Health and Human Services

Contains Recommendations*

Rural Hospital Tax Credit (2023)

Homelessness Spending

Rural Hospital Tax Credit (2024)

Rural Hospital Tax Credit (2025)025)

Personal Care Home Program

Hospital Provider Fee

Contains No Recommendations

Rural Hospital Tax Credit (2022)

Medicaid Unwinding

Prescription Drug Sales Tax Exemption

State Health Benefit Plan

Non-Profit Hospital Exemptions

Qualified Foster Child Donation Credit

Rural Hospital Tax Credit (SB 366 Version)

NOW and COMP Waivers

*Until the follow-up review is completed, the recommendation status is based on the most recent agency update to DOAA. The status is subject to change.

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

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:

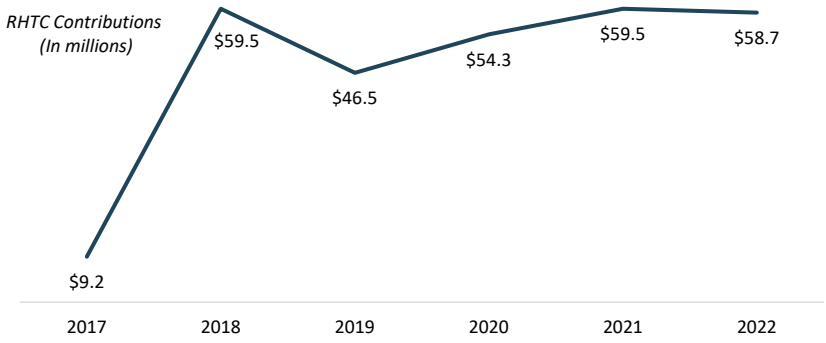
- DCH should add clarifying information or instructions to the Donation and Expenditure Report template on its website.
- Hospitals that receive RHTC funds should ensure that they are reporting accurate information on contribution expenditures and third party fees.
- DCH should review the Donation and 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 included	
Finding 2: All RHTC contributions to hospitals were within statutory limits in tax year 2022.	
No recommendations included	
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 included	
Finding 5: Rural hospital tax credits were primarily claimed by individual taxpayers in tax year 2021.	
No recommendations included	
Finding 6: Administrative fees retained by Georgia HEART in tax year 2021 were within statutory limits.	
No recommendations included	
Finding 7: Undesignated donations are distributed to rural hospitals in accordance with state law.	
No recommendations included	

Performance Audit Division
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Homelessness Spending

Requested Information on Programs and Services

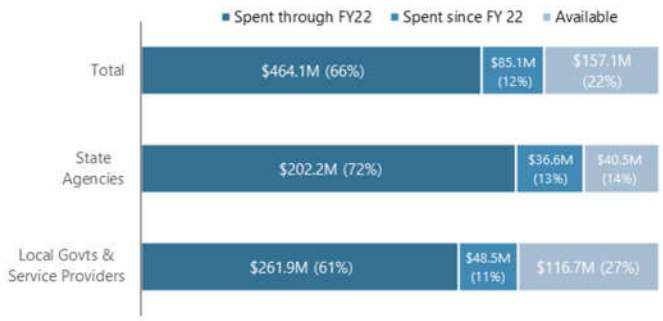
BACKGROUND

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.	Not Implemented
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.	Not Implemented

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Rural Hospital Tax Credit

Credit Administration Largely Consistent with Statutory Requirements

BACKGROUND

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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:

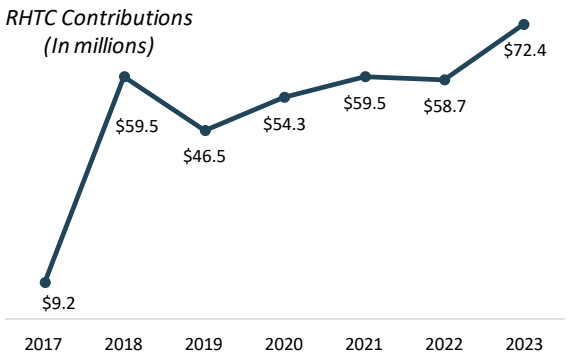
- Ensure that it does not report inaccurate contributions.
- Notify DOR about erroneous reporting identified during its internal audits.

