Table of Contents

State/Territory Name: Georgia

State Plan Amendment (SPA) #: GA-24-0009

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

October 31, 2024

Stuart Portman
Executive Director
Medical Assistance Plans Division
2 Martin Luther King Jr. Drive SE
East Tower, 19th Floor
Atlanta, Georgia 30334

RE: TN GA-24-0009

Dear Director Portman:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Georgia state plan amendment (SPA) to Attachment 4.19-A GA-24-0009, which was submitted to CMS on August 14, 2024. This plan amendment revises the allocation methodology for the DSH program. Eligible hospitals in Pool 2 that are classified as a Rural Referral Center (RRC) by CMS and that are not eligible to participate in the Advancing Innovation to Deliver Equity (AIDE) or Strengthening The Reinvestment Of a Necessary-Workforce in Georgia (STRONG) state directed payment programs will receive an allocation no less than 25% of their DSH Limit.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2) of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact James Francis at 857-357-6378 or via email at James.Francis@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24-0009

2. STATE: GA

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
USC§ 1396r-4 (Section 1923 of the Social Security Act)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 0
b. FFY 2025 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A, Pages 15, 16, 17, and 17-A

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A, Pages 15, 16, 17, and 17-A

9. SUBJECT OF AMENDMENT
This Stae Plan Amendment seeks to revise the allocation methodology used to calculate the hospital specific DSH payments.

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Lynnette R. Rhodes

13. TITLE
Chief Health Policy Officer

14. DATE SUBMITTED
8/14/2024

15. RETURN TO
Stuart Portman
Executive Director
Medical Assistance Plans Division
Department of Community Health
2 Martin Luther King Jr. Drive SE
East Tower, 19th Floor
Atlanta, GA 30334
Email: stuart.portman@dch.ga.gov

FOR CMS USE ONLY

16. DATE RECEIVED
August 14, 2024

17. DATE APPROVED
October 31, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2024

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS

FORM CMS-179 (09/24)

Instructions on Back

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

III. Disproportionate Share Hospitals (DSH)

A. Eligibility

Effective for DSH payment adjustments made on or after July 1, 2024, hospitals that are eligible to receive DSH payment adjustments under federal DSH criteria per Social Security Act Section 1923(d) will be eligible to receive an allocation of available DSH funds.

Federal Criteria:

1. The hospital has a Medicaid inpatient utilization rate of at least 1%; AND
2. The hospital has at least two (2) obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid recipients. This requirement does not apply to a hospital of which the inpatients are predominately individuals under 18 years of age or to hospitals which did not offer non-emergency obstetric services to the general population as of December 22, 1987. In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. For rural hospitals subject to a federal requirement to provide obstetric services, as an alternative to determining whether deliveries are provided at the hospital, the Department will consider the following factors:
    a. The hospital must have two or more physicians with staff privileges that are:
        i. Enrolled in the Medicaid program.
        ii. Credentialed to provide OB services at the hospital in family practice, general practice, or obstetrics; and
        iii. Located within 25 miles of the hospital or in an office in the hospital network or must attest to attendance at the hospital on some routine basis; and
    b. The hospital must be able to provide at least one obstetric service that is currently covered by Medicaid and appropriate to be provided in a hospital-based setting.

    For federal DSH criteria, a hospital will be considered a rural hospital if a hospital's county is not in a Metropolitan Statistical Area, as defined by the United States Office of Management and Budget, OR is a county having a population of less than 50,000 according to the United States decennial census; provided, however, that for counties which contain a military base or installation, the military personnel and their dependents living in such county shall be excluded from the total population of that county.

B. Allocation Methodology

Effective for DSH payment adjustments made on or after July 1, 2024, the following methodology will be used for determining payment amounts:

1. For each federal fiscal year, the amount of funds available for DSH payments will be determined based on the state's Medicaid DSH federal allotment and required state matching contribution.
2. Hospitals that meet federal DSH eligibility criteria will be eligible to receive an allocation of available DSH Payments.

