage. Cost settlements are conducted on a lag; DCH staff, for example, indicated the agency recently completed settlements for fiscal year 2022.
[7] DCH makes graduate medical education payments to teaching hospitals to support medical education in the state. See Finding 4 for more information.

Exhibit 1

The hospital provider fee program has two components—fees hospitals pay and add-on payments hospitals receive



[1] DCH contracts with an independent entity to audit a sample of HFS data annually. Based on the audit findings, hospitals may be required to revise various reported metrics in the HFS, including net patient revenue. When this occurs, fee amounts are adjusted to reflect the updated net patient revenue amount.

[2] Hospitals may also receive add-on payments through outpatient cost settlements or graduated medical education payments. Additionally, add-on payment amounts may be adjusted if the original amount paid for the claim is adjusted.

Source: DCH documentation and DCH staff interviews

Add-on payments are provided to hospitals participating in the provider fee regardless of the payer of the claim. There are two payers for Georgia Medicaid: DCH, which insures members directly through a fee-for-service (FFS) model, and managed care organizations (CMOs), which DCH contracts with to insure members under care network models. To cover the costs of CMO members' care, DCH pays CMOs monthly premium payments, referred to as "capitation payments," for each member enrolled. Whether a member is insured via DCH or a CMO generally depends on the specific Medicaid program in which they are enrolled. (See **Appendix D** for more information on FFS and CMOs.)

Because add-on payments are included in Medicaid claims reimbursement, the total amount of add-on payment a hospital receives varies based on total

reimbursement for Medicaid claims. Even if hospitals have comparable net patient revenue—and therefore comparable provider fee amounts—their total add-on payment amounts may differ because one hospital receives a greater portion of its revenue from Medicaid. Importantly, the provider fee is not intended to return fees paid via add-on payments to all individual hospitals that participate; this would violate federal provider tax regulations.

Update on limits to pass-through payments

In our 2016 report on the Indigent Care Trust Fund, we noted CMS considers the 11.88% add-on payments included in claims paid by CMOs to be "pass-through payments." Under 2016 regulations issued by CMS, pass-through payments must be phased out by January 1, 2027 unless an exception is granted. At the time, DCH stated it could continue to direct CMOs to pay the add-on if it could meet the criteria for one of the exceptions. CMS staff confirmed these payments are permissible and do not need to be phased out by 2027.

Requested Information

Finding 1: DCH processes could be strengthened to ensure hospitals pay the full amount owed on time.

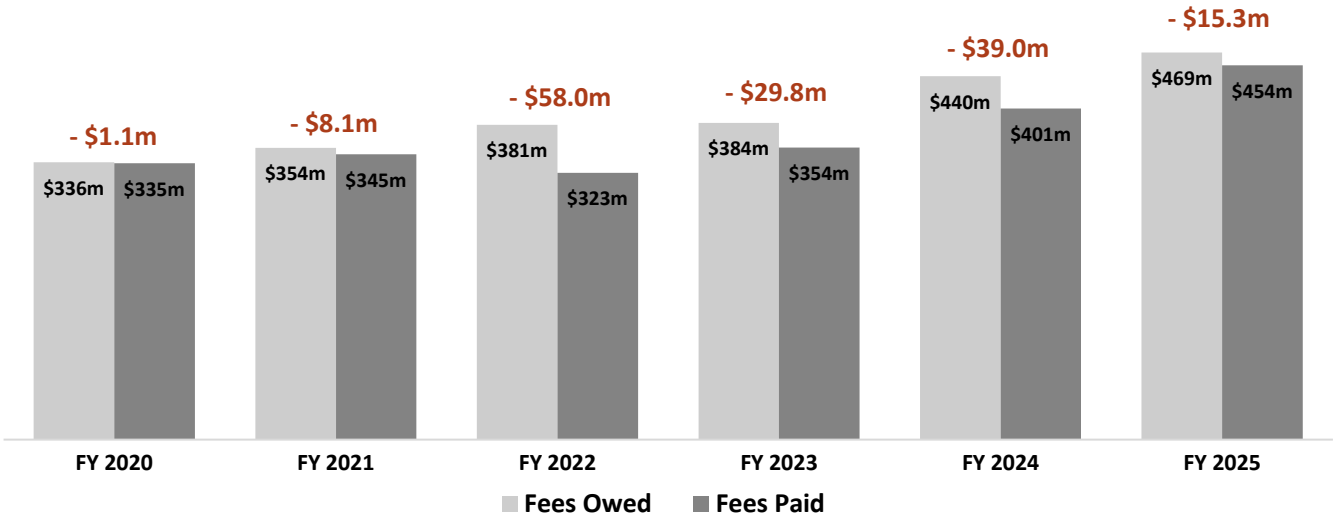
Hospitals paid $2.2 billion of the $2.4 billion in provider fees owed in fiscal years 2020-2025. In all years reviewed, total fee payments were less than total fees owed. DCH does not currently impose penalties for late payment or underpayment, and oversight of payment amounts is limited.

DCH payment records[8] indicate hospitals paid $2.2 billion in provider fees in fiscal years 2020-2025, ranging from $323 million in fiscal year 2022 to $454 million in 2025. The largest increase in payment amounts was from 2024 to 2025, when fees paid increased by $52 million (a 13% increase). Using the average federal medical assistance percentage (FMAP) for each fiscal year, we estimate provider fee payments allowed DCH to draw down $5.3 billion in federal funding for Medicaid in fiscal years 2020-2025.

As shown in **Exhibit 2**, hospitals paid less than fees owed in all six years reviewed. This led to an overall difference of $151 million (6% of total fees owed) during the period. The greatest difference ($58 million, or 15% of fees owed) was in fiscal year 2022, when hospitals paid $323 million but owed $381 million.

Exhibit 2

Hospitals paid less than what they owed in all six years reviewed[1,2] (FY 2020-2025)



[1] Fourteen of the 126 hospitals (11%) included in this analysis lacked data for the entire period. Data gaps are attributable to absences from DCH payment records in one or more quarters (7 of 14 hospitals), hospital openings or closures (7 hospitals), or changes in hospital ownership affecting participation in the provider fee (4 hospitals).

[2] Fee increases between fiscal years 2023 and 2024 are related to the periods used for calculating the fees. As discussed on page 1, DCH generally calculates how much a hospital owes in fees using financial data from three years prior. Because the amounts owed in 2023 were calculated using 2020 revenues (the first year of the pandemic), there was a smaller increase in fees owed between 2022 and 2023 than between 2023 and 2024.

Source: DCH Hospital Provider Payment Schedules for FY 2020-2025 and DCH provider fee tracking spreadsheets for FY 2020-2025

[8] *Due to limitations encountered in determining provider fee revenues using DCH's accounting records, we used hospital provider fee tracking spreadsheets prepared by DCH staff to report total fees paid for all years in our scope.*

DCH rules require hospitals to pay 25% of the total annual fee amount by the last day of the last month of the quarter (e.g., the first quarterly payment is due September 30). Quarterly payment dates are indicated on the hospital provider fee schedule, which DCH publishes each year and is shared with hospitals via email and posted online.

Our review of DCH records noted several issues related to hospital payments, discussed below. Not all hospitals fully complied with payment deadlines and amounts—in fiscal year 2025, 66% (79 of 119) of hospitals paid the full amount owed within a week of the due date each quarter, compared to 48% (57 of 120) in fiscal year 2024.

- **Late or missing payments** – In fiscal year 2025, 21% of hospitals did not submit all four quarterly payments (30% did not submit all payments in fiscal year 2024). Of those that did submit four payments during the year, 10% submitted one or more payments over a week after the due date in 2025, compared to 32% in 2024.
- **Underpayments –** As previously stated, hospitals are informed of how much they owe each quarter via a provider fee schedule. DCH records indicate 27 (23%) of 119 hospitals had overall balances for fiscal year 2025—with 6 having balances that exceeded $500,000. During the entire six years, DCH records indicate underpayments totaling $151 million.
- **Overpayments –** While not prohibited by DCH rules or statute, hospitals may occasionally pay more than they owe. We identified 25 instances of hospital overpayment and 5 overall balances exceeding the amount owed in fiscal year 2025 (totaling approximately $125,000). Staff indicated they note overpayments when they occur and apply them to balances of fees owed.

When hospitals fail to pay on time or do not pay the full amount owed, DCH does not receive all of the revenue it would use to support Medicaid costs. This may require DCH to use other non-federal funds, such as state general funds, to support payment gaps. Claims amounts do not change based on provider fee or other revenues for Medicaid, but ultimately they must be paid using both non-federal funds and FMAP funds (as discussed on page 2).

Late and underpayments would likely be improved with additional notifications or communication from DCH, as well as further enforcement.

- **Payment notification** – DCH staff reported they do not send hospitals invoices or other notification of fees owed other than the fee schedule, which is emailed to hospitals once per year (although updated schedules may also be sent if revisions are needed). Additionally, DCH's system does not indicate how much hospitals owe when they make an online

payment;[9] rather, hospital staff enter the amount they wish to pay in the online system. Finally, DCH does not contact hospitals that do not pay on time or do not pay the full amount, despite requirements in agency rules. DCH also does not contact hospitals in the event of overpayment.

- **Enforcement** – If a hospital fails to pay on time or does not pay the full amount, DCH does not assess a 6% penalty for each month the payment or fraction of the payment is overdue—a practice authorized by state law and by DCH rules. In fiscal year 2025, one hospital would have accrued approximately $136,000 in penalties based on balances owed. Another hospital's accrued penalties would have totaled approximately $799,000.

  Staff indicated DCH previously imposed this penalty but stopped during the pandemic due to the financial pressures hospitals experienced. Staff also reported that in the program's early years, there were greater efforts to collect fees—including withholding outpatient cost settlement funds from hospitals with outstanding balances. It should be noted that under state law hospital provider fees are considered a debt to the state and may be collected via civil action.

Due to the siloed nature of program responsibilities, no single member of DCH staff oversees the entirety of provider fee collections. Staff in the Reimbursement division calculate fee amounts owed and communicate these amounts to hospitals. Staff in the Financial Services division manage the collection of fee payments and record the amount of fees paid in a tracking spreadsheet that compares fees paid to fees owed. However, Financial Services does not communicate underpayments to Reimbursement unless specifically requested, and Reimbursement lacks a regular process for reviewing amounts owed.

RECOMMENDATIONS

1. DCH should assign responsibility for fee payment enforcement to a specific role and implement a process for regularly communicating outstanding balances across divisions.
2. DCH should consider implementing a mechanism that regularly informs hospitals of fees owed, such as invoicing, routine email reminders, or an online dashboard.
3. DCH should impose required penalties on hospitals that fail to pay on time or fail to pay the entire amount. DCH could also consider implementing other corrective actions to ensure fees are collected or could consider reevaluating the late penalty percentage.

DCH Response:

DCH partially agreed with this finding.

[9] *As noted on page 2, hospitals may pay provider fees through DCH's online payment system, an automated clearinghouse, a wire transfer, or by mailed check. Most hospitals pay online.*

Recommendation 1: *DCH agreed with this recommendation.*

Recommendation 2: *DCH agreed with this recommendation.*

Recommendation 3: *DCH partially agreed with this recommendation, noting that it acknowledges it must ensure hospitals pay the full amount owed on time. However, DCH also recognized "the need to avoid placing unnecessary financial strain on the healthcare system." DCH indicated it will develop payment plans with hospitals that have balances to ensure the full amount is paid within the corresponding fiscal year to minimize fiscal impacts to the state.*

Finding 2: In all years reviewed, hospitals paid more in fees than they received in add-on payments.

As discussed on page 3, federal regulations prohibit the direct or indirect returning of fees paid to individual hospitals via add-on payments. However, total fees paid and total add-on payments received by all hospitals may be equal.