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)
Follow-Up completed as part of 2025 RHTC report

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 included	
Finding 2: All RHTC contributions to hospitals were within statutory limits in tax year 2023.	
No recommendations included	
Finding 3: Rural hospitals that received RHTC contributions were generally in compliance with state law.	
No recommendations included	
Finding 4: Rural hospitals reported spending $58 million of RHTC funds in 2022, with approximately $40 million in funds remaining unspent.	
No recommendations included	
Finding 5: Individual taxpayers claimed the majority of rural hospital tax credits in tax year 2022.	
No recommendations included	
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.	Fully Implemented
Georgia HEART should notify DOR about erroneous reporting identified during its internal audits.	Fully Implemented
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.	Fully Implemented
Georgia HEART should stop reporting inaccurate $1 contributions.	Fully Implemented
DOR should continue to improve controls related to corporate credits.	Fully Implemented
Finding 7: Administrative fees retained by Georgia HEART in tax year 2022 were within statutory limits.	
No recommendations included	
Finding 8: Undesignated donations are distributed to rural hospitals in accordance with state law in tax year 2023.	
No recommendations included	

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Rural Hospital Tax Credit

Credit Administration Largely Consistent with Statutory Requirements

BACKGROUND

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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:

- Continue to ensure contribution amendments are reported and credits are adjusted based on reported amendments.
- Consider formalizing policies for reporting contributions that require amendment to preserve institutional knowledge.
- Ensure controls regarding corporate credit limits are implemented appropriately and within the statute of limitations.

Georgia HEART should:

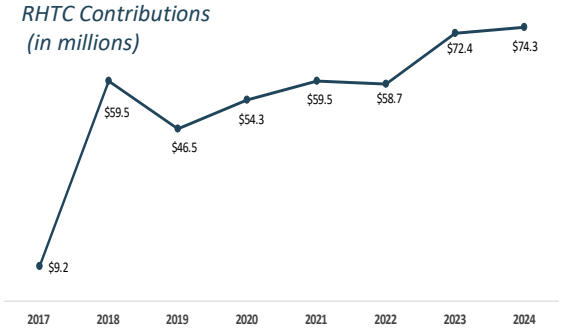
- Continue reporting contribution amendments.

KEY FINDINGS

Taxpayer credits nearly reached the annual aggregate limit of $75 million in tax year 2024. In 2023, hospitals reported spending nearly $70.5 million and having accumulated another $42.0 million in donations still available for future years. Hospitals, state agencies, and other entities with program responsibilities were largely compliant with program requirements.

Contributions to rural hospitals totaled $74.3 million in 2024.

- In tax year 2024, taxpayers contributed $74.3 million to eligible rural hospitals, nearly reaching the $75 million aggregate limit. Contributions to each hospital ranged from nearly $71,000 to $4.0 million.
- In 2024, 34 of the 54 eligible hospitals received more than $1 million, and 11 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 (Northeast Georgia Medical Center Lumpkin).



Hospitals spent $70.5 million in RHTC funds and had $42.0 million in unspent funds in 2023.

- Hospitals reported that the majority of the RHTC funds were spent on capital expenditures or regular operating expenses in 2023.
- Twenty-five hospitals reported having unspent funds, ranging from $8,000 to $8.8 million.

DCH and DOR have improved processes and generally complied with state law.

- DCH verified that all hospitals receiving contributions in tax years 2023 and 2024 were eligible based on statutory criteria. Based on discussions during last year's audit, DCH added steps to its eligibility review procedures to ensure hospital reports are current and accurate.
- In response to recommendations made in last year's audit, DOR requested Georgia HEART communicate contributions requiring amendment to DOR via email and modified its systems to allow for the reporting of $0 contributions. DOR also finalized its process for identifying excess credits claimed by corporate taxpayers based on statutory limits; however, we found excess credits claimed on 2022 returns have not yet been adjusted.
- No hospital exceeded the $4 million contribution limit, and all paid Georgia HEART no more than 3% of contributions. Georgia HEART also improved contribution reporting based on last year's recommendations.

Rural Hospital Tax Credit (2025)

