



# INCREASING ACCESS TO QUALITY HEALTHCARE FOR LOW-INCOME UNINSURED GEORGIANS

POLICY RECOMMENDATIONS FOR THE STATE OF GEORGIA

BY: PATRICK KAISER AND ERIC COCHLING | JUNE 2014



**GEORGIA**  
CENTER for OPPORTUNITY

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## ABOUT GEORGIA CENTER FOR OPPORTUNITY

Georgia Center for Opportunity (GCO) is an independent, non-partisan think tank dedicated to increasing opportunity and improving the quality of life for all Georgians. We research ways to help remove barriers to opportunity, promote those solutions to policymakers and the public, and help innovative social enterprises deliver results on the ground. The primary pathways to opportunity – strong families, quality schools, and stable employment – which historically gave people a chance to succeed, regardless of social and economic background, have experienced a rapid decline in recent decades. We study and understand the obstacles along these pathways and work to break through the barriers to opportunity so that Georgia will become a state where all have a real chance to prosper.

Our work is focused on five primary impact areas:



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## Acknowledgements

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## EXECUTIVE SUMMARY

Almost one out of every five Georgians lacks health insurance, the sixth highest percentage in the country. Without insurance, many individuals are unable to access affordable healthcare, leading to many negative health and financial outcomes. When uninsured individuals do access care and are unable to pay for it, much of the cost is covered by the government and those with individual insurance through provider cost shifting. Thus, Georgia's high rate of uninsurance is costly to both the uninsured and wider society.

Under the Affordable Care Act, Georgia has the option to expand Medicaid to cover all nonelderly adults who make up to 138 percent of the federal poverty level. The expansion would make an estimated 684,000 low-income uninsured adults newly eligible for Medicaid, costing the state an estimated \$2.1 billion and the federal government \$30 billion from 2014 to 2023. Governor Nathan Deal and the Georgia General Assembly have elected not to expand Medicaid due to the cost to the state and uncertainty over the federal government's ability to cover its portion of the expansion in the long-term.

If Georgia continues to elect not to expand Medicaid, individuals who make between 100-138 percent of the federal poverty level can receive subsidized private insurance through the healthcare marketplace. Thus, many of these individuals may still get coverage. However, an estimated 534,000 uninsured adults in Georgia making less than 100 percent of the federal poverty level, who would be newly eligible for Medicaid, will likely continue to have limited access to affordable healthcare without a change in the state's expansion policy or other health policy changes.

Georgia should work to find solutions that will improve healthcare for low-income uninsured individuals in the state. New health policies or programs should meet the following goals:

1. Expand access to affordable healthcare
2. Improve health outcomes
3. Provide long-term sustainability

Any solution has significant challenges to overcome. These challenges include state fiscal constraints, Georgia's physician shortage, limits on nurse practitioners, and fiscal challenges of the state's safety-net hospitals. Despite these challenges, something must and, importantly, can be done to expand access to healthcare among Georgia's poorest individuals.

As a means of addressing these challenges and to improve healthcare for low-income uninsured individuals, Georgia should support the expansion of its charity clinics. The state's 96 charity clinics currently serve over 183,000 low-income uninsured patients but have the potential to serve significantly more individuals at a relatively small cost.

To support its charity clinics and the state's safety-net hospitals, Georgia should pursue the following actions:



## PROVIDE STATE GOVERNMENT SUPPORT FOR CHARITY CLINICS

Georgia's charity clinics saved the state over \$200 million in 2012 while not receiving any government funding. However, many states do financially support their charity clinics. The state should provide financial support so its charity clinics can expand their hours and services and provide care to more individuals in need.

## EXPAND TELEMEDICINE INTO CHARITY CLINICS

Telemedicine has the potential to improve access to care in charity clinics by making it easier for providers to volunteer at clinics across the state. This would be especially beneficial to individuals who live in rural areas and often do not have access to specialty care. The Georgia legislature should include funding to pilot the use of telemedicine in its charity clinic appropriation.

## MODERNIZE NURSE PRACTITIONER LAWS AND REGULATIONS

Georgia's laws and regulations for nurse practitioners are some of the most restrictive in the country. The state should implement the licensing model recommended by the National Council of State Boards of Nursing and the Institute of Medicine so that nurse practitioners can provide the high level of care that they are educated and prepared to deliver. Updating these restrictions would expand nurse practitioners' ability to work and volunteer at charity clinics, increasing the number of providers that could deliver care to low-income uninsured individuals.

## REINSTATE SALES TAX EXEMPTION FOR CHARITY CLINICS

The state sales tax exemption for charity clinics ended in 2010. The tax break allowed clinics to provide more care with the donations and other funding they received. The Georgia legislature should reinstate this exemption.

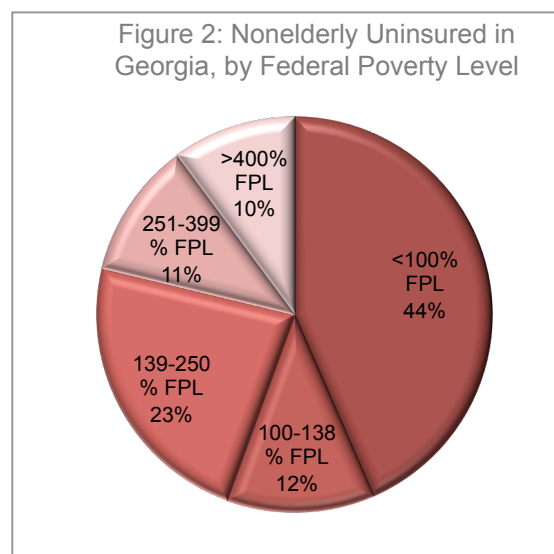
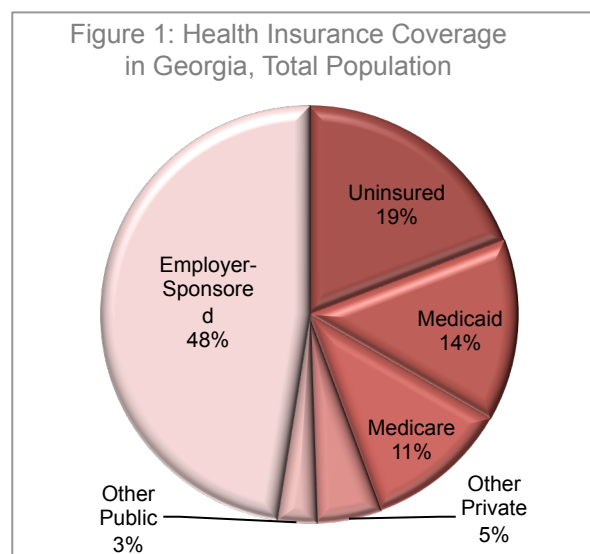
## REPLACE LOST FEDERAL DSH FUNDS WITH STATE DOLLARS

The reduction in federally funded disproportionate share hospital (DSH) payments from state Medicaid programs to safety-net hospitals is expected to place fiscal strain on some of the state's largest providers of care to uninsured individuals. The state should replace the lost funds so hospitals can continue to provide many low-income individuals with essential care.

