



Health and Human Services

Contains Recommendations*

Medicaid Dental

Rural Hospital Tax Credit (2023)

Homelessness Spending

Rural Hospital Tax Credit (2024)

Contains No Recommendations

Regulatory Requirements of Selected Health Professions

Rural Hospital Tax Credit (2022)

Medicaid Unwinding

Prescription Drug Sales Tax Exemption

State Health Benefit Plan

Non-Profit Hospital Exemptions

* Until the follow-up review is completed, recommendation status shown is based on the agency's response and is subject to change.



Performance Audit Division

Greg S. Griffin, State Auditor | 404.656.2180 | audits.ga.gov

Medicaid Dental

Coordinated management needed to ensure oral health care is being delivered

BACKGROUND

Studies show that declining utilization of dental services, especially preventive care, may lead to increasing negative health outcomes for Medicaid children and ultimately higher health care costs. These include direct outcomes associated with tooth decay, as well as indirect outcomes associated with longer-term health problems such as heart disease, stroke, and obesity.

Federal law requires that state Medicaid programs provide all children (members under 21 years of age) with full dental benefits. Such benefits include restorative, preventive, and emergency treatments.

Although federal law does not require state Medicaid programs to provide dental coverage to adults, the Georgia Medicaid program provides adults (members 21 years of age and older) with emergency-level coverage through the Adult Dental Program.

KEY RECOMMENDATIONS

To address overall management, DCH should:

- Assign staff to implement a coordinated, data driven approach to managing the Medicaid dental program.

To address utilization, DCH should:

- Monitor dental service utilization among its Fee-For-Service member children and identify potential causes for declining or insufficient rates.
- Analyze the number of providers who accept new patients and actively participate in Medicaid.
- Systematically and routinely assess Fee- For-Service reimbursement rates for dental services.

To address coverage, the General Assembly should consider:

- Providing adult members access to preventive and diagnostic dental care with annual caps or co-payments.

KEY FINDINGS

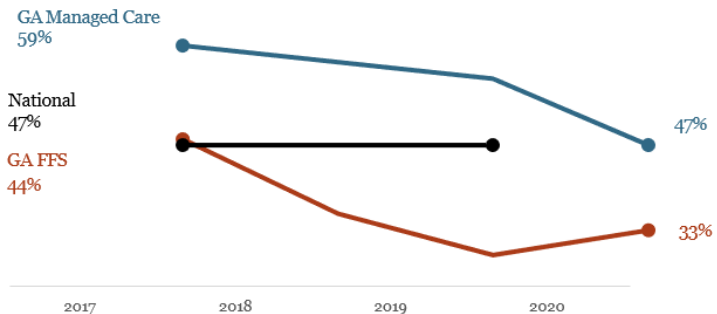
While multiple units have responsibilities related to the Medicaid dental program, DCH lacks the coordinated, data-driven management approach recommended by the federal Centers for Medicare and Medicaid Services (CMS). As a result, the agency was unaware of declining utilization among children in its fee-for-service program and has not sufficiently assessed the capacity of its provider network.

DCH does not analyze dental claims or provider networks to ensure adequate dental services are delivered.

- DCH was unaware of declines in dental utilization among Fee-For-Service children. Without an analysis of claims, the agency is unaware of potential service gaps and trends, and it cannot develop informed strategies to improve dental care.

Fee-for-service children are less likely to receive dental services than those in managed care or in many other states.

- Although 2020 rates were impacted by the COVID-19 pandemic, the percentage of children in Fee-For-Service who receive dental services has trailed the national average and Georgia managed care children during the last four years.



Provider networks meet federal standards but may not provide sufficient access to dental services.

- States are required to ensure that members have access to at least one in- network dental provider within 30 miles in an urban area and within 45 miles in a rural area.
- The Fee-For-Service provider networks meet standards, but they do not meet the stricter standards that DCH requires of its care management organizations (CMOs).
- Less than a quarter of providers accepted new patients in the last year, and less than one-fifth filed a claim indicating active participation. Nearly 30 counties have no providers accepting new patients.
- Medicaid reimbursement rates may contribute to network issues for the Fee-For-Service population given the higher cost for providers to treat some children with physical or developmental disabilities.