Hospitals received $1.7 billion in add-on payments in fiscal years 2020-2025—$539 million less than provider fees paid during the period. DCH rules indicate that total provider fees paid should be substantially equivalent to total add-on payments received, but in all years reviewed total fee payments were significantly higher (between $41 million and $196 million) than total add-on payments. In addition, hospitals we determined to have a greater level of financial need generally received less in add-on payments than those with a lower level of need.

As discussed on page 3, hospitals participating in the provider fee receive an 11.88% increase in Medicaid rates for inpatient and outpatient services in recognition of the fee. The add-on payment is calculated by multiplying the amount to be paid for the claim by 11.88%; for example, if the hospital will be paid $100, the add-on payment will be $11.88 (11.88% of $100) and the final payment amount will be $111.88. Add-on payments are also included in two supplemental payments hospitals receive outside of claims—outpatient cost settlements and graduate medical education payments.

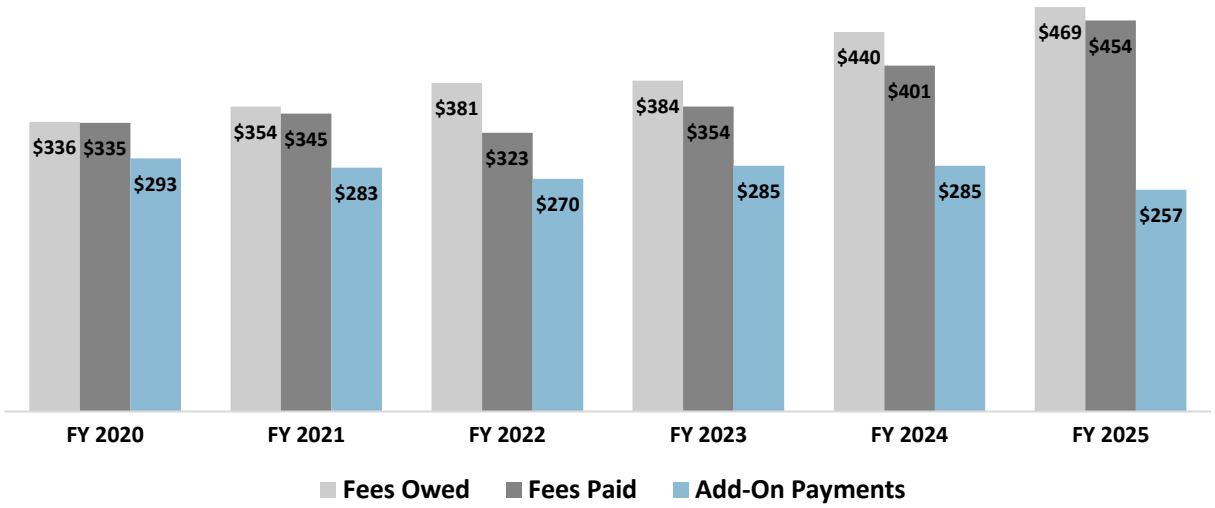
Total Add-on Payments

Hospitals received $1.7 billion in add-on payments in fiscal years 2020-2025, or approximately $279 million per year. Annual amounts ranged from $257 million to $293 million, with the greatest amount paid in 2020. According to the claims data we reviewed, $1.6 billion of add-on payments (98%) came from claims and the remainder came from outpatient cost settlements and graduate medical education payments.

As shown in **Exhibit 3** on the next page, total add-on payments reported were less than total provider fees assessed by DCH or fees paid by hospitals in all fiscal years. The greatest difference between fees paid and add-on payments was in fiscal year 2025 ($196 million, or 43% difference), though payments for this year

may change as hospitals continue to submit claims data.[10] Differences were smaller in prior years—in fiscal year 2020, add-on payments to hospitals were approximately 12% less than the fees paid; by contrast, add-on payments were 29% less than fees in fiscal year 2024.

Exhibit 3
Total add-on payments were less than total fees owed or paid in all years reviewed[1,2,3] (FY 2020-2025)



[1] Amounts in millions.

[2] As stated in Exhibit 2, 14 of the 126 hospitals (11%) included in our analysis of fee payments lacked complete data for the entire period.

[3] Add-on payment amounts may change as additional claims are submitted or as claims are reviewed. This is because hospitals generally have six months to submit claims to DCH or to a CMO for payment after the service has been provided—meaning FY 2025 claims are not final. Additionally, DCH has the authority to adjust FFS claims amounts at any time.

Source: DCH Hospital Provider Payment Schedules for FY 2020-2025, DCH provider fee tracking spreadsheets for FY 2020-2025, FFS claims data from GAMMIS for FY 2020-2025, CMO claims data from GAMMIS for FY 2022-2025, and add-on payment reports for CMO claims data in FY 2020 and 2021 published by DCH's audit firm

According to DCH staff, the provider fee program is intended to assist with Medicaid costs rather than ensure hospitals receive the same amount of add-on payments as they paid in provider fees. Additionally, as discussed on page 3, federal regulations prohibit the practice of returning amounts paid to individual hospitals. However, DCH rules indicate add-on payments in the aggregate should be "substantially equivalent" to fees paid in the aggregate. To ensure aggregate amounts align, its rules further permit DCH to annually review the 11.88% percentage and adjust it if needed (see discussion in textbox on the next page). Staff indicated the agency has never reviewed the percentage. We estimate the add-on percentage would have had to be between 15% and 20% for total add-on payments to be comparable to total fees paid in recent years.

[10] Hospitals generally have six months to submit claims for services provided—meaning fiscal year 2025 claims may be submitted through the end of the calendar year.

DCH rules do not specify a time period for amounts to be equivalent

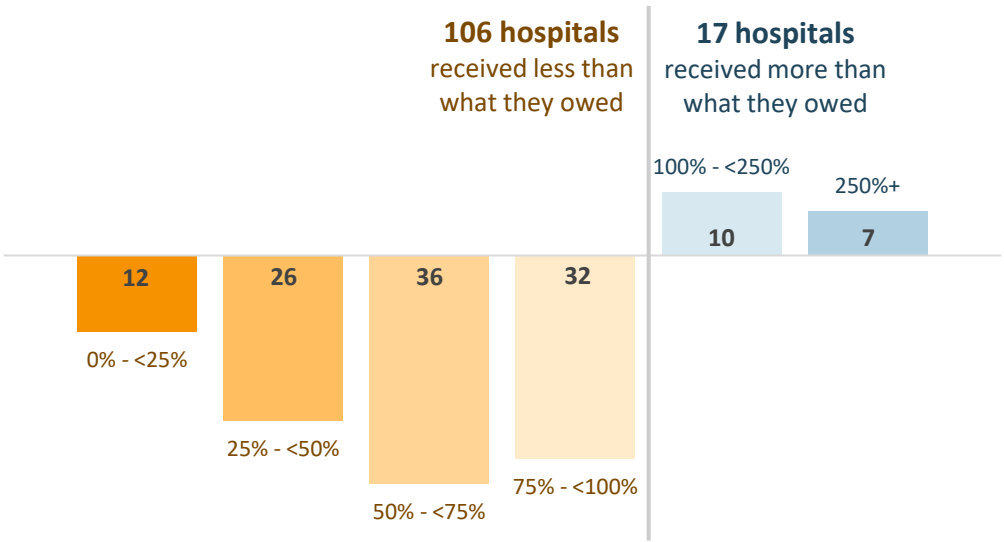
DCH rules permit staff to conduct an "annual review" of the 11.88% percentage for add-on payments. Rules further permit DCH to make "prospective adjustments to such percentage to ensure the amount of the add-on payments to hospitals are substantially equivalent in the aggregate to the total amount of provider payments made by hospitals." The rules do not define "substantially equivalent" or specify a time period for which the amounts should equal. Absent a time period, we applied the rule by comparing aggregate add-on payments received and aggregate fees paid both annually and for the entire six fiscal years reviewed. (It should be noted that federal regulations do not require aggregate amounts to be equivalent.)

Add-On Payments by Hospital

As shown in **Exhibit 4**, nearly 90% (106) of the 123 participating hospitals received less in add-on payments than they owed in fees in fiscal years 2022-2025.[11] The largest portion (36) received between 50% and 74% of the amount owed, followed by those receiving between 75% and 99% (32). The percentage of hospitals receiving fewer add-on payments has increased over time, likely because DCH has not updated the 11.88% rate since the fee's inception.[12]

Exhibit 4

Most hospitals owed more in fees than they received in add-on payments[1] (FY 2022-2025)



[1] Includes only those hospitals that participated in the provider fee program in FY 2022-2025 (123 hospitals).

Source: DCH provider fee tracking spreadsheets for FY 2022-2025 and GAMMIS claims data for FY 2022-2025

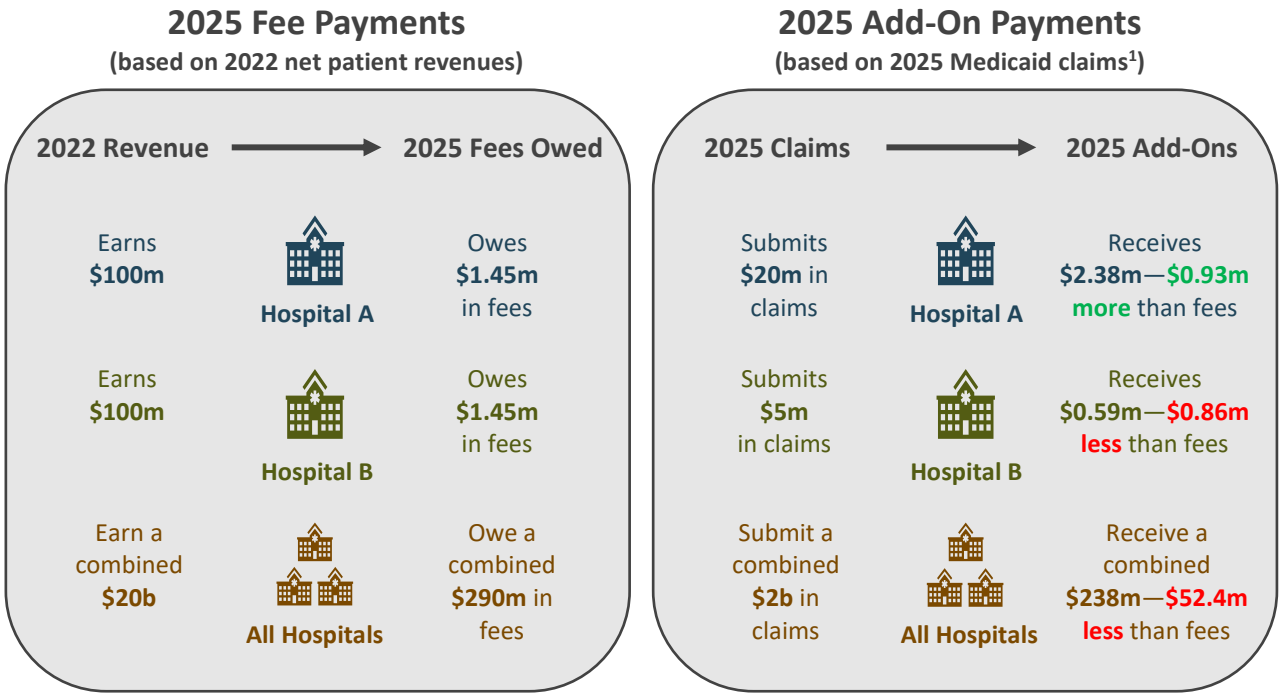
[11] A review of individual hospital receipts for the period of review (2020-2025) was not possible due to data limitations related to managed care payments in fiscal years 2020 and 2021. For more information, see ***Appendix B****.*

[12] According to DOAA's 2016 report on the Indigent Care Trust Fund, 38% of hospitals received more add-on payments than fees paid in fiscal year 2015. According to an early provider fee program report, 45% of hospitals received more than they paid in fiscal year 2011.