# INTRODUCTION

An individual's health significantly impacts his or her quality of life, and an individual's health is greatly impacted by his or her access to affordable, quality healthcare. Having health insurance is important for receiving care; people with insurance have greater access to care, are less likely to postpone or forgo care, and have better health outcomes than the uninsured.<sup>1</sup>

Unfortunately, 19 percent of Georgians lack health insurance, the sixth highest percentage in the country in 2012.<sup>2</sup> Of the nonelderly uninsured, 56 percent live in households that make less than 139 percent of the federal poverty level (FPL), which is \$16,221 for an individual and \$33,151 for a family of four.<sup>3</sup>



## HEALTHCARE SAFETY-NET

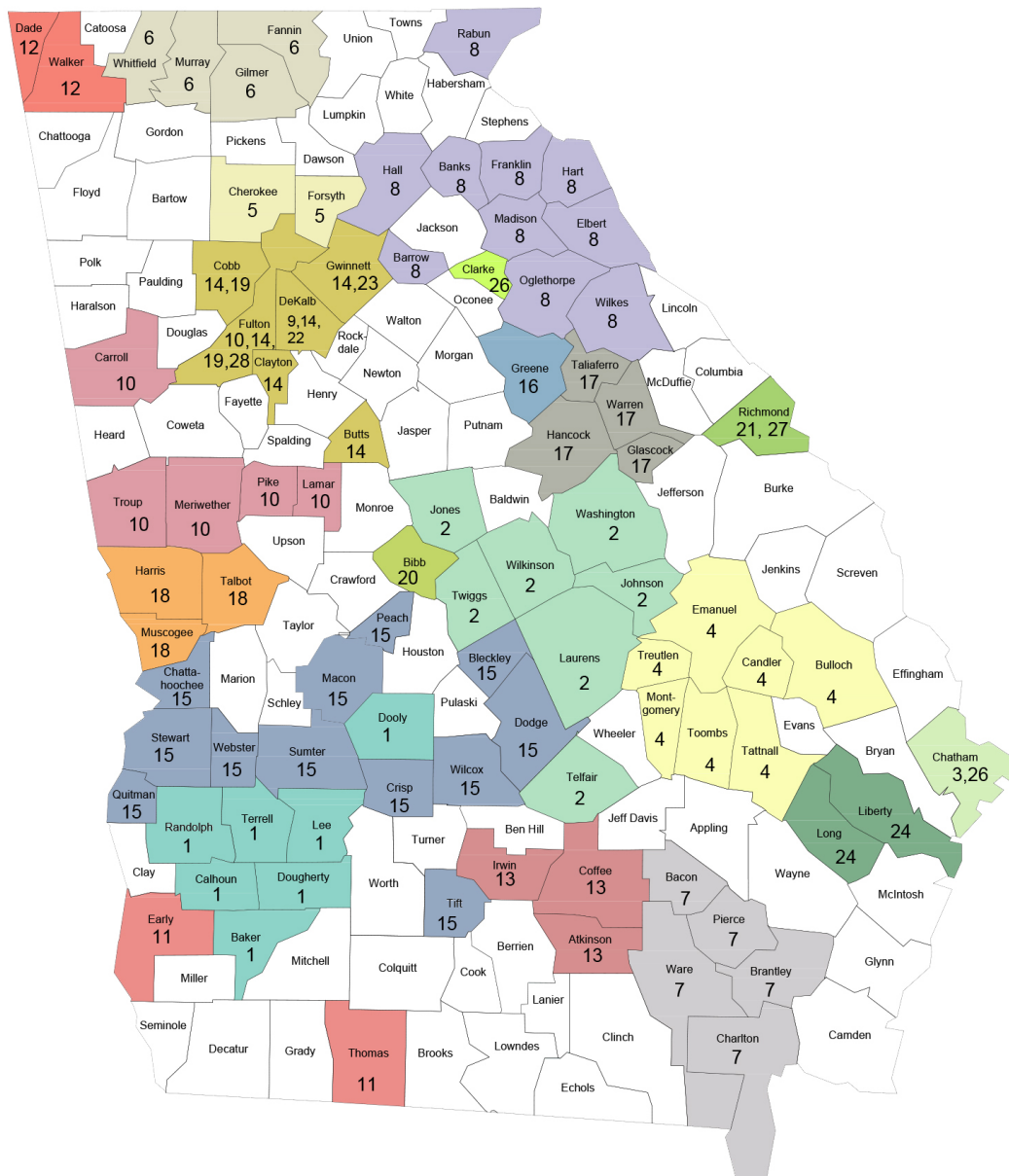
While it can be difficult for uninsured individuals to find care – particularly those with low-incomes – some uninsured individuals access care through Georgia's healthcare safety-net. These providers include community health centers, charity clinics, public hospitals, local health departments, and private office-based physicians who provide limited free care.<sup>4</sup>

### Community Health Centers

The state's community health centers provide primary and preventive care to many uninsured individuals on a sliding fee scale based on patient or family income. In 2011, Georgia's Federal Qualified Health Centers (FQHCs) – local, non-profit, community-owned healthcare providers – served more than 317,000 patients at 152 delivery sites across the state (see Figure 3). Of the FQHC patients, 51 percent were uninsured. The National Association of Community Health Centers estimates that 13 percent of Georgia's low-income uninsured population was served by an FQHC in 2011.<sup>5</sup>



Figure 3: Counties Served by Georgia's Community Health Centers



1 Albany Area Primary Health Care, Inc	8 MedLink Georgia, Inc.	15 Southwest Georgia Health Care, Inc	22 Whiteford Community Program, Inc.
2 Community Health Care Systems, Inc	9 Oakhurst Medical Centers, Inc	16 TenderCare Clinic, Inc	23 Four Corners Primary Health Care, Inc
3 Curtis V. Cooper Primary Health Care, Inc	10 Palmetto Health Council, Inc	17 Tri-County Health System, Inc	24 Diversity Health Center, Inc.
4 East Georgia Healthcare Center, Inc	11 Primary Care of Southwest Georgia, Inc	18 Valley Healthcare System, Inc	25 Athens Neighborhood Health Center, Inc.
5 Georgia Highlands Medical Services, Inc	12 Primary Health Care Center, Inc	19 West End Medical Centers, Inc	26 The J.C. Lewis Health Care Center, Inc
6 Georgia Mountains Health Services, Inc.	13 South Central Primary Care Center, Inc	20 First Choice Primary Care, Inc.	27 Christ Community Health Services, Inc
7 McKinney Community Health Center, Inc	14 Southside Medical Center, Inc	21 Neighborhood Improvement Project, Inc	28 St. Joseph's Mercy Care Services, Inc.