Medicaid Dental

Final Status Pending – Follow-Up Review will be completed in 2024

Finding 1: There is no coordinated management of the Medicaid Dental Program.	
DCH should assign staff to implement a coordinated, data driven approach to managing the Medicaid Dental Program.	Status Pending
Finding 2: The rate at which Fee-For-Service children utilize dental services is decreasing and is lower than rates for managed care and other states.	
DCH should establish goals for dental utilization among its Fee-For-Service member children, such as a minimum percent of members receiving dental care annually.	Status Pending
DCH should monitor dental service utilization among its Fee-For-Service member children and identify potential causes for declining or insufficient rates.	Status Pending
Finding 3: DCH’s compliance with federal standards does not ensure that Fee-For-Service members have sufficient access to dental services.	
In assessing its Fee-For-Service provider network, DCH should analyze the number of providers who accept new patients and actively participate in Medicaid.	Status Pending
DCH should track the ratio of Fee-For-Service beneficiaries to active providers accepting new patients on a county level to identify areas of the state that lack meaningful access.	Status Pending
DCH should conduct “secret shopper” calls similar to those used for CMO provider network studies to determine whether Fee-For-Service beneficiaries can obtain dental appointments in a reasonable timeframe.	Status Pending
Finding 4: DCH should increase its efforts to encourage provider participation in the Medicaid Dental program.	
DCH should systematically and routinely assess Fee-For-Service reimbursement rates for dental services. In these studies, DCH could compare Fee-For-Service to managed care, DOAS, and other state Medicaid rates. Based on the results, DCH should adjust rates to ensure they are competitive with other Medicaid programs and private insurers.	Status Pending
DCH’s Medicaid program should consider collaborating with the State Office of Rural Health to recruit providers to practice in HPSAs by providing assistance to these providers in obtaining eligibility for the National Health Service Corps loan repayment and scholarship program.	Status Pending
DCH should consider collaborating with DPH to encourage local public health clinics to provide dental services in counties or areas with a shortage of Medicaid dental providers.	Status Pending
DCH should research and emulate other states’ efforts to increase the number of dental providers in the Medicaid Fee-For-Service network, including providers that serve children with disabilities.	Status Pending
Finding 5: Georgia Medicaid does not cover adult members’ preventive dental care, which can lead to untreated dental issues, higher medical costs, and avoidable hospital visits.	
The General Assembly should consider providing adult members access to preventive and diagnostic dental care. To control costs, the General Assembly should consider measures such as establishing annual caps or co-payments.	Status Pending



Performance Audit Division

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Rural Hospital Tax Credit

Credit Administration Consistent with Statutory Requirements

BACKGROUND

O.C.G.A. § 48-7-29.20 requires the Department of Audits and Accounts to conduct an annual audit of the Rural Hospital Tax Credit (RHTC) program that includes the following:

1. All contributions received by rural hospital organizations;
2. All tax credits received by individual and corporate donors; and
3. All amounts received by third parties that solicited, administered, or managed donations pertaining to O.C.G.A. § 48-7-29.20 and 31-8-9.1.

The program was established in 2017 and allows taxpayers to donate to eligible rural hospitals and reduce their state income tax liability by the amounts they donate. Taxpayers may choose a specific hospital or, if one is not designated, a hospital will be selected based on a ranking of need.

The Department of Revenue (DOR) administers portions of the RHTC related to taxpayer eligibility criteria, and the Department of Community Health (DCH) administers portions related to hospital eligibility criteria. A third-party vendor (Georgia HEART) provides services to hospitals and contributors but is under contract with hospitals, not the state, for these services.

KEY RECOMMENDATIONS

To improve hospital reporting:

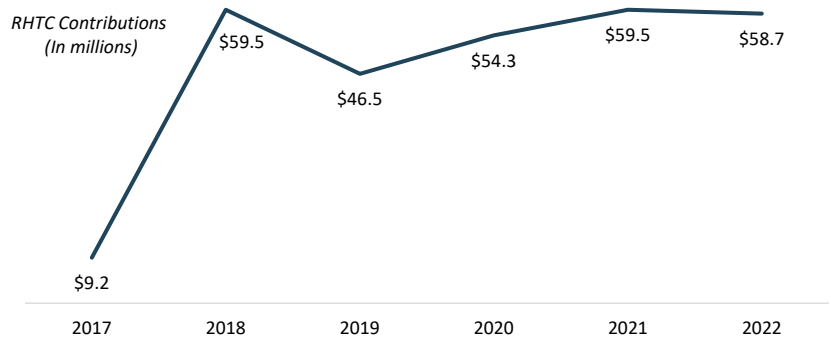
- DCH should add clarifying information or instructions to the Donation and Expenditure Report template on its website.
- Hospitals that receive RHTC funds should ensure that they are reporting accurate information on contribution expenditures and third party fees.
- DCH should review the Donation and Expenditure Reports for accuracy and require corrected/additional information from the hospitals when necessary.

KEY FINDINGS

Taxpayer credits nearly reached the annual program cap of \$60 million in tax years 2021 and 2022. In 2022, hospitals reported spending nearly \$49 million and having another \$40 million in donations still available for future years. Finally, hospitals, state agencies, and other entities with program responsibilities were largely compliant with program requirements.

Contributions to rural hospitals were approximately \$58.7 million in tax year 2022.

- Contributions decreased slightly from the tax year 2021 contribution amount of \$59.5 million but have remained well above the 2019 amount of \$46.5 million.



- In tax year 2022, 22 of 55 eligible rural hospitals received more than \$1 million and 22 received less than \$500,000.
- As required by state law, contributions not designated to a hospital by the donor were distributed to the neediest hospital on the DCH financial need list.

Hospitals spent \$49 million in RHTC funds and had \$40 million in unspent funds in tax year 2021.

- Hospitals reported that the majority of the RHTC funds were spent on capital assets or regular operating expenses in tax year 2021.
- Twenty-six of the 55 eligible hospitals reported having unspent funds. Amounts ranged from \$6,201 to \$7 million.

RHTC hospitals that received RHTC contributions were eligible and in compliance with state law, but improvements in reporting are needed.