3. The maximum amount of DSH Payments (i.e., DSH Limit) for each hospital will be the hospital's loss incurred for services provided to Medicaid patients, for whom Medicaid is the primary payor, and uninsured patients who have no health insurance or other source of third-party coverage. Medicaid patients will be defined as patients enrolled in either in-state or out-of-state Medicaid fee-for-service or in-state or out-of-state Medicaid Managed Care Organization (MCO) as their primary insurance. Medicaid costs will be determined by applying total per diem costs to Medicaid covered inpatient days and total ratios of cost to charges to Medicaid inpatient and outpatient charges grouped by cost center. The patient day and charge amounts will be determined by Medicaid and Medicaid MCO HS&R reports of paid claims or internal hospital records, while per diem costs and ratios of cost to charges will be determined by available 2552 cost reports. Medicaid payments will include actual claim payments related to Medicaid days and charges, from Medicaid, and Medicaid MCOs, patient payments, and non-claim-based Medicaid, and Medicaid MCO, and payments related to inpatient and outpatient hospital services, Medicaid outpatient settlement estimates and non-DSH rate adjustments. Uninsured costs will be determined by applying the uninsured days and charges reported on the DSH data survey to the same per diems and cost to charge ratios used to calculate Medicaid costs. Uninsured payments will include patient payments received on uninsured services accounted for on a cash basis. The DSH data surveys will also be used to determine amounts received for services provided to uninsured patients. DSH data surveys are conducted annually and subject to desk reviews and onsite reviews of supporting documentation, as warranted.

4. Each hospital's DSH limit is subject to the following DSH limit adjustments for allocation purposes:

    a. For hospitals receiving Upper Payment Limit (UPL) rate adjustments, the allocation basis will be increased by the amount of any intergovernmental transfer or certified public expenditure on behalf of the hospital.
    b. For hospitals receiving rate adjustment payments related to medical education, neonatal services or services provided under contract with the Georgia Department of Human Services, the allocation basis will be increased by the amount of such rate adjustments.
    c. For hospitals receiving direct payment program (DPP) rate adjustments, the allocation basis will be increased by the amount of any intergovernmental transfer or certified public expenditure on behalf of the hospital, effective for DSH payment adjustments made on or after December 1, 2021.

5. The amount of funds available for DSH Payments will be allocated between two pools of eligible hospitals. If hospital directed payments from Care Management Organizations (CMO) are more than 10 percent of all provider payments from CMOs, then Methodology A will be followed to determine the Allocation Pools. If hospital payments from CMOs are less than or equal to 10 percent of all provider payments from CMOs, then Methodology B will be followed.

A. METHODOLOGY A

    i. Pool 1 will be equivalent to that amount necessary to cover 100 percent of the DSH Limit for eligible critical access hospitals and rural hospitals with less than 100 beds. Pool 2 will be equivalent to the remaining DSH Payments and used in the allocation to all other eligible hospitals.
    ii. Maximum DSH allocations for critical access hospitals, rural hospitals with less than 100 beds, and state-owned and operated acute care hospitals are set at 100% of their DSH limit. All other hospitals are set at 75% of their Adjusted DSH

iii. Limit. Eligible hospitals in Pool 2 that are classified as a Rural Referral Center (RRC) by the Centers for Medicare and Medicaid Services (CMS) that are not eligible to participate in the Advancing Innovation to Deliver Equity (AIDE) or Strengthening The Reinvestment Of a Necessary-workforce in Georgia (STRONG) state directed payment programs will receive an allocation no less than 25% of their DSH Limit. No hospital will receive more than 100% of their DSH Limit.

B. METHODOLOGY B

i. Pool I will be equivalent to 13.4% of available DSH funds and used in the calculation of DSH allocations for eligible critical access hospitals and rural hospitals with less than 100 beds. Pool 2 will be equivalent to 86.6% of available DSH funds and used in the calculation of the DSH allocations for all other, eligible hospitals.

ii. The maximum DSH allocation for all hospitals is set at 75% of the Adjusted DSH Limit.