Source: The Georgia Association for Primary Healthcare<sup>6</sup>

In 2011, the average medical cost per patient visit at Georgia's FQHCs was \$131, and the average dental cost per patient visit was \$140.<sup>7</sup> Funding for the state's FQHCs comes from a wide variety of sources. Over 43 percent of the funding in 2011 came from federal grants, 27.7 percent from Medicaid and Medicare revenue, 12.7 percent from self-pay, and 7.1 percent from private insurance. The community health centers also received small amounts of revenue from state and local grants and from foundations and private grants.<sup>8</sup>

## Charity Clinics

Uninsured individuals in 90 of Georgia's 159 counties have access to a charity clinic as another option to help meet their primary care needs (see Figure 4). In 2012, the state's 96 nonprofit, independent charity clinics served 183,625 unique patients, and 62 percent of these patients were below the poverty level.<sup>9</sup>

Due to their volunteer nature, clinics are able to provide an average of \$7 worth of services for every \$1 invested, and the average cost per patient visit is \$29.<sup>10</sup> The total value of the services provided by Georgia's charity clinics in 2012 was over \$200 million.<sup>11</sup> While there is a wide range in size and services provided by the state's charity clinics, the average clinic is open for 25 hours per week, has an annual operating budget of about \$294,000, and receives almost 7,000 volunteer hours per year. Individual donations are a clinic's primary source of funding.<sup>12</sup>

**The total value of the services provided by Georgia's charity clinics in 2012 was over \$200 million.**

## Public Hospitals

In addition to community health centers and charity clinics, many uninsured patients seek care in hospital emergency rooms. Since many low-income uninsured individuals can only afford a small portion of the care they receive and hospitals are required to provide emergency healthcare to anyone needing it, providers are often uncompensated for the services they provide. In 2012, Georgia hospitals provided \$1.6 billion in uncompensated care, including \$936 million in free, indigent, and charity care and \$671 million in care for which the patient did not pay his or her bill and was not qualified for the hospital's indigent or charity care programs.<sup>i,13</sup>

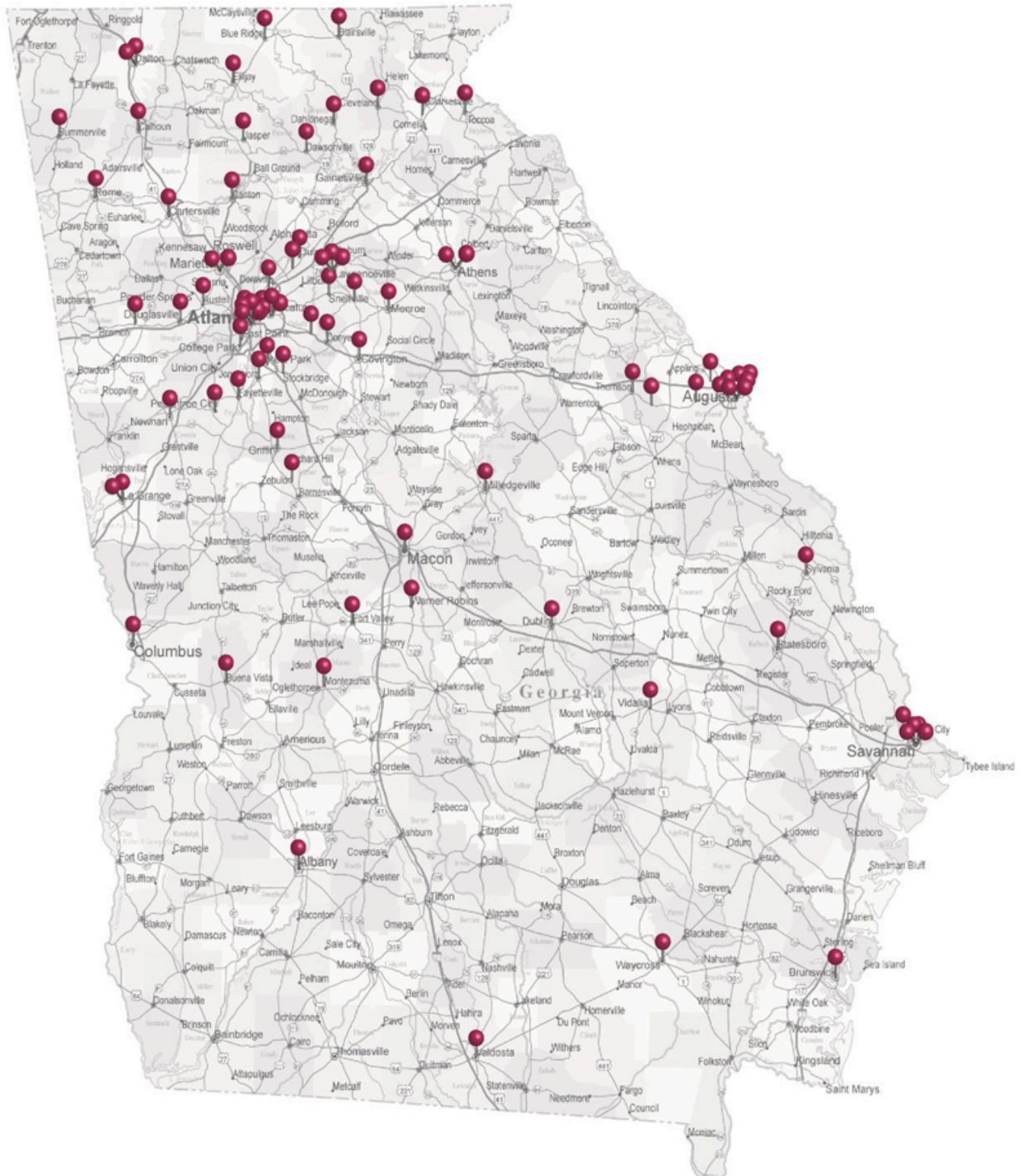
**In 2012, Georgia hospitals provided \$1.6 billion in uncompensated care.**

Despite these and other safety-net services for the uninsured population, significant needs are unmet. One study estimates that the primary care safety-net only meets about 35 percent of the projected need in metro Atlanta.<sup>14</sup> Since a larger proportion of Georgia's rural population is uninsured and low income and rural areas often have fewer primary care services available, rural uninsured individuals often face even greater challenges finding care.<sup>15</sup>

<sup>i</sup> Uncompensated care is an overall measure of hospital care provided for which no payment was received from the patient or insurer. It is the sum of care for which the hospital never expected to be reimbursed and care for which it is unable to obtain reimbursement for the care provided, called "bad debt." Uncompensated care excludes other unfunded costs of care, such as underpayment from Medicaid and Medicare.