- DCH reviewed and updated the list of eligible hospitals in tax year 2022; 55 hospitals were eligible in tax year 2022, down from 56 in tax year 2021.
- While all hospitals submitted the required reports, we identified inconsistencies in contribution expenditure reports submitted from tax years 2018 to 2021. These inconsistencies were identified in contribution amounts received, third party fees paid, expenditures exceeding available funds, and prior year unspent funds.
- No hospital exceeded the \$4 million contribution limit, and all paid Georgia HEART no more than 3% of contributions.

Rural Hospital Tax Credit (2023)

Follow-Up completed as part of 2024 RHTC Report

Finding 1: Eligible hospitals received approximately \$58.7 million in RHTC contributions in tax year 2022, with amounts to individual hospitals varying significantly.	
No recommendations	
Finding 2: All RHTC contributions to hospitals were within statutory limits in tax year 2022.	
No recommendations	
Finding 3: While rural hospitals that received RHTC contributions were eligible and in compliance with state law, improvements in reporting are needed.	
DCH should add clarifying information or instructions to the Donation and Expenditure Report template on its website. For example, the form should indicate that the Prior Year Unspent Funds should equal the Unspent Funds from the previous hospital report and that expenditures should not exceed available RHTC funds.	Fully Implemented
Hospitals that receive RHTC funds should ensure that they are reporting accurate information on contribution expenditures and third party fees.	Fully Implemented
DCH should review the Donation and Expenditure Report for obvious errors and require corrected/additional information from the hospitals when necessary.	Fully Implemented
Finding 4: Rural hospitals reported spending \$48.7 million of RHTC funds in 2021, with approximately \$40 million in funds remaining unspent.	
No recommendations	
Finding 5: Rural hospital tax credits were primarily claimed by individual taxpayers in tax year 2021.	
No recommendations	
Finding 6: Administrative fees retained by Georgia HEART in tax year 2021 were within statutory limits.	
No recommendations	
Finding 7: Undesignated donations are distributed to rural hospitals in accordance with state law.	
No recommendations	



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Homelessness Spending

Requested Information on Programs and Services

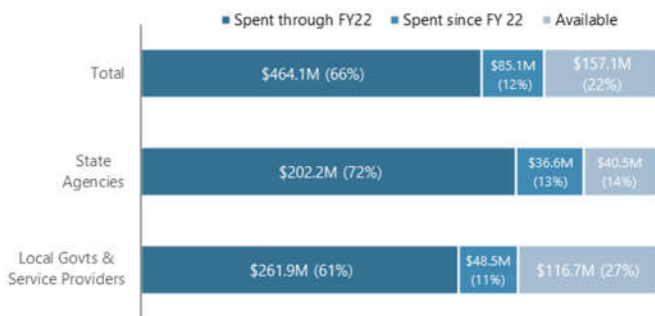
BACKGROUND

Senate Bill 62, which passed during the 2023 legislative session, required the state auditor to conduct a performance audit of spending on homeless programs and services. Accordingly, we examined the funds available from federal, state, and local fund sources and how funds were spent; the use of grants and contracts to award funds and monitor service delivery; and the use of the Georgia Homeless Management Information System (HMIS).

The Department of Community Affairs (DCA) and other state entities administer a variety of homeless programs. Some are federally funded programs that target specific populations.

In 2022, approximately 10,700 individuals were reported as experiencing homelessness in Georgia.

Approximately 78% of Total Federal Funds Available Has Been Spent



KEY RECOMMENDATIONS

The General Assembly could consider:

- Establishing a council responsible for statewide coordination, as has been done in other states.
- Requiring the council to use HMIS to conduct statewide analyses of homelessness conditions and trends.

KEY FINDINGS

In Georgia, homelessness is addressed through a network of programs and services administered at the state and local levels but primarily funded through federal grants. The majority of these federal grants can be spent over multiple years, depending on the grant period. State funding is significantly smaller for a few targeted programs. Most federal and state funding ultimately reaches the state’s network of local organizations that provide direct services to the homeless population. Though a significant amount of activity occurs locally, Georgia’s response to homelessness may be improved through statewide coordination.

Significant federal funds are awarded for and spent on homeless programs and services.

- Between federal fiscal years 2018 and 2022 (the latest year for which complete federal data was available), an estimated \$706 million in federal funds was available to state agencies, local governments, and service providers. Approximately 78% (\$549 million) of federal funds available during the period reviewed has been spent.
- Approximately 40% of funds available (\$279 million) were for state agencies, which expended approximately 85% of federal funds (\$239 million), leaving \$41 million for future spending.
- Approximately 60% of funds available were for local governments and service providers (\$214 million and \$213 million, respectively), with most funds available to spend in areas with substantial homeless populations. In total, these entities spent approximately 73% of federal funds (\$310 million), leaving \$117 million for future spending.
- Because state and local governments serve as pass-through entities for federal funds, most of the federal funding is spent by service providers. In the period reviewed, these entities spent a total of \$352 million.

State funds accounted for a small portion of total spending during the period reviewed.

- Between state fiscal years 2018 and 2023, the state spent \$158.4 million on homeless programs and services. Most state expenditures were incurred by the Department of Community Affairs and Department of Behavioral Health and Developmental Disabilities.

The state lacks a coordinated response to homelessness.

- Operations and management of homelessness related activities and services are decentralized and primarily concentrated at the local level. No state-level entity is responsible for coordinating efforts across regions.
- Other states with a designated lead entity have adopted broad strategies for preventing and addressing homelessness, including collection, aggregation, and analysis of statewide data on homelessness.