As previously noted, add-on payments to individual hospitals are not intended to be the equivalent of what they paid in provider fees, so some hospitals will receive more and others will receive less. This is because the variance between fees owed or paid and add-on payments received depends on the percentage of a hospital's revenue attributable to Medicaid claims. For example, two hospitals with comparable net patient revenues pay similar provider fees—but if one hospital receives a greater portion of its revenue from Medicaid, it will receive a greater amount of add-on payments via reimbursement for those claims (see **Exhibit 5**).

Exhibit 5

Hospitals may pay the same amount in fees but receive different amounts of add-on payment



[1] Hospitals also receive add-on payment revenues from outpatient cost settlements and graduate medical education payments. However, Medicaid claims contribute the significant majority of add-on payment revenue.

Source: DOAA conclusions using DCH documentation

Add-on Payments and Financial Need

From fiscal year 2022-2025, hospitals' total add-on payments did not necessarily align with level of financial need, as determined by the audit team based on financial metrics such as patient margin and the ratio of the cost of uncompensated care to total expenses.[13] Hospitals needier than average (i.e., those in a weaker financial position) received $355 million in add-on payments, while those less needy than average received $737 million.[14] The 10 neediest hospitals received a combined $45 million (4%) of total add-on payments during the period reviewed. By contrast, two of the three hospitals that received the most

[13] Metrics were calculated using data from the five most recently completed Hospital Financial Surveys (fiscal years 2019-2023).

[14] Due to incomplete data, this analysis includes only 122 of the 123 hospitals assessed fees in fiscal years 2022-2025.

in add-on payments (a combined $284 million, or 26%) were among the top 25 hospitals deemed financially healthiest.

However, when comparing how much hospitals received in add-on payments to how much they owed in fees, needier hospitals experienced an overall smaller difference compared to less needy hospitals ($115 million versus $467 million). Additionally, the 10 neediest hospitals received an overall greater amount in add-on payments than fees owed, while the 10 financially healthiest hospitals owed more than received ($3 million in add-on gains versus $184 million in fee losses).

It should be noted that DCH does not measure hospitals participating in the provider fee program by financial need, because add-on payment amounts are generally determined by how much Medicaid revenue a hospital receives.

RECOMMENDATION

1. DCH should review the add-on payment percentage to determine whether it is appropriate to ensure aggregate add-on payments are substantially equivalent to aggregate fees paid.

DCH Response:

DCH partially agreed with this finding.

Recommendation 1: *DCH partially agreed with this recommendation. DCH acknowledged it should "regularly evaluate its provider reimbursement levels to ensure it can communicate appropriate funding needs to appropriators and support quality healthcare for its members." However, DCH indicated that comparing fees paid to add-on payments received may not be an appropriate measure, because fees are calculated using various forms of patient revenue—unlike add-on payments, which are based on Medicaid revenue only.*

Auditor's Response*: Although the amounts are determined differently, DCH rules necessitate comparing aggregate fees paid to aggregate add-on payments to ensure they are "substantially equivalent." It is within DCH's purview to reconsider its rules.*

Finding 3: DCH oversight over managed care add-on payments could be improved.

DCH's oversight of managed care providers could be improved to ensure proper implementation of the add-on payment. According to the data reviewed, between fiscal years 2022 and 2025, nearly $5 million in add-on payments were paid to providers that did not participate in the provider fee program, which could have been identified in a report DCH currently receives but does not review. Additionally, more transparency is needed to ensure managed care add-on payments are calculated correctly.

As discussed on page 4, Medicaid members are either insured directly by DCH through a fee-for-service (FFS) model or through one of the state's managed care organizations (CMOs). Unlike the FFS model—which uses set rates to determine how much DCH will pay for claims—CMOs negotiate reimbursement rates with each provider in their networks separately. While provider rates differ, all three CMOs were required to include the 11.88% add-on payment for claims submitted by hospitals participating in the provider fee.

To determine whether CMOs applied and distributed add-on payments appropriately in fiscal years 2022-2025,[15] we reviewed encounter data submitted by CMOs to DCH to identify whether reported add-on amounts equaled 11.88% of contracted rates. We also reviewed the providers that received add-on payments to determine whether all were actually participating in the provider fee program.

We identified two issues with CMO implementation of add-on payments, discussed below. Although CMOs manage care independently from DCH, additional DCH oversight is needed to ensure amounts are paid appropriately.

Appropriate Payment Amount

CMO staff indicated add-on payments are applied to claims using business rules in their payment systems. During the period reviewed, the organizations generally reported add-on payments equal to approximately 11.88% of the final paid amount. However, encounter data does not include the level of detail needed to verify that the add-on amount reported was calculated appropriately. (This is because the data lacks a field indicating the amount upon which the add-on payment was based before the final amount was calculated.) Additionally, staff from one CMO indicated they do not always report add-on payments using the adjustment code required by DCH—meaning additional add-on payments may have been paid that are not captured in the data. As such, we were unable to verify that the 11.88% rate was appropriately applied.

Proper Payments to Hospitals

Nearly all add-on payments reported during the period were to hospitals that were assessed the provider fee. However, approximately $4.9 million of CMOs' reported payments (1.0% of total CMO payments in fiscal years 2022-2025) were made to 35[16] providers that did not participate in the fee.[17] Approximately one-third (12) received less than $10,000, while 10 received more than $100,000, with some paid significantly higher amounts. For example, one CMO reported paying approximately $607,000 to a hospital in Tennessee, and another paid approximately $859,000 to three hospitals in the same care network in Florida.

[15] As noted on page 11, we were unable to determine add-on payment amounts for CMO claims in fiscal years 2020 and 2021. Thus, this discussion is limited to 2022-2025 data.

[16] It should be noted that four of these providers met the criteria to be assessed a fee by DCH in at least one fiscal year; however, DCH did not assess the hospitals a fee because they opened recently, because of a change in hospital ownership, or because of an oversight (see discussion in text box on page 16).

[17] Reports listing providers eligible to receive add-on payments from CMOs indicate two of the three organizations could be continuing to make add-on payments to hospitals not participating in the provider fee in fiscal year 2026. While we did not review data from this period to confirm whether this has occurred, we alerted DCH and CMO staff to this issue.

CMOs also reported approximately $770,000 in add-on payments to critical access hospitals in Georgia—which do not participate in the provider fee.

CMO staff we interviewed lacked a complete understanding of the specific criteria associated with hospital participation in the provider fee. According to staff at two of the three CMOs, DCH sends reports of hospitals eligible to receive the add-on payment, but these are sent infrequently. Additionally, since 2010, DCH has not published comprehensive guidance for the add-on payment beyond general provisions in the CMO contracts.[18]

Providers not eligible for add-on payments were also identified in a quarterly report created by the audit firm DCH contracts with to review claims data. According to audit firm staff, DCH has received this report since 2010; the report includes estimates of add-on payments by provider for both CMO and FFS claims. DCH does not review the information, however, to ensure add-ons are paid only to hospitals participating in the provider fee. Improper payments could result in higher state costs for managed care.

DCH staff indicated that the nature of managed care allows CMOs to pay 11.88% add-on payments to providers not participating in the fee because CMOs may establish rate increases for providers independently from DCH. CMO contracts require that the add-on be paid to hospitals participating in the provider fee, and they do not explicitly prohibit CMOs from paying the add-on to other providers. However, DCH rules state that add-on payments are made "in recognition" of fee payment. Further, the amounts we identified were reported using the adjustment code intended only for 11.88% add-on payments—meaning they represent hospital provider fee add-on payments rather than other add-on payments a CMO could choose to provide as part of a different rate increase.

[18] DCH published a guidance document for add-on payments in September 2010. However, this document is no longer linked on DCH's website.

FFS add-on payments to hospitals that did not pay the provider fee were also identified

In our review of FFS claims data for fiscal years 2022-2025, we identified $1.4 million in add-on payments made to hospitals that met the criteria for participating in the provider fee but did not pay a fee during the corresponding fiscal year. These payments are discussed below.

- New hospitals – In fiscal years 2022-2025, approximately $676,000 in add-on payments were paid to five hospitals that—while they were ultimately required to do so or will be required in future years—had not yet paid a provider fee. This is because they opened after the submission of the most recent Hospital Financial Survey (HFS) that DCH used to determine fee amounts. Because DCH applies add-on payments to claims based on system rules and not actual payment of fees, new hospitals that meet the criteria will receive add-on payments regardless of whether they have paid any fees. Staff indicated they are unable to assess provider fees on new hospitals because they are required to use the HFS to determine fee amounts. If DCH continues its current fee calculation practices, we expect staff to assess fees for the two hospitals that have not yet paid a fee in either fiscal year 2027 or 2028.
- Rural Emergency Hospitals – In fiscal year 2025, DCH did not assess provider fees for the state's two Rural Emergency Hospitals. Staff indicated their exclusion from the 2025 list was an oversight and included the two facilities on the list of hospitals assessed fees for fiscal year 2026. (The two facilities were also assessed fees in fiscal years 2020-2024; of the $2.1 million owed, they paid approximately $982,000.) The facilities received approximately $111,000 in add-on payments in fiscal year 2025; nearly $8,000 (7%) came from FFS payments. In fiscal years 2020-2024, they received approximately $530,000 in FFS add-on payments.

RECOMMENDATIONS

1. DCH should establish a routine procedure to verify that CMOs appropriately apply the add-on payment to the providers' contracted rates. This may require changes to how CMOs report add-on payments in encounter data.
2. DCH should utilize the existing report it receives to verify that only hospitals participating in the provider fee have received add-on payments. If needed, DCH should require CMOs to submit their own reports of add-on payment amounts.

DCH Response:

DCH partially agreed with this finding.

Recommendation 1: *DCH partially agreed with this recommendation, noting it has an "existing contract with auditors to review and validate claim amounts as well as annual financial testing to ensure accuracy."*

Recommendation 2: *DCH partially agreed with this recommendation and noted its existing contract with an audit firm to review claims (similar to above).*

Auditor's Response: *DCH should ensure the auditor is reviewing and communicating any findings related to the areas noted in the recommendations above.*

Finding 4: Hospitals participating in the provider fee receive several financial benefits from the state.

In fiscal years 2020-2025, hospitals receiving add-on payments in recognition of provider fee participation also received various other financial benefits from the state, including but not limited to tax exemptions, Rural Hospital Tax Credit donations, and Rural Hospital Stabilization Grant funds. In the aggregate, participating hospitals received the largest financial benefit from income, sales and use, and property tax exemptions. These benefits, which are not related to the provider fee, serve a variety of purposes and hospitals must meet specific criteria to qualify. Hospitals are not required to participate in the provider fee program to receive them.

Additional benefits for hospitals receiving add-on payments are discussed below.

Tax Exemptions

All hospitals in the state, including those participating in the provider fee, are owned by one of four types of entities: a nonprofit, a hospital authority, a government, or a for-profit (see **Exhibit 6**). In the period reviewed, participating hospitals owned by nonprofits or hospital authorities received exemptions for state income, state sales and use, local sales and use, and local property taxes. Because of their ownership structure, participating government-owned hospitals also received exemptions for state income, state sales and use, local sales and use, and local property taxes. Tax exemptions for eligible hospitals are intended to aid hospitals financially for services provided to the community. For-profit hospitals are not exempt from paying state income, state or local sales and use, or local property taxes; however, they may receive deductions or credits for these forms of tax, such as charity care deductions, depreciations, and business tax credits.