Figure 4: Georgia's Charitable Clinics



Source: Georgia Charitable Care Network

## IMPACT OF UNINSURANCE

The lack of access to affordable care contributes to many individuals going without important services. Uninsured individuals in Georgia are nearly four times less likely than the insured to have had a routine check-up in the past two years<sup>16</sup> and are more likely to experience avoidable hospitalizations for conditions such as pneumonia, diabetes, and asthma.<sup>17</sup> In 2011, 36 percent of low-income adults in Georgia reported that they went without care because of cost in the past year. Only two states had a higher percentage of individuals going without care.<sup>18</sup>

**In 2011, 36 percent of low-income adults in Georgia reported that they went without care because of cost in the past year.**

National studies show that nonelderly uninsured adults and those who have gaps in their coverage are less likely than the insured to receive recommended screenings such as blood pressure and cholesterol checks, Pap tests, colon cancer screenings, and mammograms.<sup>19</sup> They also have increased risk of being diagnosed with later-stage diseases such as cancer and have higher mortality rates than those with insurance.<sup>20</sup> Families USA estimates that nationally 26,100 people between the ages of 25 and 64 died prematurely due to a lack of health coverage in 2010, and 1,161 of these premature deaths occurred in Georgia, the fifth most in the country.<sup>21</sup>

High rates of uninsurance are also associated with the quality of healthcare available to and accessed by insured individuals. When a community has a relatively high percentage of uninsurance, insured adults in the community are less likely to have a usual source of care and are less likely to report being satisfied with the quality of care they receive. A higher community uninsurance rate is also linked to a higher probability of the insured reporting difficulty obtaining needed medical care.<sup>22</sup>

Uninsured individuals are financially costly for taxpayers and the insured as well. In 2013, uninsured individuals across the country spent an estimated \$25.8 billion out-of-pocket on medical care and received between \$74.9 billion and \$84.9 billion in uncompensated care. About 60 percent of the uncompensated care spending was provided by hospitals, 26.4 percent by publicly supported community providers, and 14 percent by office-based physicians who provided in-kind services or charity care.<sup>23</sup>

An estimated 65 percent of providers' uncompensated care costs in 2013 were offset by government payments designed to cover these costs, a total of \$52.6 billion. The federal government provided \$32.8 billion in financing while state and local governments contributed \$19.8 billion. Medicaid, Medicare, and the Department of Veterans Affairs were the largest sources of government payments to providers of uncompensated care.<sup>24</sup>

**Uninsured individuals are financially costly for taxpayers and the insured as well.**

Providers also attempt to recover their losses from providing uncompensated care to uninsured patients and those covered by government programs that pay below cost, such as Medicare and Medicaid, by increasing charges for those with private insurance. The higher prices charged to private insurance are passed on to families and business through higher premiums.

According to the Georgia Hospital Association, in FY 2012 hospitals were paid 96 percent of cost by Medicare, 89 percent of cost by Medicaid, and 26 percent of cost by/for the uninsured.<sup>ii,25</sup> Patients in

<sup>ii</sup> These estimates include DSH and Medicaid supplemental payments.





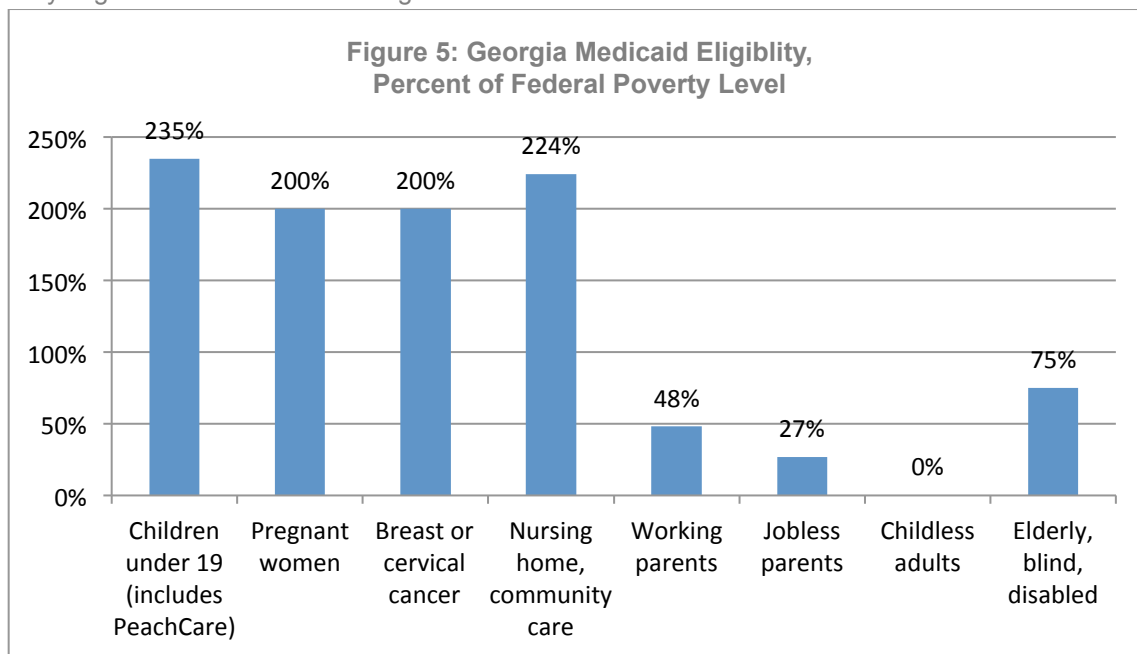
these three groups accounted for 62 percent of all Georgia's hospital patients. To offset these cost deficits, hospitals need payments made by other payers for the remaining 38 percent of patients to be in excess of cost by at least 44 percent just for hospitals to break even.<sup>26</sup> Thus, Georgia hospitals are shifting costs to patients with private insurance to recover uncompensated care costs caused by lower paying government programs and patients without insurance.

At the national level, estimates vary on how much cost shifting occurs. One study estimates that cost shifting through increased premiums and other similar strategies accounts for about 2.4 percent of private health insurance costs,<sup>27</sup> while another study estimates that uncompensated care cost shifting makes up 7.7 percent of private insurance costs.<sup>28</sup> If the higher estimates are accurate, the uninsured population is costing the average Georgia individual \$330 and the average family \$900 per year in higher premiums.<sup>29</sup>

## MEDICAID AND THE AFFORDABLE CARE ACT

Medicaid is the country's main public health insurance program for low-income families and individuals, including children, parents, pregnant women, seniors, and people with disabilities. A joint federal/state program, the federal government sets mandatory eligibility groups and general guidelines for benefits, while states establish individual eligibility criteria within federal standards. States can apply to the Centers for Medicare & Medicaid Services (CMS) for a waiver to expand coverage beyond the minimum requirements.<sup>30</sup>

In Georgia, children from families who earn up to 235 percent of FPL are eligible for Medicaid or PeachCare.<sup>iii</sup> Pregnant women up to 200 percent of FPL, working parents up to 48 percent of FPL, and nonworking parents up to 27 percent of FPL are also eligible for Medicaid. Childless adults are not currently eligible for Medicaid in Georgia.<sup>31</sup>



<sup>iii</sup> PeachCare for Kids provides comprehensive healthcare to children through the age of 18 who do not qualify for Medicaid and live in households with incomes at or below 235 percent of the federal poverty level.