6. The department will utilize the following steps to determine the amount each hospital is eligible to receive in DSH payments when Methodology A is followed.
   a. Step 1: Calculate 25% of the DSH limit (as determined in section (III)(B)(3)) for hospitals classified as Rural Referral Center (RRC).
   b. Step 2: Reduce the adjusted DSH limit (as determined in section (III)(B)(4)) by the amount calculated in Step 1.
   c. Step 3: Determine the adjusted DSH limit as calculated in Step 2 as a percentage of total cost for each hospital.
   d. Step 4: For each hospital, multiply the hospital-specific percentage determined in Step 3 by the hospital's adjusted DSH limit as calculated in Step 2. For private hospitals, the outcome of this calculation will be multiplied by the rate of federal matching funds for Medicaid benefit payments.
   e. Step 5: For each hospital, divide the hospital-specific amount identified in Step 4 by the aggregate "step 4" amount derived from all hospitals in the applicable pool, as defined in section (III)(B)(5), which will result in a hospital-specific allocation factor.
   f. Step 6: Apply the hospital's allocation factor calculated in Step 5 to the total amount of DSH funds available in the applicable pool, as defined in section (III)(B)(5). DSH funds available in Pool 2 will be reduced by the amount calculated in Step 1. This will result in the hospital's DSH payment for all hospitals except RRCs. For RRCs the amount calculated in Step 1 will be added to the DSH payment calculated based on the hospital's allocation factor. Should the DSH payment amount calculated for a hospital exceed the hospital's DSH limit, as determined in section (III)(B)(3), the excess amount will be redistributed to the remaining hospita1s in the applicable allocation pool.

7. The department will utilize the following steps to determine the amount each hospital is eligible to receive in DSH payments when Methodology B is followed.
   a. Step 1: Determine the adjusted DSH limit (as determined in section (III)(B)(4)) as a percentage of total cost for each hospital.
   b. Step 2: For each hospital, multiply the hospital-specific percentage determined in Step 1 by the hospital's adjusted DSH limit. For private hospitals, the outcome of this calculation will be multiplied by the rate of federal matching funds for Medicaid benefit payments.

c. Step 3: For each hospital, divide the hospital-specific amount identified in Step 2 by the aggregate "step 2" amount derived from all hospitals in the applicable pool, as defined in section (III)(B)(5), which will result in a hospital-specific allocation factor.
d. Step 4: Apply the hospital's allocation factor calculated in Step 3 to the total amount of DSH funds available in the applicable pool, as defined in section (III)(B)(5). This will result in the hospital's DSH payment. Should the DSH payment amount calculated for a hospital exceed the hospital's DSH limit, as determined in section (III)(B)(3), the excess amount will be redistributed to the remaining hospita1s in the applicable allocation pool.

8. For allocation of DSH Payments, eligibility and DSH Limit calculations will be based on information available from hospital fiscal years ended during the most recent calendar year for which data is available.

Audit of Disproportionate Share Payments:

As required by Section 1923(j) of the Social Security Act related to auditing and reporting of disproportionate share hospital payments, the Division of Medical Assistance will implement procedures to comply with the Disproportionate Share Hospital Payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009, to ensure that the hospital specific DSH limits have not been exceeded.

Any funds recouped as a result of audits or other corrections shall be redistributed to other eligible hospitals within the state, provided each hospital remains below their hospital specific DSH limit. Funds shall be redistributed to hospitals within the pools, as identified in (III)(B)(4) above, for which funds were recouped. The recouped funds within each pool shall be redistributed to the governmental facilities that are still below their hospital specific DSH limit. The funds shall be allocated to those hospitals based on their allocation factor that was derived in (III)(B)(6)(b) above. If the redistribution causes a hospital to exceed their hospital specific DSH limit those excess funds will be redistributed using the same methodology until all funds are expended.