Homelessness Spending

Final Status Pending – Follow-Up Review will be completed in 2026

Finding 1: Between federal fiscal years 2018 and 2022, an estimated \$811.8 million in federal funds was available for homeless programs and services.	
No recommendations included	
Finding 2: Between fiscal years 2018 and 2022, 60% of federal funds available were spent on homelessness programs and services, though funds will be available for additional years.	
No recommendations included	
Finding 3: As the final recipients of federal funding, service providers spent \$347.4 million to directly serve homeless populations between fiscal years 2018 and 2022.	
No recommendations included	
Finding 4: Expenditures of state funds for homeless programs fluctuated between fiscal years 2018 and 2022.	
No recommendations included	
Finding 5: Most local government survey respondents reported they did not spend their own funds on homelessness programs in 2022.	
No recommendations included	
Finding 6: Law enforcement agencies do not track expenditures but reported performing certain activities to address homelessness during their normal duties.	
No recommendations included	
Finding 7: The state’s grant administration process is primarily based on federal requirements.	
No recommendations included	
Finding 8: While CoCs and service providers use HMIS to meet HUD requirements, its use to improve homeless service delivery statewide is not currently maximized.	
Should the General Assembly decide to establish a statewide entity to coordinate the state’s response to homelessness (as discussed in Finding 9), it should consider requiring the council to use HMIS to conduct statewide analyses of homelessness conditions and trends.	Status Pending
Finding 9: While a significant amount of funding is used to serve Georgia’s homeless populations, the state lacks a coordinated, strategic response to address the problem.	
If the General Assembly wants a more strategic approach to address homelessness, it could consider establishing a council responsible for statewide coordination, as has been done in other states.	Status Pending



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Rural Hospital Tax Credit

Credit Administration Largely Consistent with Statutory Requirements

BACKGROUND

O.C.G.A. § 48-7-29.20 requires the Department of Audits and Accounts to conduct an annual audit of the Rural Hospital Tax Credit (RHTC) program that includes the following:

1. All contributions received by rural hospital organizations;
2. All tax credits received by individual and corporate donors; and
3. All amounts received by third parties that solicited, administered, or managed donations pertaining to O.C.G.A. §§ 48-7-29.20 and 31-8-9.1.

The program was established in 2017 and allows taxpayers to donate to eligible rural hospitals and reduce their state income tax liability by the amounts they donate. Taxpayers may choose a specific hospital or, if one is not designated, a hospital will be selected based on a ranking of need.

The Department of Revenue (DOR) administers portions of the RHTC related to taxpayer eligibility criteria, and the Department of Community Health (DCH) administers portions related to hospital eligibility criteria. A third-party vendor (Georgia HEART) provides services to hospitals and contributors but is under contract with hospitals, not the state, for these services.

KEY RECOMMENDATIONS

DOR should:

- Create a mechanism to allow contribution reports to be amended.
- Strengthen controls related to contributions that are not made and for statutory limits related to tax liability.

Georgia HEART should:

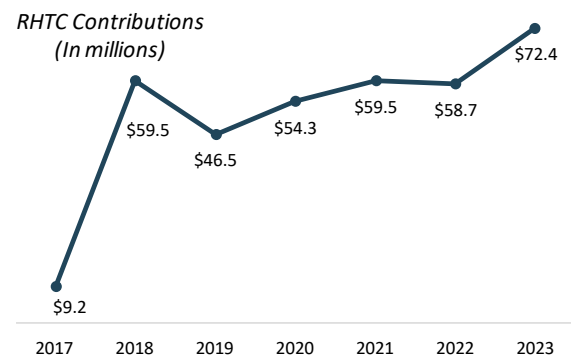
- Ensure that it does not report inaccurate contributions.
- Notify DOR about erroneous reporting identified during its internal audits.

KEY FINDINGS

Taxpayer credits nearly reached the annual aggregate limit of \$75 million in tax year 2023. In 2022, hospitals reported spending nearly \$58.1 million and having another \$40 million in donations still available for future years. Finally, hospitals, state agencies, and other entities with program responsibilities were largely compliant with program requirements.

Contributions to rural hospitals totaled \$72.4 million in 2023.

- In tax year 2023, the RHTC annual aggregate limit increased from \$60 million to \$75 million. Contributions have been close to the annual aggregate limit in most years since the RHTC was established.
- In 2023, 28 of the 55 eligible hospitals received more than \$1 million, and 9 received less than \$500,000.
- As required by state law, contributions not designated to a hospital by the donor were distributed to the neediest hospital on the DCH financial need list (Irwin County Hospital).



Hospitals spent \$58 million in RHTC funds and had \$40 million in unspent funds in 2022.

- Hospitals reported that the majority of the RHTC funds were spent on capital assets or regular operating expenses in 2022.
- Twenty-five of the 55 eligible hospitals reported having unspent funds. Amounts ranged from \$10,000 to \$7.2 million.

Entities have improved controls and were generally in compliance with state law, but controls should continue to be strengthened.