**1.8 million Georgians will enroll in Medicaid and PeachCare in 2014, more than 18 percent of the state's population.**

The Georgia Department of Community Health projects that over 1.8 million Georgians will enroll in Medicaid and PeachCare in 2014 – 18.56 percent of the state's population. The Department estimates that the state will spend \$2.85 billion on these programs – 15.57 percent of state revenue. The federal government will cover the remaining \$6.65 billion for a total expenditure of \$9.5 billion. While only 29 percent of enrollees are covered in Aged, Blind, and Disabled Medicaid, this group makes up 58 percent of expenditures. Those qualifying for Low-Income Medicaid constitute 71 percent of the enrollees but only 42 percent of expenditures.<sup>32</sup>

## MEDICAID EXPANSION THROUGH THE AFFORDABLE CARE ACT

In 2010, Congress passed and President Obama signed into law the Patient Protection and Affordable Care Act (Affordable Care Act or ACA). The ACA is intended to “expand health insurance, increase consumer protections, emphasize prevention and wellness, improve quality and system performance, expand the health workforce, and curb rising health costs.”<sup>33</sup> A major component of the extension of health insurance is the expansion of Medicaid eligibility to all nonelderly adults who make up to 138 percent of FPL.<sup>iv</sup>

In 2012, the Supreme Court found the ACA's Medicaid expansion to be unconstitutionally coercive of states because states did not have adequate notice to voluntarily consent to changes in the Medicaid program, and all of a state's existing federal funds for Medicaid were at risk for states that did not accept the expansion. As a result of the ruling, expanding Medicaid is now optional for states. If a state chooses not to expand, they can only lose ACA Medicaid expansion funds.<sup>34</sup>

After the Supreme Court's decision, states began to decide whether or not to expand Medicaid to cover all nonelderly adults who make up to 138 percent of FPL. As of June 2014, 26 states and Washington D.C. have begun to implement the Medicaid expansion. Twenty-one states are not currently planning to expand Medicaid, and three states are still deciding (see Figure 6).<sup>35</sup> There is not a deadline for the expansion decision. States that are currently not planning to expand can change their policy at any time.

Georgia Governor Nathan Deal has consistently declared that the state will not expand its Medicaid program. During a 2012 interview with the *Atlanta Journal-Constitution* and other news outlets, Governor Deal explained his position: “No, I do not have any intentions of expanding Medicaid. I think that is something our state cannot afford. And even though the federal government promises to pay 100 percent for the first three years and 90 percent thereafter, I think it is probably unrealistic to expect that promise to be fulfilled in the long term, simply because of the financial status that the federal government is in.”<sup>36</sup>

In many states, the governor has made the decision to expand Medicaid. This was originally possible in Georgia. However, during the 2014 legislative session, the Georgia General Assembly passed a bill that

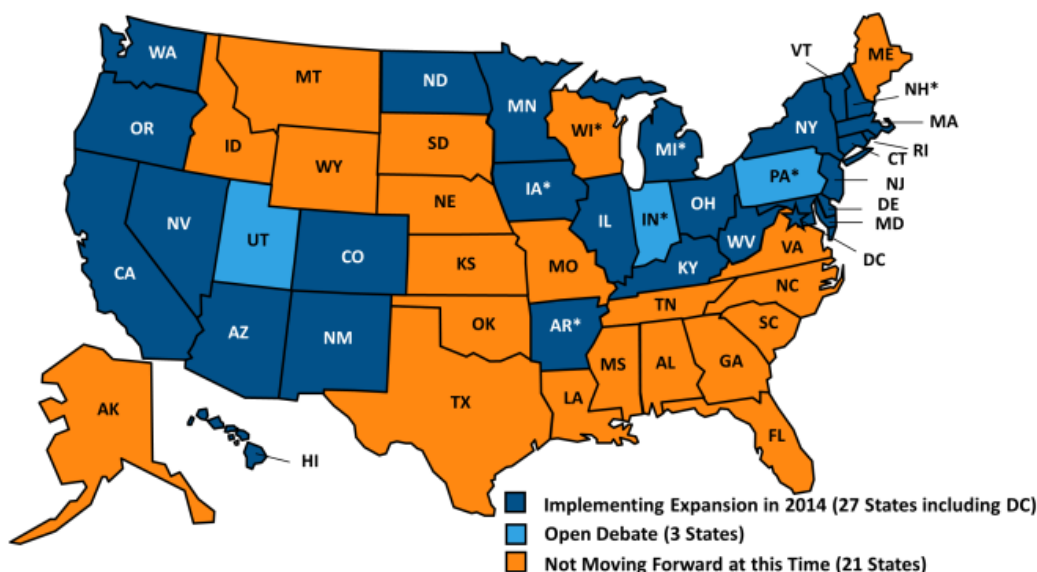
**In 2012, the Supreme Court found the ACA's Medicaid expansion to be unconstitutionally coercive of states.**

<sup>iv</sup> The Medicaid eligibility limit established under the ACA is 133 percent of the federal poverty level but includes an income disregard of 5 percent, effectively making the income limit 138 percent of FPL.



prohibits the expansion of Medicaid eligibility through an increase in the income threshold without prior legislative approval.<sup>37</sup>

Figure 6: Current Status of State Medicaid Expansion Decisions<sup>38</sup>



NOTES: Data are as of June 10, 2014. \*AR and IA have approved waivers for Medicaid expansion. MI has an approved waiver for expansion and implemented in Apr. 2014. IN and PA have pending waivers for alternative Medicaid expansions. WI amended its Medicaid state plan and existing waiver to cover adults up to 100% FPL, but did not adopt the expansion. NH has passed legislation approving the Medicaid expansion in Mar. 2014; the legislation calls for the expansion to begin July 2014.

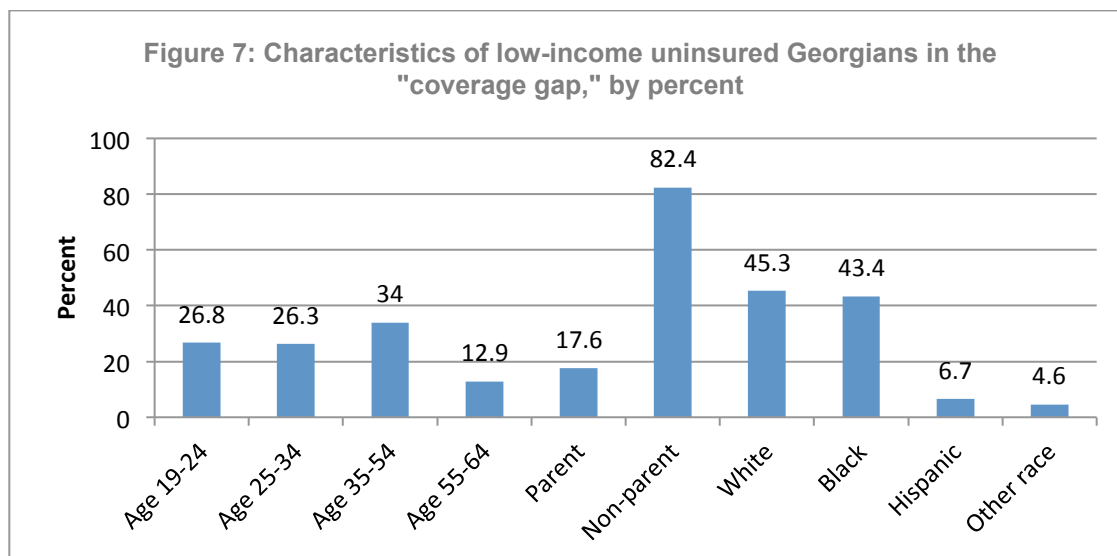
SOURCES: States implementing in 2014 and not moving forward at this time are based on data from CMS [here](#). States noted as "Open Debate" are based on KCMU analysis of State of the State Addresses, recent public statements made by the Governor, issuance of waiver proposals or passage of a Medicaid expansion bill in at least one chamber of the legislature.



