



Financial Management Group

DEC 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,

A handwritten signature in blue ink, appearing to read 'Kristin Fan', is positioned above the printed name and title.

Kristin Fan
Director

cc:
Anna Dubois
Dan Yablochnikov

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER <u>19 — 0008</u>	2. STATE GEORGIA
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE July 1, 2019	
5. TYPE OF PLAN MATERIAL (Check One)			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION Section 1917(b) et seq. of the Act, 1917(a)(1)(B) of the Act, and 42 C.F.R. 700 et seq.		7. FEDERAL BUDGET IMPACT a. FFY__2019 (FFS only) \$ __\$24,169,379____ b. FFY__2020 (FFS only) \$ __\$96,220,007____	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19-A, Page 7a and Attachment 4.19-B, Page 8.6		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Attachment 4.19-A, Page 7a and 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)			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED Single State Agency Comments Attached	
12. SIGNATURE OF STATE AGENCY OFFICIAL 		16. RETURN TO Georgia Department of Community Health Division of Medical Assistance Plans 2 Peachtree Street, NW, 36th Floor Atlanta, Georgia 30303-3159	
13. TYPED NAME LYNNETTE R. RHODES, ESQ.			
14. TITLE EXECUTIVE DIRECTOR, MEDICAL ASSISTANCE PLANS			
15. DATE SUBMITTED 9/27/19			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED		18. DATE APPROVED DEC 23 2019	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL JUL 01 2019		20. SIGNATURE OF REGIONAL OFFICIAL 	
21. TYPED NAME Kristin FAN		22. TITLE Director, FMS	
23. REMARKS			

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

Hospitals in the statewide peer group have hospital specific base rates calculated from the statewide base rate with adjustments for Medicaid utilization (MIUR), medical education (IME) if applicable, and a stop-loss/stop-gain factor if applicable.

Hospitals in the pediatric peer group have hospital specific base rates calculated from the statewide base rate with adjustments for Medicaid utilization (MIUR), medical education (IME) if applicable, the Pediatric Peer Group Add-On Amount, and a stop-loss/stop-gain factor if applicable.

The statewide base rate is the average cost of claims in the base data for hospitals in the statewide peer group, adjusted for budget neutrality.

The Pediatric Peer Group Add-On Amount is the difference between the average cost of claims in the pediatric peer group, adjusted for budget neutrality, and the average cost of claims in the statewide peer group, adjusted for budget neutrality.

The stop-loss/stop-gain factor adjusts hospital specific base rates such that the hospital does not experience a loss due to the rebasing and does not experience a gain greater than 4.01% due to the rebasing.

2. Hospital Provider Fee Add-On Amount

For admissions on or after July 1, 2013 through June 30, 2025:

Effective July 1, 2013, an adjustment to hospital inpatient base rates, capital add-on and GME add-on rates will be added to hospitals' inpatient rates. Critical Access Hospitals (CAHs), Psychiatric Hospitals and State-Owned / State-Operated Hospitals are exempt from the provider fee and the rate adjustment. Trauma hospitals will participate in the provider fee but at a lower percentage than other participating hospitals. The table below shows the provider fee and associated rate increase for different classes of hospitals.

Effective on or after July 1, 2015 an adjustment to the Graduate Medical Education (GME) Supplemental Payments (see Section D1) will be made for participating GME hospitals that are not exempt from the provider fee and rate adjustment and as detailed in the table below.

TN No.: 19-0008
Supersedes
TN No.: 19-0001

Approval Date: DEC 23 2019 Effective Date: July 1, 2019

**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,