- DCH verified that all 55 hospitals receiving contributions in tax years 2022 and 2023 were eligible based on statutory criteria. DCH also fully implemented recommendations made in last year's audit, including adding clarifying information to its hospital reporting template and modifying work processes to improve the accuracy of hospital reporting.
- DOR controls ensure that total contributions do not exceed individual hospital limits or annual aggregate limits. However, between tax years 2018 and 2023, we identified a small amount of credits—\$335,000, or 0.1% of all credits—that were available to be claimed because of erroneous reporting to DOR or because corporate credits exceeded statutory limits.
- No hospital exceeded the \$4 million contribution limit, and all paid Georgia HEART no more than 3% of contributions. We found a limited number of errors in contribution reports that Georgia HEART submitted to DOR, which impact available tax credits.

Rural Hospital Tax Credit (2024)
Final Status Pending – Status will be updated in 2025

Finding 1: Eligible hospitals received approximately \$72.4 million in RHTC contributions in tax year 2023, with amounts to individual hospitals varying significantly.

No recommendations

Finding 2: All RHTC contributions to hospitals were within statutory limits in tax year 2023.

No recommendations

Finding 3: Rural hospitals that received RHTC contributions were generally in compliance with state law.

No recommendations

Finding 4: Rural hospitals reported spending \$58 million of RHTC funds in 2022, with approximately \$40 million in funds remaining unspent.

No recommendations

Finding 5: Individual taxpayers claimed the majority of rural hospital tax credits in tax year 2022.

No recommendations

Finding 6: Individual taxpayers claimed the majority of rural hospital tax credits in tax year 2022.

DOR should create a mechanism to allow or require rural hospital organizations/Georgia HEART to report contributions that require amendment, and DOR should adjust credits that need to be lowered.

Status Pending

Georgia HEART should notify DOR about erroneous reporting identified during its internal audits.

Status Pending

DOR should modify its information system to allow rural hospital organizations/Georgia HEART to report a \$0 contribution if the preapproved donor has indicated they will not contribute.

Status Pending

Georgia HEART should stop reporting inaccurate \$1 contributions.

Status Pending

DOR should continue to improve controls related to corporate credits.

Status Pending

Finding 7: Administrative fees retained by Georgia HEART in tax year 2022 were within statutory limits.

No recommendations

Finding 8: Undesignated donations are distributed to rural hospitals in accordance with state law in tax year 2023.

No recommendations



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Regulatory Requirements of Selected Health-Related Professions

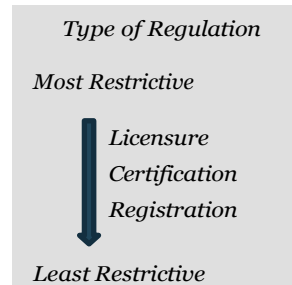
Georgia’s requirements are largely the same as other states

Overview

Overall, we found that Georgia’s requirements are similar to those of other states. Of the 14 professions reviewed, Georgia regulates 11 at the highest level as licensed professions. Practitioners of these professions must meet established educational, training, and/or testing requirements to obtain a license.

Georgia’s regulatory requirements are largely the same—or very similar to—those in other states for most professions reviewed (see highlights in box to the left). However, Georgia applicants for Skin Care Specialists (known as Estheticians in Georgia) and Pharmacy Technicians face requirements that differ the most from other states. In particular:

- Georgia’s Skin Care Specialists pay higher licensing and renewal fees than most other states. Additionally, Georgia’s training and minimum age requirements are significantly more restrictive than other states.
- Georgia requires Pharmacy Technicians to register with the state, which is more lenient than most other states’ licensure requirement. However, Georgia’s initial and renewal fees are higher than those in other states—even those that require a license.



When reviewing specific data points within all 14 professions, we found that for 9 professions Georgia’s initial and renewal fees are lower than most other states. We also found Georgia was the same as other states on the following points:

- Licensure, certification, or registration requirement (11 professions);
- License, certification, or registration renewal periods and the time allowed to complete any continuing education requirements (10 professions);
- Requirements for education, training, experience, and professional exams (11 professions);
- Restrictions on applicants with prior criminal history (9 professions); and
- Reciprocity allowances (11 professions).

Finally, Georgia differs from other states in several ways. For EMTs, it is less restrictive than most states in that it does not set a minimum age requirement (46 states do) or a training requirement (49 states do). Georgia is more restrictive than other states in that it requires:

- A minimum age of 18 for Dieticians (34 states have no requirement or a lower one) and
- 2,000 hours of experience for Skin Care Specialists (46 states require fewer hours).

Background

Using data collected by the National Conference of State Legislatures (NCSL), we compared Georgia’s regulatory requirements for 14 health-related professions to requirements in all other states and the District of Columbia. Overall, we found that Georgia’s requirements are similar to those of other states.

Why we did this review

NCSL staff collected data on 48 regulated professions—licensed, regulated, or certified—with a projected employment growth rate above zero and for which regulation could pose unnecessary barriers to employment. Additionally, to be selected, the profession had to be regulated in at least 30 states. We reviewed 14 health-related professions from this group because they represent some of the fastest growing professions nationwide and a significant portion of the licenses and renewals handled in Georgia.



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Rural Hospital Tax Credit

Requested Information on Contributions and Compliance

BACKGROUND

O.C.G.A. § 48-7-29.20 requires the Department of Audits and Accounts to conduct an annual audit of the Rural Hospital Tax Credit (RHTC) program that includes the following:

1. All contributions received by rural hospital organizations;
2. All tax credits received by individual and corporate donors; and
3. All amounts received by third parties that solicited, administered, or managed donations pertaining to O.C.G.A. § 48-7-29.20.