Final Status Pending – Status will be updated in 2026

Finding 1: Eligible hospitals received $74.3 million in RHTC contributions in tax year 2024, with amounts to individual hospitals varying significantly.	
No recommendations included	
Finding 2: All RHTC contributions to hospitals were within statutory limits in tax year 2024.	
No recommendations included	
Finding 3: Rural hospitals that received RHTC contributions were generally in compliance with state law. DJJ should better ensure that facilities consistently adhere to incident reporting requirements and timelines.	
No recommendations included	
Finding 4: Rural hospitals reported spending $70.5 million of RHTC funds in 2023, with $42.0 million in funds remaining unspent.	
No recommendations included	
Finding 5: Individual taxpayers claimed the majority of rural hospital tax credits in tax year 2023.	
No recommendations included	
Finding 6: DOR has taken steps to improve reporting for contributions that require amendment, though further improvements to controls can be made.	
DOR and Georgia HEART should continue to ensure contribution amendments are reported and credits are adjusted based on reported amendments. In addition, DOR should consider formalizing its policies and/or procedures for reporting contributions requiring amendment to ensure institutional knowledge is preserved.	Status Pending
DOR should ensure recently finalized controls regarding corporate credit limits are implemented appropriately and within the statute of limitations.	Status Pending
Finding 7: Administrative fees retained by Georgia HEART in tax year 2023 were within statutory limits.	
No recommendations included	
Finding 8: Undesignated donations were distributed to rural hospitals in accordance with state law in tax year 2024.	
No recommendations included	

Performance Audit Division
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Personal Care Home Program

Improvements needed to better ensure residents' safety and well-being

BACKGROUND

The Healthcare Facility Regulation Division (HFRD) within the Department of Community Health licenses and monitors more than 2,800 personal care homes, assisted living communities, and community living arrangements that provide residential care to nearly 48,000 residents. This audit evaluated HFRD's efficiency and effectiveness in conducting routine inspections, addressing complaints, and ensuring violations are corrected.

In addition to overseeing state-licensed facilities, HFRD is the state surveying agency that conducts inspections and investigations of federally certified facilities (such as hospitals and nursing homes) on behalf of the federal Centers for Medicare & Medicaid Services.

In fiscal year 2024, HFRD received approximately $40 million in state and federal appropriations to oversee state-licensed and federally certified facilities, of which at least $3.1 million was used for oversight of Program facilities.

KEY RECOMMENDATIONS

The General Assembly should:

- Consider codifying a required frequency for HFRD to perform routine inspections, similar to other states.

HFRD should:

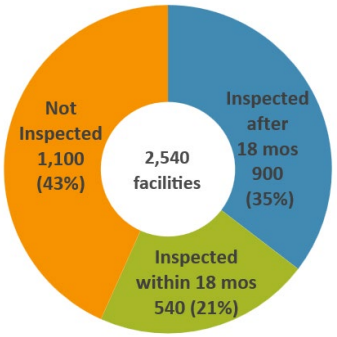
- Perform routine inspections within its established timeframe.
- Establish additional guidance related to prioritizing complaints (which determines complaint investigation timelines).
- Ensure facilities deemed noncompliant with state requirements are appropriately penalized.
- Continue efforts to formalize policies and procedures specific to state operations.

KEY FINDINGS

HFRD could improve oversight over the residential facilities that serve elderly and disabled adults. Over the past six years, HFRD has not routinely inspected many facilities or fully utilized its authority to assess penalties for identified violations. Most routine inspections and some complaint investigations were also initiated after internally established deadlines. Finally, HFRD lacks written guidance for certain core operations but has been in the process of writing some.

HFRD has conducted few routine inspections, leading to limited oversight.

- Between 2019 and 2024, HFRD did not ensure all facilities received a routine inspection, and those that did were often less frequent than HFRD's established 18-month goal.
  - Of the 2,540 active facilities due for a routine inspection, 43% (1,100) had no routine inspection between January 2019 and November 2024.
  - Of the 1,440 that received an inspection, 63% (900) were not inspected within HFRD's established 18-month goal.
- Many facilities have received site visits related to complaint investigations, though routine inspections are intended to be more comprehensive.



HFRD has not consistently followed its standards related to complaint investigations or penalties.

- Of the 190 complaints reviewed, approximately 30% (54) could have been categorized at a higher priority than what HFRD assigned during intake—potentially delaying investigations.
- Among the most serious complaints (which indicate harm may be occurring or resident health and safety is in immediate jeopardy), 15% (14) were not investigated within the required two days. Similarly, 13% (1,492) of investigations into other complaints occurred outside the 45-day requirement.
- It does not appear HFRD imposed fine amounts on all serious violations (defined as Category I or II violations), which HFRD procedures state incur a mandatory fine.
- Approximately 30% of fines assessed since 2022 ($93,200) remain outstanding.

HFRD lacks written, formalized policies for certain core operations.

- We found that certain HFRD core operations lacked written policies and procedures, which help ensure program obligations are met, communicate clear expectations to staff, and maintain sufficient knowledge even as experienced staff leave.
  - There are no written procedures for determining which facilities should be routinely inspected or which requirements to sample when inspecting facilities; HFRD instead relies on individual surveyor judgment to make such decisions.
  - While HFRD has written procedures on complaint triage and penalty assessment, they are not comprehensive or exclude some processes HFRD mentioned in interviews.