Researchers at the Urban Institute estimate that 684,000 uninsured, nonelderly adults in Georgia would become newly eligible for Medicaid under the ACA expansion. Approximately 150,000 of these uninsured adults have incomes between 100-138 percent of the Federal Poverty Level (FPL). Without expansion, these individuals have become eligible for subsidized health insurance through the health insurance exchange, a marketplace where individuals and small employers can shop for insurance coverage. These individuals become eligible because, through the ACA, individuals with family income between 100-400 percent of FPL who are purchasing coverage through the exchanges are eligible for government subsidies towards their health insurance premiums.<sup>39</sup>

The remaining 534,000 uninsured adults in Georgia making less than 100 percent of FPL who would be newly eligible for Medicaid under the expansion will likely continue to have limited access to affordable health coverage without a change in the state's expansion decision or other health policy changes.<sup>v,40</sup> This group of individuals is often referred to as the "coverage gap" (see Figure 7).

<sup>v</sup> A report by the Kaiser Family Foundation estimates that 409,350 uninsured adult Georgians fall in the coverage gap.



## IMPROVING HEALTHCARE FOR LOW-INCOME GEORGIANS

Georgia, like most other states that do not plan to expand Medicaid, has proposed very few policies to improve access to quality healthcare for the 534,000 low-income uninsured individuals who would benefit from the expansion. Given the negative health and financial outcomes for individuals without insurance and the costs to insured individuals, health providers, and the government, it is in society's best interest to find a solution to this challenge rather than maintain the status quo.

Any health policy or program to provide care to low-income uninsured Georgians in the coverage gap should meet the following goals:

1. Expand access to affordable healthcare
2. Improve health outcomes
3. Provide long-term sustainability

## CHALLENGES

Georgia faces many challenges and barriers to expanding access to quality healthcare for low-income uninsured individuals, particularly for those in the coverage gap. These challenges include state fiscal constraints, a physician shortage, limits to nurse practitioner's scope of practice, and fiscal challenges for safety-net hospitals.



## STATE FISCAL CONSTRAINTS

Preliminary estimates projected that providing Medicaid to newly eligible adults through the expansion would cost the state approximately \$2.1 billion from 2014 to 2023. Since the federal government covers 100 percent of the cost for the first three years and then slowly reduces its contribution until it is set at 90 percent in 2020, expansion is projected to first cost the state about \$120 million in 2017. In 2023, the final year of the projection, state costs will have risen to almost \$406 million.<sup>41</sup>

Governor Deal and other state leaders maintain that the state cannot afford Medicaid expansion and have expressed serious concerns that the federal government will be unable to live up to its obligations under Medicaid expansion. The financial condition of both the state and federal governments indicate that these reservations are well-founded. Therefore, any policy or program that would improve access to healthcare for low-income uninsured Georgians must cost significantly less than Medicaid expansion and must rely upon state-based sources of funding.

**Any policy or program that would improve access to healthcare for low-income uninsured Georgians must cost significantly less than Medicaid expansion.**

## PHYSICIAN SHORTAGE

Georgia ranked 41<sup>st</sup> in the country in active physicians and 44<sup>th</sup> in primary care physicians per capita in 2010.<sup>42</sup> According to the U.S. Department of Health & Human Services, almost 2 million Georgians live in a “Primary Care Health Professional Shortage Area,” meaning there are a low number of primary health professionals relative to the population.<sup>43</sup> In 2010, 31 of Georgia’s 159 counties did not have an internal medicine physician; 63 did not have a pediatrician; 79 did not have an OB/GYN; and 66 did not have a general surgeon.<sup>44</sup>

The shortage is caused in large part by the state not training enough physicians to meet the demand of the state’s growing population. While the state’s medical schools have significantly increased enrollment over the past decade, there are not enough residency positions to meet the demand.<sup>45</sup> This causes many Georgia-educated doctors to complete their medical training out of state, decreasing the likelihood that they will practice in Georgia.<sup>46</sup>

**Almost 2 million Georgians live in a “Primary Care Health Professional Shortage Area.”**

The current physician population in the state is aging as well. In 2010, almost 53 percent of Georgia’s physician workforce was 50 years or older, an increase of 19 percentage points since 2000.<sup>47</sup> Thus, the shortage is expected to get worse as a higher percentage of physicians retire.

Many physicians also do not accept Medicaid patients, mostly due to low reimbursement rates, making it even harder for individuals with Medicaid to find care. In 2010, 74.1 percent of Georgia physicians accepted Medicaid patients, down from 85.4 percent in 2000. Only 67.3 percent of physicians were accepting new Medicaid patients in 2010.<sup>48</sup>

Georgia’s Fiscal Year 2015 budget allocates \$2 million in additional funds to develop new graduate medical education programs to train residents.<sup>49</sup> While an important step, the state must continue to

pursue efforts to address its shortage of primary care providers. Without more providers, many Georgians may not have access to primary care, even if they have health insurance coverage.