Exhibit 6

Hospitals participating in the provider fee were owned by different entity types (FY 2020-2025)

Owning Entity	Description	Number of Hospitals[1]
Hospital authority	Hospital is owned by a quasi-governmental entity and is exempt from various taxes	47
Nonprofit	Hospital is organized and operated for a charitable purpose and is exempt from various taxes	40
For-profit	Hospital distributes profits to owners and pays various taxes	26
Government-owned[2]	Hospital is owned by a local, state, or federal government entity and is tax-exempt	12

[1] Counts reflect the ownership status of 125 of 126 hospitals that participated in the provider fee program in FY 2020-2025. Populations used for the tax exemption analyses varied based on available data.

[2] State-owned hospitals are statutorily exempt from participating in the provider fee, but local government-owned hospitals participate.

Source: FRC tax exemption analysis

We contracted with the Georgia State University Fiscal Research Center (FRC) to estimate the amount of tax exemptions that hospitals participating in the

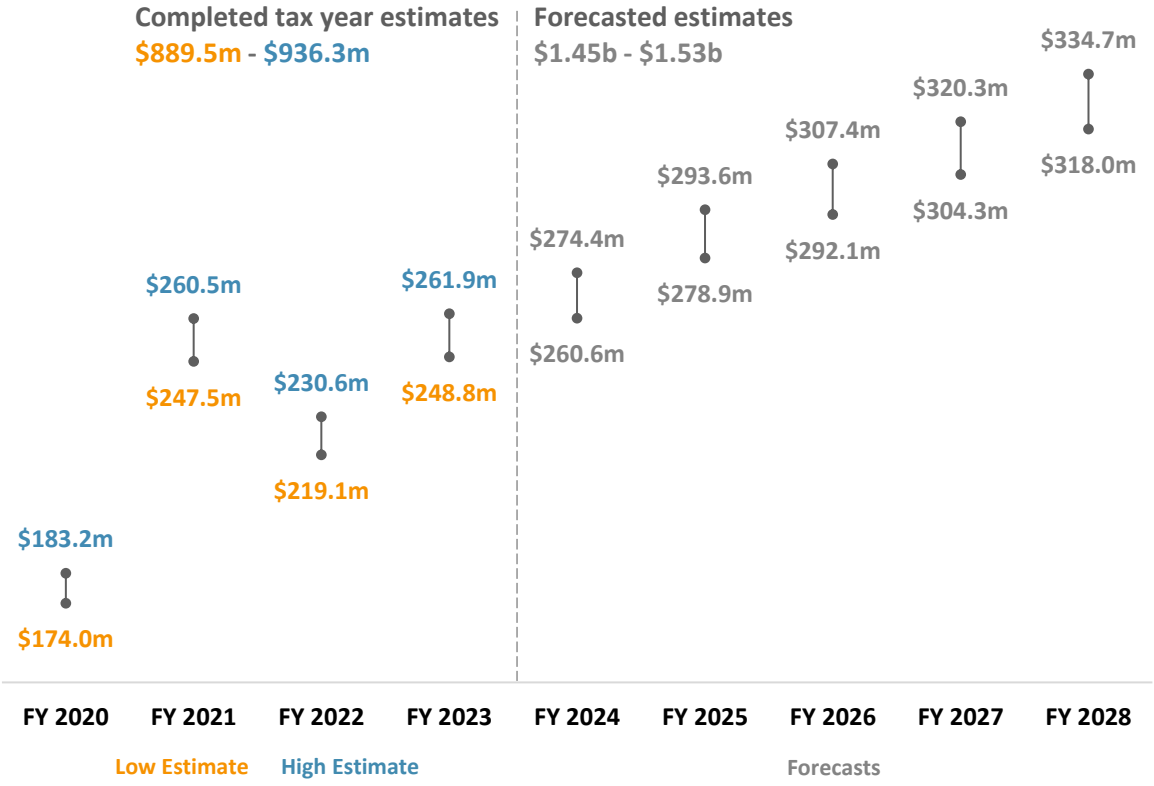
provider fee received and are forecasted to receive. For each tax exemption, FRC utilized a "high" and "low" model to calculate a range of tax exemption amounts that hospitals received during fiscal years 2020-2023. For fiscal years 2024-2028,[19] the same models were used to forecast a range of tax exemption amounts hospitals may receive based on available tax data.

State Income Tax

FRC estimates between $889.5 and $936.3 million in state income tax exemptions went to hospitals participating in the provider fee program (including those owned by nonprofits, hospital authorities, and government entities) in fiscal years 2020-2023 (see **Exhibit 7**). FRC also forecasted between $1.45 and $1.53 billion in exemptions for hospitals in fiscal years 2024-2028.[20]

Exhibit 7

Hospitals participating in the provider fee were estimated to receive between $889.5 and $936.3 million in state income tax exemptions[1] (FY 2020-2023)



[1] This analysis includes 97 of the 126 hospitals that participated in the provider fee program in FY 2020-2025.

Source: FRC tax exemption analysis

[19] For the purposes of this report, figures reported for fiscal years 2024 and 2025 are considered forecasts because complete tax data for these years is not yet available. We also use "forecast" for fiscal years 2026-2028 because tax data for the years will not be available until they are complete.

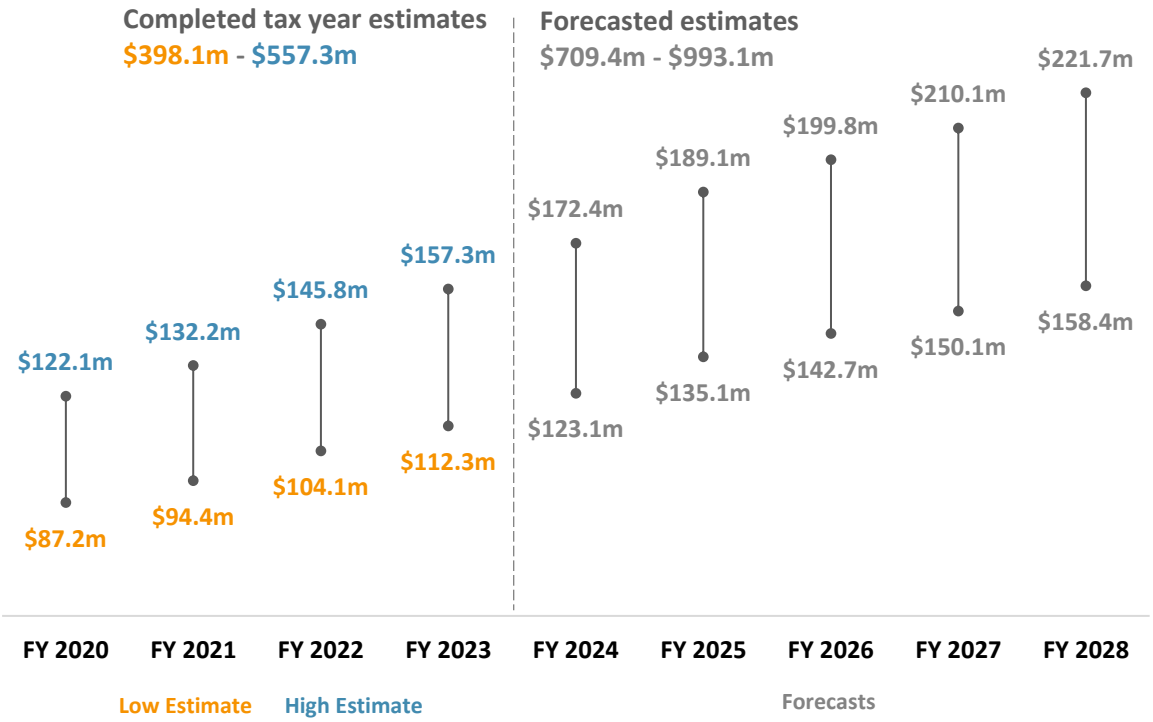
[20] FRC expects the forecasted state income tax exemptions to increase each year based on increases in total expenditures, which were used to estimate increases in net revenues.

State Sales and Use Tax

FRC estimates between $398.1 and $557.3 million in state sales and use tax exemptions went to hospitals participating in the provider fee in fiscal years 2020-2023 (see **Exhibit 8**). FRC also forecasted between $709.4 and $993.1 million in exemptions for hospitals in fiscal years 2024-2028. The state provides sales and use tax exemptions to the three eligible hospital types (hospitals owned by nonprofits, authorities, and governments).

Exhibit 8

Hospitals participating in the provider fee were estimated to receive between $398.1 and $557.3 million in state sales and use tax exemptions[1] (FY 2020-2023)



[1] This analysis includes 101 of the 126 hospitals that participated in the provider fee program in FY 2020-2025.

Source: FRC tax exemption analysis

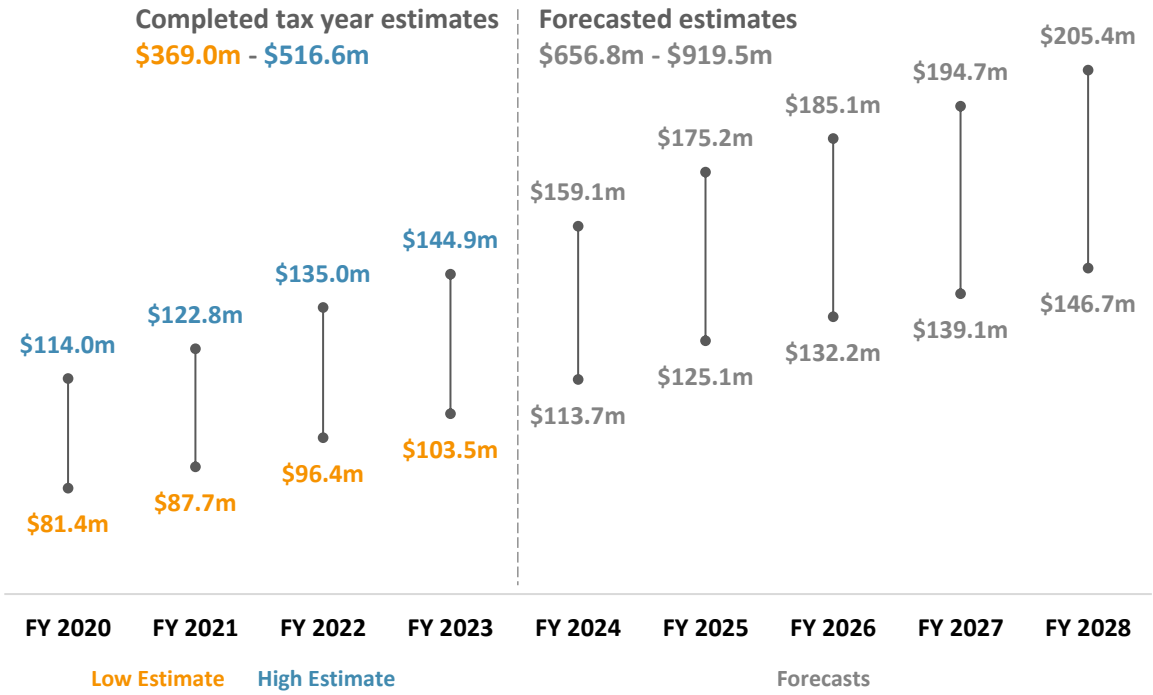
Local Sales and Use Tax

Local tax exemptions do not represent a state tax expenditure because the tax revenues are foregone at the local level, not the state level.

At the local level, counties and municipalities provide sales and use tax exemptions to the three eligible hospital types (those owned by nonprofits, authorities, and governments). Local sales and use tax exemptions do not represent a tax expenditure for the state, but the state authorizes these exemptions in state law. FRC estimates between $369.0 and $516.6 million in local sales and use tax exemptions went to hospitals participating in the provider fee in fiscal years 2020-2023 (see **Exhibit 9** on the next page). FRC also forecasted these hospitals will receive between $656.8 and $919.5 million in local sales and use tax exemptions in fiscal years 2024-2028.