Personal Care Home Program
Final Status Pending – Follow-Up Review will be completed in 2027

Finding 1: HFRD has conducted few routine inspections, leading to limited oversight.	
The General Assembly should consider codifying a required frequency for HFRD to perform routine inspections of residential facilities within the Program. Consideration could be given to additional staffing needs, but additional analysis would be necessary.	Status Pending
HFRD should perform routine inspections in accordance with its internal frequency goal. When this is not feasible, HFRD should strategically identify facilities most in need of routine inspections and perform them jointly with complaint and incident investigations whenever possible.	Status Pending
In its new online portal, HFRD should incorporate a place for facilities to document their accreditation status and provide copies of inspection reports performed by accrediting bodies. HFRD should review these documents to determine whether routine inspections are needed. HFRD should resume its routine inspections for all facilities that lack accreditation.	Status Pending
Finding 2: HFRD has not consistently followed its standards for how severe allegations are categorized and when they are investigated.	
HFRD should establish guidelines within written procedures that identify allegations that may be border between priority categories, set clearer criteria, and clarify more examples on which allegations fall in each category.	Status Pending
HFRD should require Intake and Triage staff to document all factors that contributed to determining how an allegation was ultimately prioritized.	Status Pending
HFRD should take steps to ensure that IJ and non-IJ High allegations are investigated within their required timeframes.	Status Pending
HFRD senior management should perform regular reviews of overall complaint categorization and investigation timeframes to ensure consistent adherence to internal standards.	Status Pending
Finding 3: HFRD has not consistently sanctioned noncompliant facilities or verified they return to compliance.	
HFRD should ensure that facilities found to have violated state requirements are appropriately fined in accordance with state law, rules, regulations, and established internal procedures.	Status Pending
HFRD should document penalizing actions taken against specific violations.	Status Pending
HFRD should establish timeframes for notifying facilities of payment obligations when fines are assessed and if facilities fail to pay.	Status Pending
With its new data system, HFRD should ensure that facilities submit required Plans of Correction within 10 days and consider subsequent sanctioning actions (such as fines) for facilities that do not comply.	Status Pending
HFRD should establish clear criteria and relevant documentation related to suspending or revoking facilities' licenses.	Status Pending
Finding 4: Websites maintained by HFRD and facilities do not enable the public to easily identify violations and compare them across facilities.	

Personal Care Home Program
Final Status Pending – Follow-Up Review will be completed in 2027

HFRD should ensure facilities comply with the requirement to post violations on their websites.	Status Pending
HFRD should consider penalizing facilities that fail to post inspection reports and Plans of Correction on their websites.	Status Pending
The General Assembly could consider requiring HFRD to publish on its website aggregated data on facilities' noncompliance so consumers can more easily compare facilities by the number and severity of their violations. Additional funding may be needed to implement any legislative mandate.	Status Pending
Finding 5: HFRD and DBHDD's shared oversight of community living arrangements could be improved with increased coordination.	
While DCH and DBHDD responsibilities remain shared: a. HFRD should coordinate with DBHDD to establish criteria to determine when a complaint or incident should be investigated by HFRD or DBHDD. b. HFRD should coordinate with DBHDD to investigate opportunities for sharing data and detailed information about CLA investigations.	Status Pending
Finding 6: HFRD lacks written, formalized policies for certain core operations.	
HFRD should develop and implement formal policies and procedures specific to state operations, including survey processes and staff training.	Status Pending
HFRD should assess the sufficiency of existing procedures and consider what procedures may be missing from them, particularly regarding how the division ensures consistency across operations.	Status Pending

Performance Audit Division
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Hospital Provider Fee

Requested Information on Administration and Outcomes

BACKGROUND

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.

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.

KEY RECOMMENDATIONS

The Department of Community Health should:

- Strengthen its oversight of fee payment processes, including imposing required penalties on hospitals that fail to pay the full amount owed on time;
- Implement oversight processes for add-on payments paid by managed care organizations; and
- Review the 11.88% rate to determine whether it should be increased to ensure total add-on payments are substantially equivalent to fees paid.

