DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Financial Management Group

February 16, 2023

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

RE: State Plan Amendment (SPA) GA-21-0014

Dear Director Rhodes:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State Plan submitted under transmittal number (TN) 21-0014. This State Plan Amendment revises Disproportionate Share Hospital (DSH) methodology by increasing the allocation for hospitals receiving direct payment program (DPP) rate adjustments by the amount of the intergovernmental transfers (IGT) or certified public expenditures (CPE) on behalf of the hospital. The amendment also revises the definition of individuals eligible for inclusion in the DSH calculation for uncompensated care (UCC). This change eliminates the Medicare/Medicaid crossover dual-eligible population as well as the Medicaid secondary payor population from the UCC calculation and limits eligible individuals to (1) those who are eligible for medical assistance under the State Plan or under a waiver of such plan for whom the State plan or waiver is the primary payor for such services or (2) those who have no health insurance or other source of third-party coverage.

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.

This is to inform you that Medicaid State Plan Amendment GA-21-0014 is approved effective December 1, 2021. The CMS-179 and the amended plan pages are attached.

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

Sincerely,

Rory Howe

Rory Howe
Director

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 December 1, 2007, 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 35,000 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 December 1, 2007, the following methodology will be used for determining payment amounts:

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1. For each federal fiscal year, the amount of funds available for DSH payments will be determined based on the state's 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 allotment funds.

3. Effective for DSH payment adjustments made on or after December 1, 2021, 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. The amount of funds available for DSH payments will be allocated among eligible hospitals. Total available DSH funds will be divided into two pools:
   - Pool I - For FY 2008 DSH payments, Pool 1 will be equivalent to $53,735,261 and used in the calculation of DSH allocations for small, rural hospitals. For DSH payments after FY 2008, Pool I would change relative to changes in the state's federal DSH allotment as compared to the FY 2008 state DSH allotment.
   - Pool 2 – For FY 2008 DSH payments, Pool 2 will be equivalent to $347,439,065 and used in the calculation of the DSH allocations for all other, eligible hospitals. For DSH payments after FY 2008, Pool 2 would change relative to changes in the state's federal DSH allotment as compared to the FY 2008 state DSH allotment.

5. 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

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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.

6. The department will utilize the following steps to determine the amount each hospital is eligible to receive in DSH payments.

a. Step 1: Determine the adjusted DSH limit (as determined in section (III)(B)(5)) 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)(4), 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)(4). 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.

7. To mitigate significant increases and decreases in hospital specific DSH payments as compared to state fiscal year 2007, the following adjustments will be applied for the allocation of DSH funds:
   - Maximum DSH allocations for all hospitals are set at 75% of their specific adjusted DSH limits; however, for facilities ineligible for DSH payment adjustments prior to December 1, 2007 but newly eligible under the criteria specified in section A above or facilities who did not receive a DSH payment prior to December 1, 2007, their maximum DSH allocation factor, as calculated in Section (III)(B)(6), step 2, effective January 1, 2013 is limited to 75% of the calculated amount.
   - Final DSH payment amounts for all other hospitals reflects 100% of the allocation calculation based on the methodology specified in section (III)(B)(6).
   - Effective July I, 2013 the maximum DSH allotment for all hospital are set at 75% as calculated in section (III)(B)(6).

8. For private hospitals that meet the eligibility requirements of Section (III)(A) and meet Social Security Act Section 1923(b) criteria, allocations payments will be made at 100 % of calculated allocation amounts as determined by steps 1 through 7 of Section (III)(B). For

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private hospitals that meet the eligibility requirements of Section (III)(A) but do not meet Social Security Act Section 1923(b) criteria, allocation payments will be made at 100% of calculated allocation amounts as determined by steps 1 through 7 of Section (III)(B).

For allocation of 2010 DSH funds, provider eligibility and DSH limit calculations will be based on information available from hospital fiscal years ending in 2007; for hospitals not in operation during 2007, data for 2008 may be used. For allocation of DSH funds after 2010, eligibility and DSH limit calculations will be based on the most recent year for which comparable data would be 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.