**Many Georgians may not have access to primary care, even if they have health insurance coverage.**

## LIMITS TO NURSE PRACTITIONER SCOPE OF PRACTICE

Nurse practitioners (NPs) are an important provider of primary care across the country. In many states, NPs evaluate and diagnose patients, order and interpret diagnostic tests, and initiate and manage treatments. A literature review by the National Governor's Association found that most studies show that NPs provide comparable care to physicians and achieve equal or higher satisfaction rates among their patients. The review did not find any studies that raised concerns about the quality of care offered by NPs.<sup>50</sup>

Georgia's laws and regulations for NPs are more restrictive than almost any other state. A 2007 study ranked Georgia's NP regulations 48<sup>th</sup> in the country because the state's NP limitations affect patients' freedom to choose providers and NPs' ability to provide primary care.<sup>51</sup> Georgia's restrictions include requiring NPs to be supervised by a physician and to have a collaborative agreement with a physician or a physician's supervisor/delegation in order to prescribe drugs. These limitations do not exist in over one-third of states.<sup>52</sup>

## FISCAL CHALLENGES OF SAFETY-NET HOSPITALS

Hospitals that serve a large number of Medicaid and low-income uninsured patients receive state and federally funded supplemental payments from state Medicaid programs. Called disproportionate share hospital (DSH) payments, the funding offsets the disadvantaged financial situation of hospitals that provide large amounts of uncompensated care to uninsured individuals and serve a substantial number of patients in the relatively low-paying Medicaid program. Georgia's federal DSH allotment was \$282 million in state fiscal year 2013, about 66 percent of the total DSH allocation.<sup>53</sup>

**Georgia laws and regulations for nurse practitioners ranked 48<sup>th</sup> most restrictive in the country.**

The ACA was expected to reduce the number of uninsured individuals and, therefore, reduce hospital uncompensated care costs. This would create less need for DSH payments. Thus, the ACA required annual aggregate reductions in federal DSH funding from FY 2014 through FY 2020. The Budget Control Act of 2012 and the American Taxpayer Relief Act of 2013 extended the ACA cuts through 2022. In FY 2014, DSH allotments were to be reduced nationally by \$500 million, and the amount was to gradually increase each year and peak in FY 2019 with a \$5.6 billion reduction.<sup>54</sup> However, as part of the Bipartisan Budget Act of 2013, Congress removed the 2014 and 2015 DSH cuts and increased the FY 2016 cut from \$600 million to \$1.2 billion. The DSH cuts were also extended one more year to 2023.<sup>55</sup>



Figure 8: Medicaid DSH Federal Funding Reductions (in millions)<sup>56</sup>

Year	National Allotment	Georgia DSH Allotment
2013	\$11,544	\$282
Year	National Annual Reduction	Georgia Annual Reduction (Est.)
2014	\$0 (originally \$500)	\$0 (originally \$11)
2015	\$0 (originally \$600)	\$0 (originally \$13)
2016	\$1,200 (originally \$600)	\$26 (originally \$13)
2017	\$1,800	\$40
2018	\$5,000	\$111
2019	\$5,600	\$124
2020	\$4,000	\$89

In 2011, almost 40 percent of Georgia hospitals lost money. Rural hospitals are in an even worse financial situation as 55 percent had negative total margins.<sup>57</sup> Given their financial struggles, Georgia hospitals have expressed concern regarding the DSH reduction. Since Georgia does not plan to expand Medicaid, the reduction in DSH payments would not be offset by an increase in revenue through having more patients being covered by Medicaid. Thus, the hospitals are likely to receive less funding, while the demand for uncompensated care is expected to persist.

Grady Health System in Atlanta, the state's largest safety-net hospital, provided \$200 million in charity care in 2012.<sup>58</sup> The hospital expects to lose \$45 million in DSH funding between now and 2018.<sup>59</sup> In 2012, Grady had \$738.1 million in expenses and finished the year with \$27.2 million in excess revenue.<sup>60</sup>

According to Grady's chief executive, the funding reduction may force the hospital to cut services such as mental health. The DSH cuts could also cause 15 rural hospitals to close.<sup>61</sup> According to the governor's chief of staff, Governor Deal is considering options to support hospitals that serve a large number of uninsured patients. These options range from a one-time state payment to an ongoing commitment.<sup>62</sup>

**In 2011, almost 40 percent of Georgia hospitals lost money.**

## RECOMMENDATIONS

While these and other challenges are significant barriers to providing low-income uninsured Georgians with quality healthcare, there are cost-efficient, state-based solutions Georgia can implement in the short-term that can positively impact health outcomes for Georgians in the coverage gap.

### GEORGIA'S CHARITY CLINICS

**There are cost-efficient, state-based solutions Georgia can implement.**

Georgia's charity clinics are an essential provider of health services to the state's low-income uninsured population, serving more than 183,000 unique patients in 2012. The clinics have shown to improve health outcomes for its patients – such as reduced hypertension and A1C levels and increased medication compliance – while reducing non-urgent usage of the emergency room by 14 to 20 percent. These outcomes are achieved with an average cost of \$29 per patient visit.<sup>63</sup>

The state's existing charity clinics have the capacity to serve more patients, but funding and unnecessary state restrictions limit their ability to meet their full potential. The state of Georgia should support its

charity clinics so they can reach capacity and fulfill much of the unmet need for care among the state's low-income uninsured population.

### Provide State Government Support

The state's 96 clinics saved the state over \$200 million in 2012 while not receiving any state funding. However, other state governments do financially support their charity clinics. Virginia provides \$3.5 million to its 53 clinics; Ohio gives \$435,000 for 46 clinics; West Virginia provides \$4.3 million to 11 clinics; and South Carolina recently approved \$2 million for 51 clinics.<sup>64</sup>

The Georgia Charitable Care Network requested a \$2 million appropriation from the Georgia legislature in 2014.<sup>65</sup> Since clinics can provide \$7 worth of services for every \$1 spent, this relatively small amount of government funding would allow clinics to be open more hours and serve an estimated 100,000 additional patients.<sup>66</sup> With the increase in funds, the expansion in capacity could take place at many clinics with little delay, providing much needed care to Georgia's most vulnerable citizens. However, funding for Georgia's charity clinics was not included in the state's FY 2015 budget.

While a \$2 million appropriation would allow Georgia's current clinics to serve more patients, over 40 percent of counties do not have a charity clinic. A larger appropriation would allow for the Georgia Charitable Care Network to help underserved communities open new clinics. Since many rural areas have limited access to care, new clinics could have a significant impact on communities across the state.

To address the coverage gap, in 2015, the state should provide \$10 million in funding to support the dramatic expansion of current clinics and the creation of new ones in underserved communities. Compared to the \$2.1 billion cost of Medicaid expansion over ten years, this appropriation is affordable for the state and sustainable in the long-term while still expanding access to quality healthcare to a significant portion of the state's low-income uninsured population.

### Expand Telemedicine into Charity Clinics

Telemedicine is the provision of care through real-time interactive communication between the patient and provider from one site to another via electronic communications. The electronic communication – which usually includes at least video and audio – allows a provider to care for a patient at a different location. Telemedicine can be used to provide primary and specialty care, remote patient monitoring, and medical education. Care through telemedicine can take place at hospitals, clinics, community health centers, nursing homes, and schools.<sup>67</sup>

Telemedicine has improved access to care for many individuals – especially those in rural areas that have a physician shortage – because instead of traveling across the state to see a provider, a patient can go to a local clinic or hospital and be connected with a provider located anywhere in the state. Physicians and health facilities benefit from telemedicine because it expands their reach beyond their own office. Studies have shown that the quality of healthcare delivered through telemedicine is as good as care provided through traditional in-person services.<sup>68</sup> Telemedicine has also been shown to reduce the cost of healthcare and increase efficiency through

**The Georgia legislature  
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to support charity  
clinics and to pilot the  
use of telemedicine in  
those clinics.**

better management of chronic diseases, reduced travel times, shared health professional staffing, and fewer or shorter hospital stays.<sup>69</sup>

Georgia has one of the most robust and developed telemedicine networks in the country. Through the Georgia Partnership for TeleHealth network, the state has over 285 presentation sites where patients can be seen by its network of over 175 specialists representing 32 specialties. In 2012, there were over 75,000 telemedicine clinical encounters in the state.<sup>70</sup> Nursing home and school-based clinics led to the avoidance of 278 ER visits in 2011, resulting in savings of \$834,000.<sup>71</sup>

Georgia's charity clinics are not currently using telemedicine. However, utilizing telemedicine in the clinics would enhance their ability to deliver services. Setting up telemedicine presentation sites in charity clinics would allow providers to volunteer their time at clinics across the state without leaving their office. This would be especially beneficial to individuals who live in rural areas and often do not have access to specialty care.