Exhibit 9

Hospitals participating in the provider fee were estimated to receive between $369.0 and $516.6 million in local sales and use tax exemptions[1] (FY 2020-2023)



[1] This analysis includes 101 of the 126 hospitals that participated in the provider fee program in FY 2020-2025.

Source: FRC tax exemption analysis

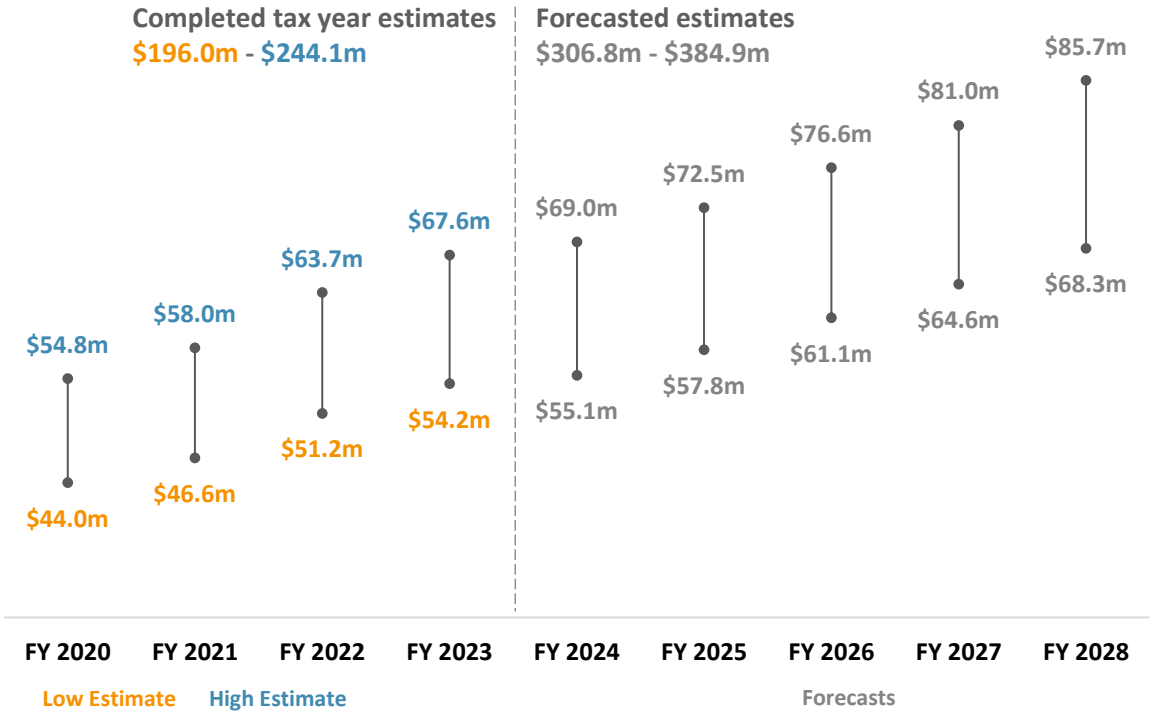
Local Property Tax

Like local sales and use taxes, local property tax exemptions do not represent a tax expenditure for the state but are authorized by state law. FRC estimates hospitals owned by nonprofits, authorities, and governments that participated in the fee received between $196.0 and $244.1 million in property tax exemptions in fiscal years 2020-2023 (see **Exhibit 10** on the next page). FRC also forecasted hospitals would receive an additional $306.8 and $384.9 million in exemptions in fiscal years 2024-2028.[21]

[21] Data used to estimate property tax exemptions is not as current or reliable as the data used to estimate other exemptions. FRC staff indicated that parcel values for exempt hospitals are not frequently assessed, and that property tax exemptions were estimated using a single year of data rather than data that reflects changes in hospital ownership type or relocations.

Exhibit 10

Hospitals participating in the provider fee were estimated to receive between $196.0 and $244.1 million in local property tax exemptions[1] (FY 2020-2023)



[1] This analysis includes 93 of the 126 hospitals that participated in the provider fee program in FY 2020-2025.

Source: FRC tax exemption analysis

Other Financial Benefits

In addition to state tax exemptions, provider fee hospitals received other financial benefits from the state in the period reviewed. A hospital's participation in the provider fee does not determine its eligibility for other financial benefits provided by the state; similarly, receiving other financial benefits from the state does not affect a hospital's requirement to participate in the provider fee. The other financial benefits provided are discussed below.

- **Rural Hospital Tax Credit (RHTC) Donations** – The RHTC was established in 2017 to allow taxpayers to donate to eligible rural hospitals and reduce their income tax liability by the amount they choose to donate. Because the credits reduce state income tax revenue, the RHTC represents a tax expenditure for the state. The RHTC is intended to aid hospitals with costs of improvements and improve their overall financial health.

  Of the 126 hospitals that participated in the provider fee program between fiscal year 2020 and 2025, 35 received a total of nearly $203 million in RHTC donations in calendar years 2020-2024. RHTC

donations increased from calendar year 2020 ($33 million) to 2024 ($46 million). Donations per hospital ranged from approximately $203,000 to nearly $4 million in calendar year 2024.

- **Disproportionate Share Hospital (DSH) Payments** – DSH is a federal program that aims to improve healthcare access for the medically indigent (i.e., individuals who are unable to pay for medical services received). DSH payments for private hospitals are funded using state appropriations and federal funds (those for public hospitals are funded via provider payments and federal funds). Fifty of the 57 private hospitals that received DSH payments in fiscal years 2020-2025 also participated in the provider fee program, and approximately $201 million in state appropriations supported payments to these hospitals.
- **Graduate Medical Education (GME) Payments** – Since January 2019, hospitals with GME programs have received a supplemental GME payment that is financed using a combination of federal Medicaid funds (i.e., FMAP funds) and state funds. The payment is intended to aid hospitals with the costs of medical graduate training and is made quarterly. The payment amount is determined using a formula that incorporates the number of residents at the hospital and the percentage of the hospital's revenue derived from Medicaid. Thirty-three of the 126 hospitals participating in the provider fee received GME payments during the period reviewed, which were supported by nearly $31 million in federal and state funds (an estimated $9 million were state funds).
- **Rural Hospital Stabilization Grant (RHSG) Funds** – The RHSG was established in 2016 to help improve rural hospitals' financial and operational stability. Unlike many hospital grant programs, RHSG is funded solely by state general funds. Seventeen of the 126 hospitals participating in the provider fee received nearly $20.6 million in RHSG funds between May 2021 and May 2026.
- **Other Benefits –** Hospitals may receive other state benefits through programs that include, but are not limited to, the Cancer State Aid and Georgia Trauma Commission programs.

Hospitals may also receive financial benefits from programs not funded by the state but administered by DCH or another state agency. For example, hospitals receive supplemental payments via state-directed payment programs (discussed on page 24), which are financed using provider payments (separate from the hospital provider fee) and federal funds.

DCH Response:

DCH agreed with this finding.

Finding 5: Recent federal changes to Medicaid do not currently impact the hospital provider fee.

New federal requirements for provider tax programs do not impact the hospital provider fee because Georgia is not a Medicaid expansion state. However, the new requirements could impact DCH's ability to increase fee revenues in the future because they prohibit states from increasing existing tax rates. DCH staff indicated the agency has not considered increasing the current rate of 1.45% (1.40% for trauma hospitals) since the program's inception.

Expansion states expanded Medicaid eligibility to adults earning up to 138% of the federal poverty level under the Affordable Care Act. Expansion is primarily financed by the federal government.

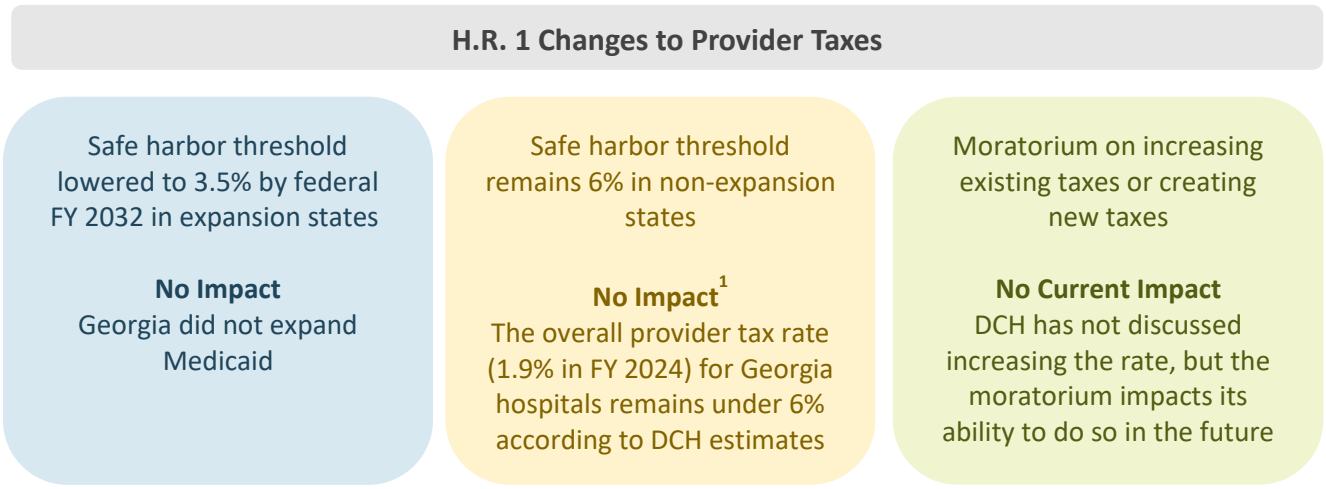
Non-expansion states (including Georgia) did not expand Medicaid eligibility.

Signed into law on July 4, 2025, U.S. House Resolution 1[22] (H.R. 1) modifies various federal statutes governing healthcare programs, including those governing provider taxes. H.R. 1 made the following changes:

- In all states, the law imposes a moratorium on increasing existing tax rates or creating new taxes.
- In expansion states, the law lowers the overall allowable tax rate on net patient revenues, referred to as the "safe harbor threshold." As discussed on page 3, the safe harbor threshold in all states was 6%; under H.R. 1, the threshold will be lowered by 0.5% annually in expansion states until it reaches 3.5% (changes will occur between federal fiscal years 2028 and 2032). In non-expansion states, it remains 6%.

As shown in **Exhibit 11**, Georgia is a non-expansion state with an estimated overall tax rate on hospitals of 1.9% in fiscal year 2024. (This overall rate includes all provider payments hospitals make, including the provider fee,

Exhibit 11
H.R. 1 does not impact Georgia's hospital provider fee



[1] Before H.R. 1, the safe harbor threshold was 6% regardless of Medicaid expansion. As such, DCH's overall provider tax rate (which includes provider taxes imposed by the hospital fee and other provider payment programs) has always been required to be below 6% to comply with CMS regulations.

Source: Federal and non-federal reports, news articles, DCH staff analysis, and DCH staff interviews

[22] *H.R. 1 is commonly referred to as the "One Big Beautiful Bill Act."*

upper payment limit fees,[23] and payments made under directed payment programs, which are discussed in the textbox below.) As such, the new threshold for provider taxes in expansion states (3.5%) does not currently impact the provider fee, and the fee remains unaffected by the 6% limit that remains in non-expansion states. However, DCH staff stated the moratorium could impact the program in the future because DCH would be unable to increase the 1.45% rate. It should be noted that staff indicated DCH has not discussed increasing the rate since the program began in 2010.

