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**State/Territory Name: Georgia**

**State Plan Amendment (SPA) #: 13-005**

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

September 13, 2013

Dr. Jerry Dubberly, Chief
Georgia Department of Community Health
Medicaid Division
2 Peachtree Street, NW, 40th Floor
Atlanta, Georgia 30303-3159

RE: Title XIX State Plan Amendment, GA 13-005

Dear Dr. Dubberly:

The Centers for Medicare & Medicaid Services has reviewed Georgia's proposed amendment to Attachment 4.19-B of its Medicaid state plan submitted under transmittal number 13-005. Effective July 1, 2013, this amendment extends the state's current reimbursement methodology for setting payment rates for outpatient hospital services through June 30, 2017.

As part of our review of this amendment, we reviewed the state's upper payment limit demonstration and approved the state's methodology of using a Medicare cost to charge ratio versus a total cost to charge ratio. However, we do want to put the state on notice that we will be reviewing this method again in the near future and may require that the state adopt a more precise method to determine a reasonable estimate of what Medicare would pay for these services.

We conducted our review of your amendment according to the statutory requirements of sections 1902(a)(13),1902(a)(30),1903(a) and 1923 of the Social Security Act and the implementing federal regulations at 42 CFR Part 447. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved the State Plan Amendment with an effective date of July 1, 2013. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please contact Amr Ali at (404) 562-7338 or Joyce Wilkerson at (404) 562-7426.

Sincerely,

/s/

Charna R. Pettaway
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL | 1. TRANSMITTAL NUMBER: **13-005** | 2. STATE **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, 2013** | |

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

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

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

| 6. FEDERAL STATUTE/REGULATION CITATION: | 7. FEDERAL BUDGET IMPACT: |
|---|---|
| **42 C.F.R. §433.68 ; 42 C.F.R. § 447.250** | FFY 2013 $11,923,232<br>FFY 2014 $47,692,927 |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br>**Attachment 4.19-B: Page 8.1** | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:<br>**Attachment 4.19-B: Page 8:1** |

10. SUBJECT OF AMENDMENT: **The Georgia Hospital Medicaid Financing Program Act, which authorizes the Department to assess one or more provider payments on hospitals based upon a percentage of net patient revenue, takes effect on July 1, 2013. The provider payment will result in increased hospital outpatient rates.**

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:<br>//s// | 16. RETURN TO:<br>Department of Community Health<br>Division of Medicaid<br>2 Peachtree Street, NW, 36th Floor<br>Atlanta, Ga 30303-3159 |
|---|---|
| 13. TYPED NAME:<br>Jerry Dubberly | |
| 14. TITLE: Chief, Division of Medicaid | |
| 15. DATE SUBMITTED: | |

**FOR REGIONAL OFFICE USE ONLY**

| 17. DATE RECEIVED: 04/03/13 | 18. DATE APPROVED: 09/12/13 |
|---|---|
| PLAN APPROVED – ONE COPY ATTACHED | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL:07/01/13 | 20. SIGNATURE OF REGIONAL OFFICIAL:<br>//s// |
| 21. TYPED NAME:<br>Charna R. Pettaway | 22. TITLE: Acting Associate Regional Administrator<br>Division of Medicaid & Children Health Opns |

23. REMARKS: Approved with the following changes to item 7a, 7b, 8, 9 and 10 as authorized by State Agency e-mails dated 06/27/13

Block # 7a and 7b Changed to read: FFY 13 0 and FFY 14 0; Block # 8 Changed to read: Attachment 4.19-B pages 8.1 thru 8.11; Block # 9 Changed to read: Attachment 4.19-B pages 8.1 thru 8.11; Block #10 Changed to read: The purpose of this amendment is to extend Georgia's hospital provider fee which is set to expire June 30, 2013.

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R. OUTPATIENT HOSPITAL SERVICES

1. Outpatient services by Georgia hospitals are reimbursed on a determination of allowable costs. The determination of allowable costs is made retrospectively and is based on an appropriate CMS Form 2552 cost report submitted by the hospital and audited by the Department or its agents. Only costs incurred in providing patient care are eligible for reimbursement. Fees paid to the Department of Community Health pursuant to the Hospital Medicaid Financing Program Act of 2013 shall be considered allowable cost but will not be included in the retrospective cash settlement and reconciliation of the providers cost report.