KEY FINDINGS

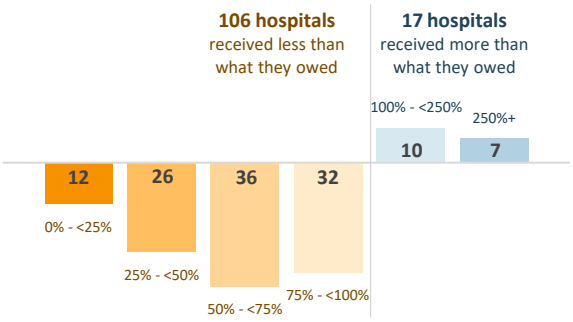
In fiscal years 2020-2025, hospitals paid $2.2 billion in hospital provider fees and received $1.7 billion in Medicaid add-on payments made in recognition of the fee. DCH oversight of fee and add-on payment processes could be improved. Recent federal changes to Medicaid are not currently expected to 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 provider fees owed. DCH does not currently impose penalties for late or underpayments, and communication regarding fee balances across agency staff and to hospitals is limited.
- Fiscal years 2022-2025 Medicaid claims data indicates managed care organizations distributed nearly $5 million in add-on payments (1% of total managed care payments) to providers that did not pay the hospital provider fee. While DCH receives a report containing managed care add-on payment information, it does not review it.

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 in fiscal years 2020-2025—$539 million less than total fees paid. DCH rules state that total fees paid should be substantially equivalent to total add-on payments.



- In fiscal years 2022-2025, nearly 90% of hospitals received less in add-on payments than what they owed in fees. In accordance with federal requirements, individual hospitals should not expect add-on payments to equal fees paid.

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

- In fiscal years 2020-2023, total state income tax exemptions for hospitals participating in the provider fee were estimated to be between $889.5 million and $936.3 million. Hospitals also received other state and local tax exemptions.
- Some participating hospitals received other financial benefits supported in full or in part by the state, such as Rural Hospital Tax Credit donations, Rural Hospital Stabilization Grant funds, and Graduate Medical Education payments.

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

- Changes to Medicaid made by U.S. House Resolution 1—which became law on July 4, 2025—do not currently impact hospital provider fee revenues. The legislation's moratorium on increasing existing fee rates could limit DCH's ability to raise provider fee revenues in the future; however, a rate increase has not been proposed since the program's inception.

Full report available at: https://www.audits2.ga.gov/reports/summaries/hospital-provider-fee/

Hospital Provider Fee

Final Status Pending – Follow-Up Review will be completed in 2028

Finding 1: DCH processes could be strengthened to ensure hospitals pay the full amount owed on time.	
DCH should assign responsibility for fee payment enforcement to a specific role and implement a process for regularly communicating outstanding balances across divisions.	Status Pending
DCH should consider implementing a mechanism that regularly informs hospitals of fees owed, such as invoicing, routine email reminders, or an online dashboard.	Status Pending
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.	Status Pending
Finding 2: In all years reviewed, hospitals paid more in fees than they received in add-on payments.	
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.	Status Pending
Finding 3: DCH oversight over managed care add-on payments could be improved.	
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.	Status Pending
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.	Status Pending
Finding 4: Hospitals participating in the provider fee receive several financial benefits from the state.	
No recommendations included	
Finding 5: Recent federal changes to Medicaid do not currently impact the hospital provider fee.	
No recommendations included	

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

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

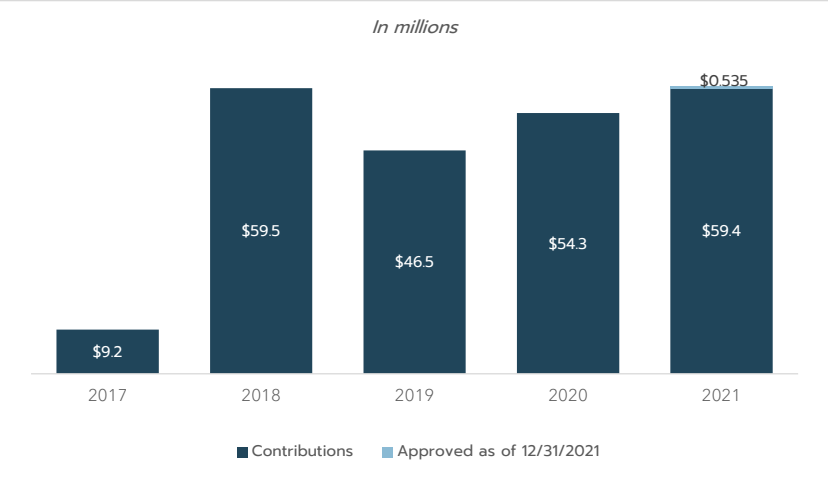
This report does not contain recommendations.