### **Georgia should join the one-third of states that provide full practice authority to nurse practitioners.**

The Georgia Charitable Care Network and the Georgia Partnership for TeleHealth have researched using telemedicine in the state's charity clinics. However, the clinics currently do not have the capital to purchase the technology and infrastructure required for telemedicine, which is relatively inexpensive given the benefit it provides.<sup>vi,72</sup> The Georgia legislature should include funding to pilot the use of telemedicine in its charity clinic appropriation.

## **Modernize Nurse Practitioner Laws and Regulations**

Many nurse practitioners and other mid-level providers deliver care to patients at charity clinics as employees or volunteers. However, the ability of NPs to provide care is limited by Georgia's restrictive laws and regulations.

Georgia should join the one-third of states that provide full practice authority to NPs. By implementing the licensing model recommended by the National Council of State Boards of Nursing and the Institute of Medicine, NPs will be able to provide the high level of care that they are educated and prepared to provide at charity clinics and other healthcare facilities across the state.<sup>73</sup> Expanded utilization of NPs could help reduce Georgia's shortage of primary care providers and – since NPs are more likely to serve urban and rural populations – increase access to healthcare in underserved areas.<sup>74</sup>

While many physician associations have opposed these reforms, a 2012 study found no evidence of differences in primary care physician earnings between states that provide NPs with full practice authority and those that maintain practice barriers.<sup>75</sup> Since the literature on NPs finds no reason to be concerned with the quality of care provided by NPs and it should not impact Georgia's physicians' earnings, there is little to no reason for the state to continue to limit the care NPs can provide.

<sup>vi</sup> A basic telemedicine equipment set-up with a laptop costs \$10-11 thousand while a more advanced mobile cart costs \$23-35 thousand. The pricing varies primarily due to the inclusion of peripherals or the specialty medical services provided.

## Reinstate Sales Tax Exemption for Charity Clinics

Many healthcare providers are exempt from the payment of Georgia's sales and use tax, including licensed nonprofit in-patient general hospitals, mental hospitals, nursing homes, and hospices.<sup>76</sup> From 2008 to 2010, Georgia's volunteer health clinics were also exempt from Georgia sales tax on medical and office supplies and other purchases.<sup>77</sup> During recent legislative sessions, the Georgia General Assembly has attempted to renew this expired tax break. In 2013, the legislature passed a bill by wide margins that, among other measures, reinstated the charity clinic tax exemption.<sup>78</sup> However, Governor Deal vetoed this legislation. The governor explained his decision in a press release:

"The 2010 Special Council on Tax Reform and Fairness for Georgians recommended 'that all nongovernment and nonbusiness input exemptions sunset so that the Legislature may determine if economic or non-economic justifications exist for renewing these exemptions.' In following their recommendation, I will request the Governor's Competitiveness Initiative taskforce to review this bill and provide an opinion on whether economic or noneconomic justifications exist for the exemptions to be renewed during the next legislative session."<sup>79</sup>

In 2014, the Georgia House again passed legislation that included a renewal of the exemption by a vote of 167 to 2. Even with this substantial bi-partisan support in the House, the bill did not make it out of the Senate Finance Committee.<sup>80</sup> The Georgia Budget and Policy Institute estimates that the legislation would have saved Georgia's charity clinics \$2.54 million in state taxes and \$1.91 million in local taxes from 2015 to 2017.<sup>81</sup> However, the actual savings to Georgia's charity clinics and cost to the state is not expected to be this high. Not all of the state's charity clinics applied for the previous sales tax exemption, and some of the clinics already receive an exemption as a hospital based clinic or a church's outreach ministry.

**Georgia should reinstate  
the sales tax exemption  
for charity clinics.**

Given the amount and quality of care charity clinics deliver and the savings this care provides to the state, Georgia should reinstate the sales tax exemption to provide the clinics with more resources to serve individuals in need of care.

## REPLACE LOST FEDERAL DSH FUNDS WITH STATE DOLLARS

Many hospitals have expressed concern about the upcoming loss of DSH funds. In 2016, Georgia hospitals will lose an estimated \$26 million in federal funds for uncompensated care. The federal funding loss increases to \$40 million in 2017 and \$111 million in 2018.<sup>82</sup>

DSH funds are an important source of revenue for many of the state's hospitals, and the federal reduction could cause some of the hospitals to cut services or completely close. To support this essential component of the state's safety-net, the state should replace the lost federal funding. Since implementing the above recommendations to support the state's charity clinics and other state and federal health policies could reduce the amount of uncompensated care provided by hospitals, the state may not need to replace the full amount of lost federal funding. Thus, the state should work with hospitals to identify the amount of uncompensated care they provide and to calculate the amount of state funding needed for hospitals to maintain services.

## CONCLUSION

Many Georgians with low incomes do not have access to insurance and the affordable healthcare that it provides, leading to many negative health and financial outcomes. High rates of uninsurance are also costly for the privately insured, healthcare providers, and the government. Georgia does not plan to expand Medicaid to the over 500,000 Georgians left in the ACA coverage gap but has not considered or proposed alternative policies or programs to improve their access to healthcare.

State-based reforms, including support for Georgia's charity clinics, offer a strong foundation for expanding care to individuals in need. These reforms will ensure that more Georgians have access to affordable healthcare, leading to better outcomes for individuals and reducing the cost of uncompensated care.



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<sup>79</sup> Governor Nathan Deal, Office of the Governor, "Deal issues five veto statements," May 7, 2013, accessed May 23, 2014, <http://gov.georgia.gov/press-releases/2013-05-07/deal-issues-five-veto-statements>.

<sup>80</sup> Georgia General Assembly Legislation, "2013-2014 Regular Session - HB 969," accessed April 9, 2014, <http://www.legis.ga.gov/Legislation/en-US/display/20132014/HB/969>.

<sup>81</sup> Estimate provided by Wesley Tharpe, Policy Analyst with the Georgia Budget & Policy Institute, [www.gbpi.org](http://www.gbpi.org).

<sup>82</sup> Georgia Hospital Association, *Hospitals 101*, 28.



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