The program was established in 2017 and allows taxpayers to donate to eligible rural hospitals and reduce their state income tax liability by the amounts they donate.

Taxpayers may choose a specific hospital or, if one is not designated, a hospital will be selected based on a ranking of need.

The Department of Revenue (DOR) administers portions of the RHTC related to taxpayer eligibility criteria, and the Department of Community Health (DCH) administers portions related to hospital eligibility criteria. A third-party vendor (Georgia HEART) provides services to hospitals and contributors but is under contract with hospitals, not the state, for these services.

KEY RECOMMENDATIONS

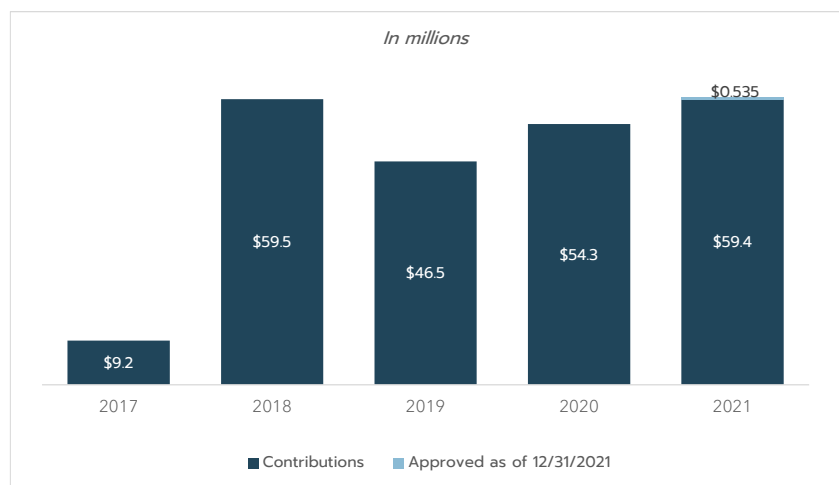
This report does not contain recommendations.

KEY FINDINGS

Hospitals, taxpayers, and third parties were compliant with statutory provisions.

Approved contributions to rural hospitals totaled \$59.4 million in calendar year 2021.¹

- Contributions have continued to increase from the low of \$46.5 million in tax year 2019 and almost met the highest amount of \$59.5 million in tax year 2018.



- In tax year 2020, 17 of the 56 eligible hospitals received more than \$1 million in contributions, and 18 received less than \$500,000. The average annual amount received by a hospital was \$970,000.
- As required by state law, contributions not designated to a hospital by the donor were distributed to the neediest hospital on the DCH ranking. In addition, in 2021 Georgia HEART implemented our 2020 recommendation to report undesignated contributions to DOR.

All RHTC hospitals met eligibility requirements and received annual contributions within the statutory limit of \$4 million.

- DCH reviewed and updated the list of eligible hospitals in 2021; 56 hospitals were eligible in 2020 and 2021.
- All hospitals submitted the required program reports to DCH.

DOR has strengthened controls related to corporate credits.

- Based on a recommendation made in the 2020 RHTC audit report, DOR implemented a new process to ensure that corporate tax credits were within legal limits.
- DOR adjusted the tax credits for the accounts identified in the 2020 audit, approximately \$96,000.

¹ Tax year 2020 data was used to report credits earned and claimed, while calendar year 2021 data reported by DOR was used to report the most recent contributions approved by DOR.



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Medicaid Unwinding

Status of State Efforts to Prepare for the End of Continuous Coverage

Key Findings

The Departments of Human Services (DHS) and Community Health (DCH), as well as the Office of State Administrative Hearings (OSAH), have developed strategies to facilitate a return to annual Medicaid renewals. Several risk areas can contribute to the improper loss of Medicaid coverage for enrollees, including administrative barriers, enrollees not being contacted, enrollee confusion, staffing deficiencies, and inadequate management information and oversight. Strategies to address these risks can generally be grouped into the categories below.

Communications

- DHS has used emails, text messages, robocalls, and its website to encourage enrollees to update contact information and select email or text communications as a preferred method of receiving official notices.
- DHS hired a public relations firm to help develop a communications plan that includes an unwinding web page, branding, informational videos, and paid media. Phase one focuses on updating contact information, while phase two will focus on educating enrollees of their responsibilities regarding renewals.

Policies

- DCH has obtained waivers from the federal government to facilitate more rapid renewals. These include greater flexibility to make renewal decisions based on third party data sources and information obtained for other benefit programs. DHS will also be able to send official notifications to enrollees based on addresses provided by care management organizations or the U.S. Postal Service.

Staffing

- DHS is attempting to hire approximately 500 additional eligibility caseworkers and creating a specialized Medicaid renewal team.
- Both DHS and OSAH will use temporary staff if needed. DHS will add call center staff, while OSAH will hire special administrative law judges if surges in hearings cannot be handled by current judges.