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.*

Performance Audit Division
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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.

DOAA
Georgia Department of Audits & Accounts

December 2022

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.

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Full report at: https://www.audits2.ga.gov/reports/summaries/tax-incentive-evaluation-prescription-drug-sales-tax-exemption

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

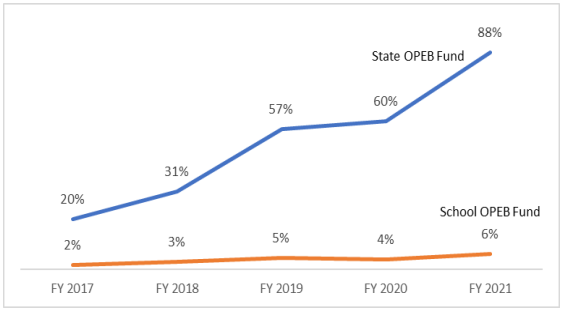
This report is intended to answer questions posed by the House Appropriations Committee and to help inform policy decisions.

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).

DOAA
Georgia Department of Audits & Accounts

December 2023

Tax Incentive Evaluation: Non-Profit Hospital Exemptions

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

BACKGROUND

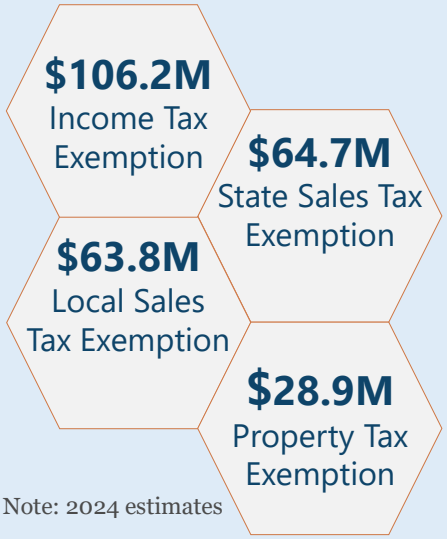
Non-profit hospitals (NPHs) are 501(c)(3) entities exempt from federal income tax. Federal nonprofit status requires these private hospitals to provide benefits to their community, including charity care and community health improvements. In Georgia, NPHs are exempt from three state and local taxes: 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.



Note: 2024 estimates

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

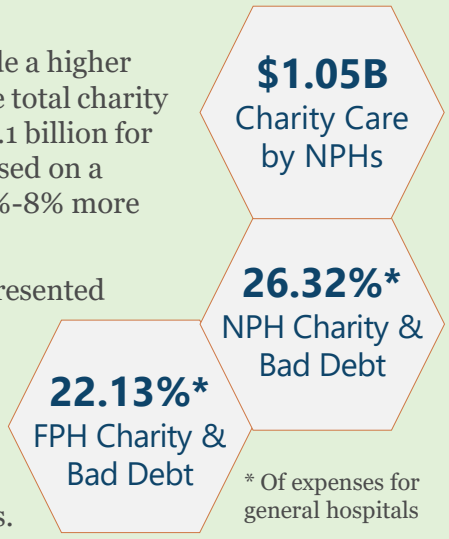
The Department of Revenue reported negligible cost associated with administering the income and sales tax exemptions. Property tax exemptions are primarily administered at the county level.

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.



* Of expenses for general hospitals

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Full report available at: Non-Profit Hospital Exemptions

DOAA
Georgia Department of Audits & Accounts

November 2025

Tax Incentive Evaluation: Foster Care Organization Tax Credit

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

The Fostering Success Act (O.C.G.A. § 48-7-29.24) was enacted in 2022 to create a state income tax credit for charitable donations made to Qualified Foster Care Support Organizations (QFCSOs).

The tax credit is equal to the donation, with limits of $2,500 for individuals and $5,000 for married couples and pass-through entities prior to July 1 of each year (unlimited after July 1). Corporations are limited to 30% of their income tax liability, while insurance companies may receive premium tax credits equal to their donations. The credit has an annual cap of $20 million for 2025; the cap increases to $30 million in 2026 with premium tax credits capped at $10 million of the total.

PURPOSE

The credit is intended to increase private support for organizations that provide support to aging foster children and justice-involved youth. FRC found that the credit has not yet been successful in increasing donations to these organizations. However, other credit programs have taken several years to reach full impact, and the cap increases and other changes made in HB 136 (2025) are not yet reflected in the data.

IMPACT ON EMPLOYMENT, ECONOMIC ACTIVITY, AND REVENUE

This credit was not created to result in state-level economic growth but to encourage donations to nonprofit organizations.