H.R. 1 may impact the state's directed payment programs

State-directed payment programs (SDPs) allow states to require Medicaid managed care organizations to pay providers using specific rates or methods. Per CMS guidance, SDPs may establish a minimum or maximum fee schedule for a provider type, make a uniform payment rate increase, or implement a payment tied to improving service quality or other value initiative. SDPs may impact state Medicaid budgets because they are primarily financed via a combination of provider payments and federal funds, like Georgia's hospital provider fee. (It should be noted the provider payments used to support SDPs are separate from the hospital provider fee.)

In non-expansion states, H.R. 1 limits new SDPs to reimbursing at 110% of the Medicare rate and requires existing SDPs to be lowered by 10% annually beginning October 1, 2027 until they reach the 110% cap. Georgia has several existing SDPs (referred to as "DPPs"), which are listed below. (DCH staff also stated they submitted two new SDPs for CMS approval shortly before H.R. 1's passage.) DCH staff indicated the new limit may impact the state's SDPs but were unable to estimate the magnitude of potential impacts until CMS issues official guidance.

- GA-AIDE – Georgia's Advancing Innovation to Deliver Equity DPP (GA-AIDE) requires CMOs to make supplemental payments to a small number of hospitals in the state in an effort to improve health outcomes for the medically underserved. Like the hospital provider fee, DCH finances the payment using funds from hospitals and federal funds. In fiscal year 2024, the estimated size of GA-AIDE was $400 million.
- GA-STRONG – The Strengthening the Reinvestment of a Necessary Workforce in Georgia DPP (GA-STRONG) requires CMOs to make supplemental payments to 22 teaching hospitals in the state (as of fiscal year 2024) in an effort to mitigate healthcare workforce shortages. Like GA-AIDE, the payment is financed using funds contributed by hospitals and federal funds; in fiscal year 2024, its estimated size was $930 million.
- Physician DPP – Eligible physicians associated with teaching hospitals receive supplemental payments from CMOs that ultimately allow for reimbursement up to the commercial equivalent. Participation is voluntary, and the payment is financed using federal funds and funds from the hospital authority or governmental entity with which the physician is associated. In fiscal year 2024, its estimated size was $210 million.
- Private Hospital DPP – Participating hospitals receive supplemental payments from CMOs that allow for reimbursement at the Medicare rate. DCH finances the payment using funds from participating hospitals and federal funds. In fiscal year 2024, 43 hospitals participated and the program's estimated size was $170 million.
- Public Hospital DPP – Participating hospitals receive supplemental payments from CMOs that allow for reimbursement at the Medicare rate. The payment is financed using funds from participating hospitals and federal funds; in fiscal year 2024, 56 hospitals participated and the program's estimated size was $285 million.

[23] *The upper payment limit (UPL) program functions similarly to the hospital provider fee. It allows DCH to make payments to participating hospitals to account for the difference between the claim's base Medicaid FFS rate and its Medicare rate. This allows DCH to increase the amount paid for a claim, like the 11.88% add-on payment increases the amount paid for a claim. There is a UPL for public hospitals and one for private hospitals (known as the "Tier 2 fee"). Like the provider fee, DCH uses hospital payments and federal funds to support UPL payments.*

DCH Response:

DCH agreed with this finding. DCH noted that although the hospital provider fee remains unaffected, the legislation may affect other supplemental payment programs.

Appendix A: Table of Findings and Recommendations

	Agree, Partial Agree, Disagree	Implementation Date[1]
Finding 1: DCH processes could be strengthened to ensure hospitals pay the full amount owed on time. (p. 6)	**Partially Agree**	**N/A**
1.1 DCH should assign responsibility for fee payment enforcement to a specific role and implement a process for regularly communicating outstanding balances across divisions.	Agree	To Be Determined
1.2 DCH should consider implementing a mechanism that regularly informs hospitals of fees owed, such as invoicing, routine email reminders, or an online dashboard.	Agree	To Be Determined
1.3 DCH should impose required penalties on hospitals that fail to pay on time or fail to pay the entire amount. DCH could also consider implementing other corrective actions to ensure fees are collected or could consider reevaluating the late penalty percentage.	Partially Agree	To Be Determined
Finding 2: In all years reviewed, hospitals paid more in fees than they received in add-on payments. (p. 9)	**Partially Agree**	**N/A**
2.1 DCH should review the add-on payment percentage to determine whether it is appropriate to ensure aggregate add-on payments are substantially equivalent to aggregate fees paid.	Partially Agree	To Be Determined
Finding 3: DCH oversight over managed care add-on payments could be improved. (p. 13)	**Partially Agree**	**N/A**
3.1 DCH should establish a routine procedure to verify that CMOs appropriately apply the add-on payment to the providers' contracted rates. This may require changes to how CMOs report add-on payments in encounter data.	Partially Agree	To Be Determined
3.2 DCH should utilize the existing report it receives to verify that only hospitals participating in the provider fee have received add-on payments. If needed, DCH should require CMOs to submit their own reports of add-on payment amounts.	Partially Agree	To Be Determined
Finding 4: Hospitals participating in the provider fee receive several financial benefits from the state. (p. 17)	**Agree**	**N/A**
No recommendations.		
Finding 5: Recent federal changes to Medicaid do not currently impact the hospital provider fee. (p. 23)	**Agree**	**N/A**
No recommendations.		

[1] DCH staff agreed to provide implementation dates during DOAA's follow-up process, which begins in June 2026.

Appendix B: Objectives, Scope, and Methodology

Objectives

This report examines the hospital provider fee administered by the Department of Community Health (DCH). Specifically, our examination set out to answer the following questions:

1. How much do hospitals pay in provider fees?
2. How much do hospitals paying the provider fee receive in add-on payments made in recognition of the fee?
3. What impacts will the state experience as a result of reductions in federal support for the provider fee program? and
4. What benefits, including state income tax benefits, does the state currently provide to hospitals receiving add-on payments made in recognition of the fee?

Scope

This special examination generally covered activity related to the hospital provider fee that occurred in state fiscal years 2020 through 2025, with consideration of earlier or later periods when relevant. Information used in this report was obtained by reviewing relevant state and federal laws, state rules, and federal regulations; reviewing federal agency and non-federal entity reports and news articles; interviewing staff from DCH, the state's Medicaid managed care organizations (CMOs), the audit firm contracted by DCH to review Medicaid data and Hospital Financial Survey (HFS) data, and the Georgia Hospital Association; analyzing data from the Georgia Medicaid Management Information System (GAMMIS) and data and reports from DCH, its audit firm, and the Georgia Hospital Association; analyzing TeamWorks financials; and contracting with the Georgia State University Fiscal Research Center (FRC) to conduct an analysis of tax exemptions hospitals received.

Government auditing standards require that we also report the scope of our work on internal control that is significant within the context of the audit objectives. We reviewed internal controls as part of our work on Objectives 1 and 2. Specific information related to the scope of our internal control work is described by objective in the methodology section below.

Methodology

To determine how much hospitals pay in provider fees, we reviewed state law, DCH rules, and program documentation and interviewed DCH staff to determine how DCH calculates fee amounts. To determine how much hospitals paid in fees in fiscal years 2020-2025, we reviewed hospital provider fee tracking spreadsheets for each year. The tracking spreadsheets, which are completed by DCH financial services staff, compare the amount of fees each hospital owed for the quarter to the amount the hospital paid and include a date of payment. Although the information in the spreadsheets is compiled manually, we believe they represent credible estimates of fees paid and payment timelines. It should be noted that we were unable to utilize TeamWorks financial records to complete this analysis because it did not contain the level of detail needed to identify total payments or payments by hospital.

To determine how much hospitals paying the provider fee receive in add-on payments made in recognition of the fee, we interviewed DCH staff, staff from DCH's Medicaid audit firm, and staff from the state's three managed care organizations (CMOs) contracted during the period to

determine how 11.88% add-on payments are applied in the claims reimbursement process. We also reviewed DCH's Medicaid policy and procedures manual for hospitals, as well as other DCH documentation, to determine how DCH applies the add-on payment to fee-for-service (FFS) claims, outpatient cost settlements, and graduate medical education (GME) payments. We analyzed DCH records of cost settlements[24] and GME payments to hospitals during the period to determine how much hospitals received in add-on payments from these supplemental payments.

To determine how much hospitals received in add-on payments from claims, we obtained claims data from the Georgia Medicaid Management Information System (GAMMIS). The data obtained represents all FFS and CMO claims including an 11.88% add-on payment made in recognition of the provider fee with a date of service in fiscal years 2020-2025. When reviewing the data, we identified limitations in managed care information for fiscal years 2020 and 2021; as such, we used a report prepared by DCH's audit firm to obtain aggregate CMO add-on payment estimates for those years. Because of this limitation, total add-on payments are reported for each year of the period reviewed, while add-on payments to individual hospitals are reported only for fiscal years 2022-2025. Apart from this limitation, our assessment of the controls over GAMMIS data determined it was sufficiently reliable for our analysis.

Finally, to compare hospital level of financial need to add-on payments received in fiscal years 2022-2025, we researched financial metrics commonly used to measure the financial health of hospitals, such as patient margin, the ratio of the cost of several forms of uncompensated care (e.g., indigent or charity care) to total expenses, and others. Using this research and insight from Georgia Hospital Association (GHA) staff, we developed a model to rank hospitals by financial need using financial metrics reported in the five most recently completed Hospital Financial Surveys (fiscal years 2019-2023) and payer mix data from the Georgia Discharge Data System, a database maintained by GHA. (Payer mix represents the breakdown of sources of hospital revenue, such as Medicaid or private insurance; this is important because Medicaid typically reimburses at a lower rate than private insurers.) Generally, hospitals with a higher level of financial need have a lower overall patient margin for the period and a higher ratio of the cost of the forms of uncompensated care we utilized to total expenses. It should be noted that our model includes hospitals that opened or closed in fiscal years 2022-2025—meaning they may lack five years of Hospital Financial Survey data. Additionally, our model excludes 1 of the 123 hospitals that participated in the provider fee during the period, because this facility had a level of incomplete data significant enough to make it an outlier in our analysis.

To determine the impacts the state will experience as a result of reductions in federal support for the provider fee program, we reviewed federal regulations and reports published by federal agencies and non-federal entities to determine the federal regulations governing provider tax programs (like the hospital provider fee) prior to the passage of U.S. House Resolution 1 (H.R. 1). After H.R. 1's passage in July 2025, we reviewed news articles and industry reports to determine the changes to federal regulations governing provider taxes and how these changes might impact the hospital provider fee and its ability to support the state's Medicaid expenses. We also interviewed DCH staff about how the changes affect the provider fee and the state's directed payment programs (see page 24).

To determine what benefits, including state income tax benefits, the state provides to hospitals receiving add-on payments made in recognition of the fee, we interviewed staff

[24] It should be noted that because outpatient cost settlements are paid on a two-to-three-year lag, we used settlement amounts from hospital fiscal years 2017-2022 to determine add-on payments paid in state fiscal years 2020-2025.

from DCH, GHA, and the Georgia State University Fiscal Research Center (FRC) to identify various state programs targeted to hospitals, including tax exemptions, the Rural Hospital Tax Credit (RHTC), the Rural Hospital Stabilization Grant (RHSG), the Disproportionate Share Hospital (DSH) program, GME programs, and other benefits based on special population services. It should be noted that we learned through interviews and programmatic research that these programs are not contingent upon participation in the hospital provider fee.