Technology/Automation

- DHS plans to use robotic processing automation (bots) to automate repetitive caseworker tasks, such as processing scanned or handwritten documents, pre-populating data from the customer portal, comparing information to third-party data interfaces, identifying red flags, and conducting certain administrative based renewals. Bots are also planned to populate some aspects of the OSAH fair hearing forms.
- OSAH has also already begun utilizing an electronic case management system and unified hearing calendar to better schedule and plan hearings and communicate with outside agencies and enrollees.
- DHS has already implemented a mobile-friendly site to allow enrollees to update contact information and upload document images directly through their mobile phone.

Background

Throughout the COVID-19 pandemic public health emergency (PHE), states have been required to suspend termination of coverage for individuals who are already enrolled or became enrolled in Medicaid. This “continuous coverage” will cease at the end of the PHE, beginning a 12-month period in which states must redetermine all enrollees’ Medicaid eligibility (this is known as the “unwinding”).

Why we did this review

When the PHE comes to an end, states must reinstitute Medicaid and PeachCare renewals that were suspended in March 2020. An increase in program enrollment and the length of time since renewals were last performed will make it difficult for states to accurately complete all renewals within the required timeframes.

This report provides an overview of Georgia’s preparation for the end of continuous coverage of the Medicaid and PeachCare benefits of approximately 2.6 million residents.

Tax Incentive Evaluation: Prescription Drug Sales Tax Exemption

DOAA summary of report prepared by Georgia State University's Fiscal Research Center

BACKGROUND

In 1984, Georgia enacted a state and local sales tax exemption for prescription drugs, glasses and contacts, as well as any insulin obtained without a prescription. The exempted state sales tax rate is 4%, while the average local sales tax rate is 3.37%, according to the Tax Foundation. The provision—O.C.G.A. § 48-8-3(47)—is commonly referred to as the prescription drug sales tax exemption.

This review was requested by the House Ways and Means Committee and performed in accordance with O.C.G.A. § 28-5-41.1. Georgia State University's Fiscal Research Center (FRC) prepared the report.

ECONOMIC ACTIVITY

Sales tax exemption is targeted to consumers, not companies. Therefore, the economic impact is a result of the additional money consumers can spend on goods and services.

While the prescription drug sales tax exemption was not created for the purpose of economic development, the increased spending by consumers benefiting from the exemption does result in additional jobs and economic activity. The figures to the right are estimated for FY 2021 by FRC, though the figures do not include a consideration of opportunity costs.

O.C.G.A. § 28-5-41.1 requires an analysis of net economic activity, which includes the opportunity cost of the forgone revenue. If the exempted tax revenue had been collected and expended by the state and local governments, FRC estimated the creation of 16,812 jobs and economic output of \$1.72 billion.



REVENUE

The exemption is estimated to grow from approximately \$852 million in FY 2021 (combined state and local government revenue expenditure) to FY 2021 to \$938.2 million in FY 2023. In 2023, the resulting economic activity is estimated to bring in \$33.0 million in state revenue and \$13.4 million in local revenue.

FRC estimated that the alternate use of the revenue in FY 2023 would generate \$53.2 million in state revenue and \$12.2 million in local revenue.

COST

The Department of Revenue reported **negligible cost** associated with the exemption.

PUBLIC BENEFIT

The exemption **lowers the price of prescriptions**, making the cost of needed healthcare more affordable for Georgians.

The exemption on prescriptions and other health-related items makes Georgia's sales tax less regressive. Lower income households spend a greater portion of their income on prescriptions than higher income households. For example, the 4% tax savings represent 0.34% of the income of those making less than \$15,000. By contrast, it represents just 0.05% of the income of households with incomes between \$100,000 and \$150,000.



Performance Audit Division

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State Health Benefit Plan Requested Information on Plan Stability

BACKGROUND

The House Appropriations Committee requested this special examination of the State Health Benefit Plan (SHBP). Based on the request, we determined: (1) how SHBP's financial status has changed; (2) what factors have contributed to changes in the Plan's financial status; and (3) what the revenue and expenditure projections were for fiscal years 2018-2022 and how they compared with actuals. This review did not examine Plan administration or contract management.

The State Health Benefit Plan was created to provide affordable, quality healthcare coverage that is competitive with other commercial benefit plans in quality of care, access to providers, and efficient management of provider fees and utilization. The Plan provides benefits for employees and dependents of the State Employees Plan, Teachers Plan, and School Employees Plan.

The Department of Community Health administers the Plan, and the Board of Community Health provides policy direction for the Plan's operation. As of November 2022, 661,514 members were covered by the Plan. Active members comprised 72% of total membership and retirees accounted for 28%.

KEY RECOMMENDATIONS

This report is intended to answer questions posed by the House Appropriations Committee and to help inform policy decisions.

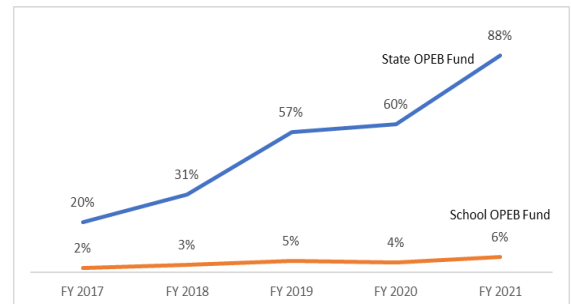
KEY FINDINGS

While State Health Benefit Plan revenue and expenditures have increased since 2018, the increase in expenditures between fiscal years 2020 and 2022 exceeded the increase in revenues. Revenue growth has been limited by policy decisions and stagnant subscriber levels.