FRC estimated a tax expenditure of $11.1 million in FY 2026. Using IMPLAN, a regional input-output model that analyzes economic activity, FRC estimated $11.1 million within the associated industry would result in 308 jobs and $13.8 million in value added to the state economy.

However, FRC also determined that the same level of economic activity would have occurred in the absence of the tax credit (i.e., the tax credit had no impact on charitable donations to QFCSOs). As a result, there was no economic activity that can be tied specifically to the tax credit. Consequently, there was also no additional tax revenue generated due to the credit.

Employment			Economic Impact			Revenue Impact		
Jobs	Cost/ Job	Labor Income	Output	Value Added	Economic ROI	State Tax Expenditure	State Tax Generated	Fiscal ROI
0	N/A	$0M	$0M	$0M	0%	$11.1M	$0	0%

ANCILLARY IMPACTS

FRC noted that QFCSOs channel resources to education and career development that can help this population of young adults achieve stability and self-sufficiency. This population might otherwise rely more heavily on state programs. In addition, while there may have been no impact overall, specific QFCSOs may have received more donations because of the credit. Finally, FRC noted that research suggests charitable tax credits can improve the efficiency of social spending by providing funds directly to social organizations.

OTHER STATES

FRC found few states offer a directly comparable tax credit for donations to foster care support organizations. Mississippi has a combined tax credit for donations to qualifying charitable organizations or qualifying foster care charitable organizations. Louisiana provides a nonrefundable, 100% credit. Indiana provides a tax credit worth 50% of the donation.

OPTIONS TO IMPROVE RETURN ON INVESTMENT

FRC did not identify a method to improve the ROI.

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

Full report available at: Tax Incentive Evaluation: Foster Care Organization Tax Credit

DOAA
Georgia Department of Audits & Accounts

November 2025

Tax Incentive Evaluation: Rural Hospital Tax Credit

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

The Rural Hospital Tax Credit (RHTC) (O.C.G.A. § 28-5-41.1) was enacted in 2017 to provide financial support to rural hospitals in Georgia. The tax credit is equal to the donation, with limits of $5,000 for individuals and $10,000 for married couples and pass-through entities prior to July 1 of each year (unlimited after July 1). Corporations are limited to 75% of their income tax liability. The credit has an annual cap of $100 million beginning in 2025, up from $75 million.

PURPOSE

The RHTC is intended to strengthen the financial stability and service capacity of Georgia's rural hospitals by allowing state income taxes to be redirected to eligible rural hospitals. The credit is intended to offset the financial pressures faced by small, rural healthcare facilities—many of which serve low-income or medically underserved populations but operate with limited economies of scale and high uncompensated care costs.

FRC noted that the RHTC has been successful in achieving its goals of providing additional support to rural hospitals. Tax credit contributions increase the viability of vulnerable, rural hospitals.

IMPACT ON EMPLOYMENT, ECONOMIC ACTIVITY, AND REVENUE

While RHTC may significantly impact a community, its purpose is not state-level economic growth.

FRC estimated forgone state revenue was $79.5 million in FY 2025. It determined that the tax credit increased donations to the state's hospitals by 28%. The increase was not greater because the credit shifted donations from non-eligible to eligible hospitals. This shift limits the economic impact to the state, but it also means the portion of donations made to the eligible, rural hospitals that can be attributed to RHTC is higher than the percentage above.

FRC used IMPLAN, a regional input-output model that analyzes economic activity, to estimate RHTC's economic impact in FY 2025. FRC estimated the tax credit resulted in an increase of 232 jobs and $25.8 million in value added to the state economy. The economic activity would have led to additional state taxes of $1.4 million, offsetting approximately 2% of the forgone revenue. The state has a negative economic ROI because the state loses more revenue ($79.5 million minus $1.4 million gain) than the value added to the economy ($25.8 million).

Employment			Economic Impact			Revenue Impact		
Jobs	Cost/ Job	Labor Income	Output	Value Added	Economic ROI	State Tax Expenditure	State Tax Generated	Fiscal ROI
232	$336,638	$18M	$44.7M	$25.8M	33%	$79.5M	$1.4M	2%

ANCILLARY IMPACTS

FRC found the tax credit enables improvements in infrastructure, staffing, and service delivery at eligible rural hospitals and reduces the likelihood of closure of financially vulnerable rural hospitals. Additionally, research on charitable tax credits suggests this type of taxpayer-directed giving can increase the efficiency of public spending by lowering administrative overhead and aligning resources with local priorities.