To identify how much hospitals participating in the fee received in tax exemptions, we contracted with FRC to estimate the state income, state sales and use, local sales and use, and local property tax exemptions hospitals received and will receive in fiscal years 2020-2028. To estimate income and sales and use tax exemptions hospitals received in fiscal years 2020-2023, FRC used data from DCH Hospital Financial Surveys, Internal Revenue Service Federal Form 990s,[25] and the Georgia Department of Revenue. To estimate income and sales and use tax exemptions hospitals will receive in fiscal years 2024-2028, FRC incorporated Centers for Medicare and Medicaid Services projections for hospital expenditures in a model that accounts for changes in future revenues or losses. To estimate property tax exemptions, FRC used 2021 property tax digest data to identify properties associated with exempt hospitals. FRC used this and other data from the Department of Revenue to establish prior and forecasted exemption estimates. Due to the nature of the datasets used, FRC then presented the tax exemption estimates using a range including a high estimate and low estimate.

We treated this review as a performance audit. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

If an auditee offers comments that are inconsistent or in conflict with the findings, conclusions, or recommendations in the draft report, auditing standards require us to evaluate the validity of those comments. In cases when agency comments are deemed valid and are supported by sufficient, appropriate evidence, we edit the report accordingly. In cases when such evidence is not provided or comments are not deemed valid, we do not edit the report and consider on a case-by-case basis whether to offer a response to agency comments.

[25] *The Federal Form 990 is an annually required form for tax-exempt organizations, such as nonprofit hospitals.*

Appendix C: Net Patient Revenues of Hospitals Participating in the Provider Fee

(As Reported in the 2017-2023 Hospital Financial Surveys)

Hospital Name[2]	Net Patient Revenues[1] (in millions)							
	2017	2018	2019	2020	2021	2022	2023	TOTAL
AdventHealth Gordon	$112.9	$116.5	$118.2	$125.5	$157.3	$147.6	$173.5	$951.4
AdventHealth Murray	$13.8	$19.8	$24.1	$25.5	$34.4	$31.4	$33.4	$182.4
AdventHealth Redmond	$213.7	$231.1	$244.5	$246.1	$264.6	$255.0	$283.3	$1,738.2
Appling Hospital	$17.3	$15.6	$15.8	$19.5	$19.8	$18.0	$16.0	$122.1
Atrium Health Floyd Medical Center	$329.9	$342.0	$372.6	$350.9	$392.2	$465.4	$473.9	$2,726.8
Blue Ridge Medical Center	$32.6	$31.0	$29.2	$27.2	$30.9	$27.9	$20.8	$199.6
Burke Medical Center	$6.2	$7.6	$4.7	$4.2	$10.4	$47.6	$63.9	$144.5
Candler Hospital, Inc.	$265.6	$270.9	$313.6	$321.2	$368.0	$403.2	$435.0	$2,377.5
CHI Memorial Hospital Georgia	$9.8	$5.4	$14.2	$13.4	$13.6	$19.5	$15.7	$91.5
Children's Healthcare of Atlanta at Egleston	$638.9	$652.7	$695.4	$718.3	$842.2	$899.9	$956.9	$5,404.3
Children's Healthcare of Atlanta at Hughes Spalding	$36.2	$39.8	$43.6	$28.1	$42.9	$55.2	$57.3	$303.1
Children's Healthcare of Atlanta at Scottish Rite	$563.4	$599.9	$660.6	$606.6	$763.2	$857.4	$912.6	$4,963.8
Coffee Regional Medical Center	$74.4	$83.7	$96.4	$108.1	$118.6	$116.2	$118.1	$715.6
Colquitt Regional Medical Center	$96.9	$106.6	$110.5	$109.0	$127.9	$129.0	$158.0	$837.9
Columbus Specialty Hospital	$5.9	$9.7	$10.5	$12.2	$10.7	$8.2	$8.9	$66.0
Crisp Regional Hospital	$57.0	$57.1	$59.0	$59.7	$70.7	$74.8	$71.2	$449.6
Doctor's Hospital of Augusta	$398.2	$422.8	$447.7	$433.5	$533.0	$478.0	$486.5	$3,199.8
Dodge County Hospital	$19.3	$19.2	$19.9	$20.5	$21.5	$19.7	$20.7	$140.9
Donalsonville Hospital, Inc.	$15.3	$26.3	$20.5	$18.9	$20.0	$16.1	$19.3	$136.4
Dorminy Medical Center	$16.5	$18.2	$21.9	$16.2	$14.0	$24.2	$21.0	$131.9
East Georgia Regional Medical Center	$166.3	$164.4	$162.1	$158.8	$179.8	$184.1	$203.3	$1,218.9
Elbert Memorial Hospital	$8.4	$7.8	$10.2	$9.1	$18.1	$14.7	$15.6	$83.9
Emanuel Medical Center	$18.2	$19.4	$20.1	$17.5	$21.8	$25.3	$23.7	$146.1
Emory Decatur Hospital	$314.5	$314.0	$310.0	$301.2	$340.1	$374.3	$391.5	$2,345.5
Emory Hillandale Hospital	$71.9	$70.9	$68.1	$76.1	$93.2	$96.5	$97.3	$574.0
Emory Johns Creek Hospital	$151.3	$172.6	$191.1	$183.8	$223.3	$241.8	$268.8	$1,432.5
Emory Long Term Acute Care	$15.1	$15.7	$18.2	$27.8	$25.9	$26.6	$26.6	$155.8
Emory Rehabilitation Hospital	$24.6	$26.8	$29.2	$31.5	$32.4	$29.9	$30.1	$204.5
Emory Saint Joseph's Hospital of Atlanta	$345.0	$373.2	$456.9	$464.9	$531.7	$555.9	$546.2	$3,273.9
Emory University Hospital	$860.4	$918.4	$949.0	$1,011.2	$1,147.3	$1,211.7	$1,298.5	$7,396.5
Emory University Hospital Midtown	$807.1	$890.9	$988.0	$1,056.9	$1,191.4	$1,215.0	$1,379.3	$7,528.6
Emory University Hospital Smyrna	$0.2	$1.5	$2.6	$1.1	$1.9	$4.9	$4.7	$17.0
Emory University Orthopaedics & Spine Hospital	$89.2	$98.9	$107.1	$99.6	$110.6	$117.1	$110.2	$732.7
Encompass Health Rehab Hospital of Savannah	$17.1	$19.7	$21.3	$23.3	$22.6	$27.9	$27.7	$159.6
Encompass Health Rehabilitation Hospital of Cumming[3]	-	-	-	-	$4.3	$23.5	$27.8	$55.6
Encompass Health Rehabilitation Hospital of Newnan	$19.1	$23.6	$26.6	$28.0	$34.6	$34.0	$33.3	$199.2

Hospital Name[2]	Net Patient Revenues[1] (in millions)							
	2017	2018	2019	2020	2021	2022	2023	TOTAL
Evans Memorial Hospital	$9.7	$9.8	$9.8	$10.4	$15.0	$15.2	$15.5	$85.4
Fairview Park Hospital	$117.9	$125.8	$135.0	$132.7	$147.6	$168.1	$164.0	$991.1
Flint River Community Hospital	$6.5	$6.5	$6.9	$5.8	$5.3	$6.0	$6.4	$43.4
Grady General Hospital	$24.6	$25.9	$28.2	$20.7	$27.3	$26.9	$27.0	$180.7
Grady Memorial Hospital	$756.4	$858.3	$918.5	$879.4	$1,024.5	$1,197.0	$1,544.7	$7,178.8
Habersham County Medical Center	$31.7	$27.3	$30.6	$29.7	$36.2	$42.1	$36.2	$233.8
Hamilton Medical Center	$228.6	$243.3	$261.2	$262.1	$285.3	$336.6	$351.8	$1,968.8
Houston Medical Center	$190.2	$193.0	$203.5	$201.0	$234.3	$211.2	$227.3	$1,460.6
Irwin County Hospital	$12.5	$10.0	$12.8	$12.0	$11.2	$14.8	$0.0	$73.2
Jefferson Hospital	$4.8	$5.2	$6.8	$5.8	$9.3	$9.7	$9.5	$51.1
John D. Archbold Memorial Hospital	$252.3	$251.7	$256.2	$251.9	$266.5	$265.9	$284.7	$1,829.2
Kindred Hospital Rome[4]	$17.8	$11.9	$7.9	-	-	-	-	$37.6
Landmark Hospital of Athens	$23.9	$16.0	$20.1	$21.1	$17.9	$16.8	$18.0	$133.8
Landmark Hospital of Savannah	$14.0	$22.0	$16.1	$17.2	$15.1	$15.1	$16.5	$115.8
Medical Center, Navicent Health, The	$509.7	$608.4	$662.0	$621.5	$659.7	$724.6	$784.9	$4,570.9
Memorial Health Meadows Hospital	$116.1	$109.6	$108.9	$99.5	$93.5	$89.5	$109.2	$726.2
Memorial Health University Medical Center	$466.0	$481.3	$575.2	$578.1	$662.3	$690.2	$897.4	$4,350.5
Memorial Hospital of Bainbridge	$28.0	$27.8	$30.2	$30.6	$31.6	$33.9	$33.1	$215.1
Memorial Satilla Health	$110.1	$119.1	$111.3	$99.3	$112.6	$107.8	$119.0	$779.1
Navicent Health Baldwin	$44.7	$44.9	$51.1	$48.4	$54.1	$48.8	$53.8	$345.9
Northeast Georgia Medical Center	$928.6	$1,025.5	$1,114.8	$1,075.8	$1,426.0	$1,484.4	$1,669.7	$8,724.7
Northeast Georgia Medical Center Barrow	$14.1	$22.6	$32.2	$32.1	$43.6	$44.6	$51.5	$240.6
Northeast Georgia Medical Center Lumpkin	$15.1	$3.5	$0.0	$10.5	$21.1	$23.2	$21.1	$94.5
Northridge Medical Center[5]	$13.9	$11.4	$6.3	$2.6	-	-	-	$34.2
Northside Hospital	$1,710.8	$1,770.5	$1,817.6	$1,884.4	$2,135.3	$2,340.5	$2,488.4	$14,147.5
Northside Hospital Cherokee	$213.7	$278.6	$332.0	$402.9	$514.5	$559.8	$598.7	$2,900.2
Northside Hospital Duluth	$156.5	$160.1	$171.7	$147.5	$171.2	$192.9	$200.5	$1,200.4
Northside Hospital Forsyth	$454.7	$460.8	$515.5	$533.6	$620.0	$637.8	$644.1	$3,866.6
Northside Hospital Gwinnett	$524.9	$517.3	$498.7	$710.9	$863.2	$1,009.5	$1,121.0	$5,245.5
Perry Hospital	$23.9	$25.6	$24.5	$25.5	$31.2	$32.7	$37.5	$200.9
Phoebe Putney Memorial Hospital	$461.8	$466.6	$515.6	$533.4	$564.4	$568.8	$626.6	$3,737.1
Phoebe Sumter Medical Center, Inc.	$61.0	$64.6	$68.4	$74.4	$79.6	$85.8	$89.3	$523.1
Piedmont Athens Regional Medical Center	$302.3	$428.1	$436.8	$419.4	$522.7	$592.5	$604.2	$3,306.1
Piedmont Augusta Hospital	$477.7	$502.8	$508.0	$452.8	$471.5	$239.3	$458.3	$3,110.3
Piedmont Cartersville Medical Center	$137.5	$146.9	$148.4	$143.0	$92.9	$148.0	$167.2	$984.0
Piedmont Columbus Regional Midtown	$283.1	$300.1	$321.9	$335.7	$396.7	$432.3	$420.2	$2,489.9
Piedmont Columbus Regional Northside	$70.7	$68.8	$80.6	$85.8	$88.4	$119.2	$134.8	$648.3
Piedmont Eastside Medical Center	$186.2	$217.4	$209.6	$199.2	$122.7	$180.6	$227.3	$1,343.2
Piedmont Fayette Hospital	$308.7	$340.2	$384.2	$383.5	$453.0	$490.3	$511.6	$2,871.5
Piedmont Henry Hospital, Inc	$246.0	$265.2	$318.6	$330.4	$373.7	$411.9	$439.9	$2,385.8
Piedmont Hospital	$901.1	$943.5	$966.8	$947.8	$1,115.2	$1,182.8	$1,318.9	$7,376.0