The SHBP Fund's net position has increased over the past five years.

- Health insurance benefits for active members are paid through the SHBP Fund. Between fiscal years 2017 and 2021, the SHBP Fund's net position (which reflects its financial stability) increased by 5%—from \$571.7 million to \$602.0 million. However, the Fund operated at a loss in fiscal year 2021, with expenditures exceeding revenues by approximately \$93.5 million.

- Health insurance benefits for retirees are paid through two Other Post Employment Benefit (OPEB) Funds. At the end of fiscal year 2021, the State OPEB Fund was 88% funded. By contrast, the School OPEB Fund was only 6% funded because surpluses in the Teachers and School Employees Plans have been significantly smaller than those in the State Employees Plan.



Over the past few years, Plan expenditures have outpaced revenues, resulting in an increasing amount of state funds to cover teachers' and school employees' healthcare costs.

- While total Plan expenditures increased by approximately 28% between fiscal years 2018 and 2022, revenues increased by only 3%.
- Revenue for the Teachers and School Employees Plans has not been sufficient to cover members' healthcare expenditures over the past few years. In fiscal year 2022, for example, SHBP expenditures for the Teachers Plan and School Employees Plan exceeded revenue by \$251 million and \$213 million, respectively. This difference was paid by the state.
- The revenue gap for the Teachers and School Employees Plans can be attributed to employer contribution rate differences. For the State Employees Plan, employers pay 29.454% of salaries for all state employees (regardless of enrollment in SHBP) annually. For the Teachers and School Employees Plans, employers pay \$11,340 annually (\$945/month) per covered employee, which—particularly for teachers—can result in a lower effective contribution rate.

Actuarial revenue and expense projections have been accurate.

- Plan revenue and expenditure projections are calculated based on historic trends and updated regularly.
- The projections—which are sent to the Governor's Office of Planning and Budget to assist in setting rates—have been accurate over the past five years (less than 3.5% difference from actual revenues and less than 2.0% difference from actual expenditures).

Tax Incentive Evaluation: Non-Profit Hospital Exemptions

DOAA summary of report prepared by Georgia State University's Fiscal Research Center

BACKGROUND

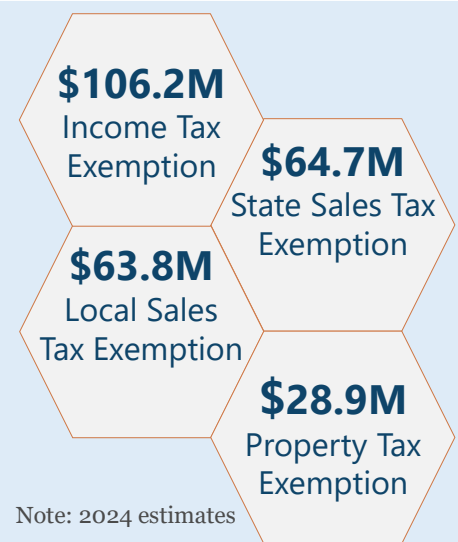
Non-profit hospitals (NPHs) are 501(c)(3) entities exempt from federal income tax. Federal nonprofit status requires these private hospitals to provide benefits to their community, including charity care and community health improvements. In Georgia, NPHs are exempt from three state and local taxes: income tax, sales and use tax, and property tax. The exemptions are intended to incentivize the hospitals to invest in the healthcare needs of low-income individuals. Every state allows at least one of these exemptions, and 29 other states allow all three.

This review was requested by the Senate Finance Committee and performed in accordance with O.C.G.A. § 28-5-41.1. Georgia State University's Fiscal Research Center (FRC) prepared the report.

REVENUE

The state-level exemptions are projected to increase from \$170.9 million in FY 2024 to \$236.6 million in FY 2028, with the corporate income tax exemption representing nearly two-thirds of the impact. Similarly, local exemptions are projected to increase from \$92.7 million to \$115.5 million, with the local sales tax exemption representing approximately 70%.

The fiscal impact is affected by ownership changes. For example, several for-profit hospitals (FPHs) have recently been sold to NPH systems, removing them from state and local taxation.



ECONOMIC ACTIVITY

FRC did not model the economic benefits of NPH patients or the opportunity costs of the exemptions. It focused on the public benefits generated by NPHs. FRC pointed to the level and sufficiency of these benefits as the primary policy question and noted that prior research has focused on this topic instead of economic benefits.

COST

The Department of Revenue reported negligible cost associated with administering the income and sales tax exemptions. Property tax exemptions are primarily administered at the county level.

PUBLIC BENEFIT

A lower level of taxation should allow NPHs to provide a higher level of public benefits than FPHs. FRC estimated the total charity care attributable to NPHs' tax-exempt status to be \$1.1 billion for fiscal year 2024, or 74% of their total charity care. Based on a review of Georgia hospitals in 2021, NPHs provide 7%-8% more charity care than FPHs.

Uncompensated care (charity care and bad debt) represented approximately 22% of NPH expenses, compared to 14% for FPHs. However, as noted on the right, the percentages were closer for general hospitals. Many FPHs were classified as other (psychiatric, specialty).

It should be noted that the analysis did not include the impact of federal tax policy on nonprofit hospitals.

