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**State/Territory Name: Georgia**

**State Plan Amendment (SPA) #: 19-0008**

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

**Financial Management Group**

December 23, 2019

Lynnette R. Rhodes, Esq.
Executive Director, Medical Assistance Plans
Department of Community Health
2 Peachtree St., 36th Floor
Atlanta, Georgia 30303-3159

RE: Georgia State Plan Amendment 19-0008

Dear Ms. Rhodes:

We have reviewed the proposed amendment to Attachment 4.19-A and 4.19-B of your Medicaid State plan submitted under transmittal number 19-0008. This amendment proposes to extend the current Hospital Provider Payment program until June 30, 2025. This payment program, currently set to expire on June 30, 2019 was enacted by the Georgia General Assembly in HB 321. This amendment extends additional payments for inpatient base rates, capital add-on and GME add-on.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of July 1, 2019. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Anna Dubois at (850) 878-0916.

Sincerely,

/s/

Kristin Fan
Director

cc:
Anna Dubois

| **TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL** | 1. TRANSMITTAL NUMBER:<br>19-0008 | 2. STATE<br>GEORGIA |
|---|---|---|
| | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR<br>CENTERS FOR MEDICARE AND MEDICAID SERVICES<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. PROPOSED EFFECTIVE DATE:<br>July 1, 2019 | |

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

| 6. FEDERAL STATUTE/REGULATION CITATION:<br>Section I917(b) et seq. of the Act, 1917(a)(l)(B) of the Act, and 42 C.F.R. 700 et seq. | 7. FEDERAL BUDGET IMPACT:<br>FFY 2019: $24,169,379<br>FFY 2020: $96,220,007 |
|---|---|
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br>Attachment 4.19-A, Page 7a and<br>Attachment 4.19-B, Page 8.6 | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:<br>Attachment 4.19-A, Page 7a and<br>Attachment 4.19-B, Page 8.6 |

10. SUBJECT OF AMENDMENT: Extend the current Hospital Provider Payment program through June 30, 2025, per HB 321

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
**Single State Agency Comments Attached**

| 12. SIGNATURE OF STATE AGENCY OFFICIAL: | 16. RETURN TO:<br><br>Department of Community Health<br>Division of Medicaid<br>2 Peachtree Street, NW, 36th Floor<br>Atlanta, Georgia 30303-3159 |
|---|---|
| 13. TYPED NAME: LYNNETTE R. RHODES, ESQ. | |
| 14. TITLE: EXECUTIVE DIRECTOR, MEDICAL ASSISTANCE PLANS | |
| 15. DATE SUBMITTED: 09/27/19 | |

**FOR REGIONAL OFFICE USE ONLY**

| 17. DATE RECEIVED: 09/27/19 | 18. DATE APPROVED: 12/23/19 |
|---|---|

PLAN APPROVED – ONE COPY ATTACHED

| 19. EFFECTIVE DATE OF APPROVED MATERIAL:<br>07/01/19 | 20. SIGNATURE OF REGIONAL OFFICIAL:<br>/s/ |
|---|---|
| 21. TYPED NAME:<br>Kristin Fan | 22. TITLE: Director, FMG |

23. REMARKS:

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

Effective for dates of service on and after July 1, 2013, through June 30, 2025, the payment method is modified as follows:

a. For enrolled hospitals other than those identified in items band c below, the reimbursement rate is 95.77% of costs.
b. For out-of-state enrolled hospitals, payments are made at the statewide average percentage of charges paid to Georgia hospitals that are reimbursed at 85.6% of costs and are not subject to cost settlement. The payment rate for out-of-state enrolled hospitals will not exceed 65% of covered charges.
c. For hospitals that are designated as a Critical Access Hospital, a historically minority-owned hospital, or as a state-owned hospital, the reimbursement rate continues at 100% of costs.

Example settlement calculation for critical access, historically minority owned hospital, or state-owned hospitals:

| | |
|---|---|
| Percentage of charges paid on interim basis | 60% |
| Charges for services provided during cost report period | $1,000,000 |
| Interim payments | $600,000 |
| Retrospective determination of allowable costs* | $585,000 |
| % of allowable costs reimbursed | 100% |
| Retrospective determination of reimbursable costs | $585,000 |
| Settlement amount due from hospital | $15,000 |

Example settlement calculation for all other enrolled Georgia hospitals:

| | |
|---|---|
| Percentage of charges paid on interim basis | 52% |
| Charges for services provided during cost report period | $1,000,000 |
| Interim payments | $520,000 |
| Retrospective determination of allowable costs* | $585,000 |
| % of allowable costs reimbursed | 95.77% |
| Retrospective determination of reimbursable costs | $560,250 |
| Settlement amount due from hospital | $24,750 |

* amount would not exceed charges for services

14. Governmental facilities and Critical Access eligible hospitals which meet departmental requirements will be eligible for rate payment adjustments. The rate adjustment payments are intended to provide supplemental funding for Medicaid services to these facilities that based on their governmental status,