Hospital Name[2]	Net Patient Revenues[1] (in millions) 2017	2018	2019	2020	2021	2022	2023	TOTAL
Piedmont Macon Medical Center	$207.3	$226.2	$224.4	$245.8	$135.5	$196.1	$207.9	$1,443.4
Piedmont Macon North Hospital	$69.3	$77.8	$71.7	$44.3	$33.3	$48.9	$57.7	$403.1
Piedmont McDuffie Hospital	$18.6	$18.3	$18.9	$17.8	$19.9	$11.2	$26.8	$131.7
Piedmont Mountainside Medical Center	$76.2	$78.5	$89.2	$82.4	$103.3	$117.6	$123.3	$670.5
Piedmont Newnan Hospital	$195.4	$215.6	$246.5	$260.9	$315.2	$340.5	$362.4	$1,936.5
Piedmont Newton Hospital	$67.9	$77.3	$92.5	$85.7	$107.6	$131.9	$145.9	$708.8
Piedmont Rockdale Hospital	$86.4	$87.4	$125.2	$136.1	$177.7	$195.8	$212.8	$1,021.3
Piedmont Walton Hospital	$48.0	$21.6	$44.1	$59.4	$96.3	$108.3	$127.0	$504.8
Regency Hospital Company of Macon	$27.8	$27.9	$25.8	$31.3	$31.3	$28.7	$27.2	$200.0
Rehabilitation Hospital of Henry[6]	-	-	-	-	-	$3.1	$19.1	$22.3
Rehabilitation Hospital, Navicent Health	$13.5	$18.6	$24.4	$20.8	$21.8	$20.9	$21.6	$141.6
Roosevelt Warm Springs Institute for Rehabilitation	$10.3	$10.0	$9.8	$10.1	$0.0	$0.0	$8.5	$48.8
Select Specialty Hospital - Midtown Atlanta, LLC	$21.5	$23.9	$23.8	$31.0	$29.0	$39.7	$36.1	$205.0
Select Specialty Hospital - Savannah	$15.4	$18.3	$18.8	$19.0	$20.4	$22.1	$19.9	$133.8
Select Specialty Hospital of Augusta	$25.1	$28.2	$25.9	$30.2	$33.4	$27.3	$37.0	$207.1
Select Specialty Hospital of South Atlanta[7]	$16.4	$22.7	$23.0	$26.3	$24.1	-	-	$112.6
Shepherd Center	$201.4	$223.8	$238.5	$268.2	$248.6	$241.5	$254.7	$1,676.6
South Georgia Medical Center	$314.7	$296.3	$302.6	$326.1	$369.7	$344.3	$383.4	$2,337.1
South Georgia Medical Center - Berrien Campus	$6.8	$5.4	$4.6	$6.1	$6.5	$8.2	$6.9	$44.4
Southeast Georgia Health System - Camden Campus	$46.6	$47.8	$50.9	$48.0	$57.8	$64.8	$52.3	$368.3
Southeast Georgia Health System - Brunswick Campus	$255.0	$262.6	$280.7	$277.3	$301.3	$307.1	$309.8	$1,993.7
Southeastern Regional Medical Center, Inc.	$552.3	$430.0	$421.3	$373.0	$309.9	$356.3	$254.8	$2,697.6
Southern Regional Medical Center	$133.7	$145.6	$135.8	$117.1	$114.6	$101.1	$260.9	$1,008.8
Southwell Medical Center a Campus of Tift Regional Medical Center	$8.4	$6.2	$3.8	$8.7	$10.5	$9.1	$16.1	$62.8
St Mary's Hospital	$176.2	$187.1	$205.7	$209.3	$222.8	$238.0	$249.2	$1,488.3
St. Francis Hospital - Emory Healthcare	$230.3	$224.5	$162.4	$185.6	$210.4	$202.8	$227.6	$1,443.8
St. Joseph's Hospital, Inc.	$203.6	$213.4	$243.5	$246.7	$272.3	$287.1	$297.7	$1,764.2
St. Mary's Sacred Heart Hospital	$24.0	$25.6	$29.0	$28.2	$34.1	$35.2	$38.7	$214.7
Stephens County Hospital	$30.6	$28.7	$28.9	$28.2	$29.0	$24.2	$31.2	$200.8
Tanner Medical Center Villa Rica	$122.9	$148.0	$160.4	$165.2	$226.7	$252.9	$280.9	$1,357.1
Tanner Medical Center-Carrollton	$251.6	$253.3	$278.9	$263.1	$298.6	$323.3	$311.2	$1,980.1
Taylor Regional Hospital	$17.5	$17.1	$18.2	$17.7	$16.9	$16.8	$14.9	$119.0
Tift Regional Medical Center	$281.7	$315.8	$354.8	$336.3	$234.6	$308.9	$333.9	$2,166.0
Union General Hospital	$49.6	$51.4	$60.5	$55.0	$75.4	$85.0	$85.8	$462.6
Upson Regional Medical Center	$66.0	$72.3	$80.7	$75.6	$97.6	$98.4	$101.1	$591.8
Walton Rehab Hospital, Affiliate of Encompass Health	$21.6	$23.5	$24.9	$29.9	$33.2	$34.4	$36.3	$203.8
Washington County Regional Medical Center	$9.8	$5.8	$14.3	$11.0	$10.8	$13.4	$19.0	$84.0
Wayne Memorial Hospital	$52.3	$54.5	$62.6	$80.0	$88.6	$86.6	$72.6	$497.1
WellStar Atlanta Medical Center[8]	$325.8	$326.1	$362.0	$326.6	$342.5	$320.7	-	$2,003.6

Hospital Name[2]	Net Patient Revenues[1] (in millions)							
	2017	2018	2019	2020	2021	2022	2023	TOTAL
WellStar Cobb Hospital	$401.4	$422.4	$464.0	$689.1	$738.4	$783.1	$914.4	$4,412.8
WellStar Douglas Hospital	$131.7	$151.3	$160.6	$159.9	$193.7	$199.7	$220.1	$1,217.1
WellStar Kennestone Hospital	$974.6	$1,038.9	$1,144.0	$1,118.3	$1,289.1	$1,387.3	$1,552.1	$8,504.2
Wellstar MCG Health	$569.0	$400.2	$1,257.7	$683.6	$772.8	$739.1	$833.8	$5,256.3
Wellstar MCG Health Warm Springs	$7.1	$6.8	$4.5	$9.2	$0.0	$0.0	$5.5	$33.0
WellStar North Fulton Hospital	$164.7	$166.0	$191.3	$196.9	$239.4	$277.5	$318.3	$1,554.1
WellStar Paulding Hospital	$131.1	$154.3	$184.3	$184.8	$235.8	$254.5	$268.7	$1,413.5
WellStar Spalding Regional Hospital	$104.3	$126.4	$133.3	$127.5	$147.6	$143.6	$153.2	$935.9
WellStar West Georgia Medical Center	$150.6	$154.9	$176.3	$164.1	$193.9	$223.2	$227.8	$1,290.8
WellStar Windy Hill Hospital	$80.0	$86.2	$106.3	$106.4	$125.2	$135.2	$159.6	$799.0

[1] As noted on page 1, net patient revenue represents gross patient revenue less certain deductions, which include contractual adjustments and costs associated with bad debt, charity care, and indigent care. Hospitals are also instructed to deduct an estimate of total add-on payments received when calculating net patient revenue; staff from the audit firm that reviews Hospital Financial Survey data indicated this practice is intended to prevent hospitals from paying a fee on add-on revenues received in recognition of the fee.

[2] Hospital names may change over the years due to changes in ownership or other reasons. For consistency, we used the name of the facility according to the hospital provider fee schedule for the most recent year the hospital was assessed a fee. Additionally, this table includes only those hospitals that participated in the provider fee program in fiscal years 2020-2025.

[3] Opened in CY 2021.

[4] Closed in CY 2020.

[5] Closed in CY 2020.

[6] Opened in CY 2021.

[7] Closed in CY 2022.

[8] Closed in CY 2022.

Source: DCH Hospital Financial Survey data, 2017-2023

Appendix D: Georgia Medicaid Overview

Georgia's Medicaid program provides healthcare coverage for low-income adults and children. The state has three Medicaid programs that serve different populations:

- Aged, Blind, and Disabled (ABD),
- Low-Income (LIM), and
- PeachCare for Kids (PCK).

As of April 2025, 1.9 million individuals are enrolled in the three Medicaid programs. The total budget for Medicaid in fiscal year 2025 was $16.9 billion (including federal and state funds).

Service Delivery

Members enrolled in ABD receive services through a fee-for-service (FFS) Medicaid model administered by DCH. Under this model, DCH is responsible for enrolling providers in Medicaid and reimbursing providers directly for care provided to ABD members. Providers are reimbursed using rates set by DCH, which are required by federal law to be consistent with efficiency, economy, and quality of care.

Most members enrolled in LIM or PCK receive services via a Medicaid managed care organization (CMO) through a partnership with DCH, known as Georgia Families. Under managed care, DCH pays a monthly fee to a CMO for each enrolled member, which is referred to as a "capitation payment." These payments cover healthcare and administrative costs for each member. In turn, CMOs are responsible for coordinating and financing their members' healthcare, developing provider networks, and monitoring provider compliance with Medicaid laws, rules, and regulations. Unlike DCH under the FFS model, CMOs negotiate reimbursement rates separately with each provider in their network.

Eligibility Requirements

Medicaid eligibility in Georgia is generally restricted to those who are low-income and:

- Are blind,
- Have a disability,
- Need nursing home care,
- Are over the age of 65,
- Are pregnant,
- Are a child aged 18 or under, or
- Have been diagnosed with breast or cervical cancer.

Exhibit D-1 on the next page outlines the guidelines for eligibility for the three programs.

Exhibit D-1: Medicaid Program Eligibility Requirements (CY 2025)

Program	Medicaid Program Eligibility Requirements (2025)
Aged, Blind, & Disabled (ABD)	Generally, ABD members can be any age, are low-income, have few financial resources, and: • Receive Supplemental Security Income for a disability, • Reside in nursing homes, • Remain at home but need regular nursing care, • Qualify for Medicare, • Are terminally ill and will receive hospice services, or • Are immigrants or refugees meeting certain status.
Low-Income Medicaid (LIM)	Generally, LIM members are low-income between the ages of 0 and 64 with few financial resources and are: • Pregnant women, • Children under age 19, • Parents or caretakers of children under age 19, • Medically needy, • Un- or under-insured women under 65 with breast or cervical cancer, • Youth aged out of foster care up to age 25, or • Immigrants who qualify for Emergency Medical Assistance (EMA) Medicaid. While income limits vary by specific LIM program, the income limit for Right from the Start Medicaid (RSM) for Pregnant Women is 220% of the federal poverty level (FPL)—between $46,536 and $70,716 annually in 2025, depending on family size. The limit for RSM for Children varies between 133% and 205% of the FPL, depending on the child's age. For a family of one, the income limit for RSM for Children was between $20,820 and $32,100 in 2025; for a family of four, it was between $42,756 and $65,892.
PeachCare for Kids (PCK)	PCK membership is limited to children under the age of 19 whose family income is too high to qualify for Medicaid but is between 138% and 247% of the FPL. For a family of one, the income limit in fiscal year 2025 was $38,676; for a family of four, it was $79,404.

Source: DCH documentation

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