OTHER STATES

FRC found only one of Georgia's neighboring states, Alabama, had adopted a tax credit comparable to the RHTC. Tennessee and North Carolina support rural hospitals through grants and other initiatives.

OPTIONS TO IMPROVE RETURN ON INVESTMENT

FRC did not identify a method to improve the ROI.

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

Full report available at: Tax Incentive Evaluation: Rural Hospital Tax Credit

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

NOW and COMP Waivers

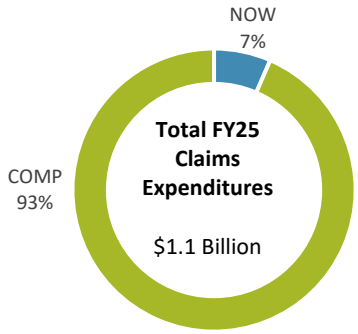
Requested information on waiver participation and costs

BACKGROUND

The Senate Appropriations Committee requested this special examination of the New Options Waiver (NOW) and Comprehensive Supports Waiver (COMP). Our review focused specifically on who has been served and their services over time, how expenditures have changed, how long applicants wait to receive services, the impact of separating NOW and COMP waiver appropriations, and the extent to which NOW and COMP providers are overseen by state agencies.

NOW and COMP waivers serve individuals with intellectual and developmental disabilities who are eligible for Medicaid and require a level of care provided in an intermediate care facility. Individuals served under both waivers may also have similar disabilities, though the level and setting of support provided may differ. The NOW waiver provides services designed to allow individuals to continue living in their own home or with caregivers. The COMP waiver serves those needing more intensive supports (e.g., out-of-home residential care) to avoid institutionalization. The Department of Behavioral Health and Developmental Disabilities is responsible for most of the programmatic administration and oversight.

In fiscal year 2025, the waivers served approximately 14,100 individuals, with the majority (69%) receiving COMP services. Federal and state expenditures related to waiver claims totaled $1.1 billion.



KEY RECOMMENDATIONS

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

KEY FINDINGS

Individuals with intellectual and developmental disabilities eligible for the Comprehensive Supports (COMP) waiver account for a growing share of services and costs, driven by higher service needs and expenditures. According to the Department of Behavioral Health and Developmental Disabilities (DBHDD), individuals with the highest unmet needs are prioritized for new waiver slots regardless of waiver type. The net increase in COMP participation was higher over the period reviewed; this resulted in fewer new slots available for New Options Waiver (NOW) individuals, who generally have fewer service needs and are thus less expensive. Additional appropriations would be necessary to decrease the number of people waiting for waiver services while also ensuring those with the highest needs are served.

Waiver expenditures have increased due to higher costs for COMP participants, which account for the larger share of services.

- Between fiscal years 2021 and 2025, total expenditures for waiver services increased by 50%, from $725.5 million to $1.1 billion.
- COMP participants have steadily increased as a proportion of total waiver participants, representing nearly 70% between fiscal years 2021 and 2025.
- COMP participants on average cost approximately $104,000 in fiscal year 2025, compared to $16,200 for NOW participants (an approximately 40% increase since 2021). Member cost increases can be attributed to more expensive claims, which are generally due to provider rate increases passed during the period of review.

DBHDD prioritizes individuals with the highest unmet needs on the planning list for new waiver slots.

- Most individuals on the planning list are waiting for NOW services; as of September 2025, 43% of those on the list have been waiting at least six years. These individuals still typically receive services funded by Medicaid while they are waiting.
- Since fiscal year 2021, the General Assembly funded 1,313 new waiver slots; however, the increase in number of participants (462 after accounting for attrition) served has not matched the number of funded slots. This is largely due to increasing COMP participation, increasing service costs for existing participants, and allocating funds for system capacity building and other administrative expenses.

Additional funding may be necessary to ensure NOW individuals are serviced without impacting COMP availability.

- The current funding structure favors COMP participants and may increase time on the planning list for individuals waiting for NOW services.
- Separating NOW and COMP waiver funding could increase the number of NOW participants served, though an emphasis on lowering the total number of individuals on the planning list could result in fewer COMP individuals obtaining the waiver.
- Maintaining COMP participation while also increasing NOW participation would likely require higher appropriations than typically provided in recent years.

Oversight activities ensure waiver services and costs are appropriate.

- Oversight of NOW and COMP providers is shared between DBHDD and the Department of Community Health, with responsibilities spanning provider enrollment, service delivery, and claims monitoring.