   Allowable costs will not include costs that are in excess of charges. Allowable costs are documented costs that are ordinary and necessary in the delivery of a cost-effective service. Allowable costs shall be determined in accordance with the CMS Provider Reimbursement Manual 15, except as may be modified in this plan or modified in the Department's "Policies and Procedures for Hospital Services" as published on January 1, 2013.

   The amount of interim payment is calculated as a percentage of covered charges. This payment rate is defined by covered as allowable outpatient costs divided by outpatient charges. An interim payment rate cannot exceed one hundred percent of covered charges and is subject to cash settlement determination after an audited cost report is received, reviewed and accepted.

   Clinical diagnostic laboratory services performed for outpatients and non-hospital patients are reimbursed at the lesser of the submitted charges or at the Department's fee schedule rates used for the laboratory services program.

   Clinical diagnostic laboratory services are subject to an upper payment limit (UPL) at section 1903(i)(7) of the Act, which is the amount Medicare would pay on a per test basis (or per billing code basis for a bundled/panel of tests) from Medicare's clinical laboratory fee schedule. Federal matching funds are available to the extent a state pays at or below the per test rate paid by Medicare for these services.

2. The Department will provide for appropriate audit to assure that payments made to providers for outpatient hospital services meet the requirements of reasonable cost.

3. Outpatient services provided by non-participating non-Georgia hospitals are reimbursed at 45% of covered charges.

4. The maximum allowable payment for outpatient services will be 85.6% of the hospital specific inpatient per case rate, which includes the base rate amount plus

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Capital add-on, Graduate Medical Education add-on, Newborn add-on and the Hospital Provider Fee rate add-on, for enrolled Georgia hospitals. This case rate for enrolled non-Georgia hospitals does not include the Hospital Provider Fee add-on amount.

5. Emergency room visits for minor and non-acute illnesses which are not considered as true or potential medical emergencies will be reimbursed at an all-inclusive rate of $50.00.

6. The maximum allowable payment to enrolled Georgia and non-Georgia hospitals for Medicare outpatient coinsurance (crossover claims) will be 85.6% of the hospital-specific Medicaid per case rate. The maximum allowable payment to non-Georgia hospitals not enrolled the Georgia Medicaid program for Medicare outpatient crossover claims will be 85.6% of the average hospital-specific inpatient per case rate for enrolled non-Georgia hospitals.

7. For the determination of reasonable and reimbursable costs, the costs listed below are non-allowable (this list is not exhaustive):

   a) Costs related to lobbying and government relations, including costs for employees with duties related to lobbying and government relations, honorariums and reimbursement of travel or other expenses of elected officials;

   b) Memberships in civic organizations;

   c) Out-of-state travel paid by the provider for persons other than board members or those employed or contracted by the provider. Out-of-state travel for provider personnel must be related to patient care;

   d) Vehicle depreciation or vehicle lease expense in excess the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles; provided, however, such limit shall not apply to specialized patient transport vehicles(e.g., ambulances);

   e) Air transport vehicles that are not used to transport patient care staff or patients. If these vehicles are sometimes used for patient care staff or

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patient transport, the portion of cost that is unrelated to patient care staff or patient transport is non-allowable;

f) Fifty percent (50%) of membership dues for national, state, and local associations;

g) Legal services for an administrative appeal or hearing, or court proceeding involving the provider and the Department or any other state agency when judgment or relief is not granted to the provider. Legal services associated with certificate of need issuance reviews, appeals, disputes or court proceedings are not allowable regardless of outcome. Legal services associated with a provider's initial certificate of need request shall be allowable; and

h) Advertising costs that are (a) for fund-raising purposes, (b) incurred in the sale or lease of a facility or agency or in connection with issuance of the provider's own stock, or the sale of stock held by the provider in another corporation, (c) for the purpose of increasing patient utilization of the provider's facilities, (d) for public image improvement, or (e) related to government relations or lobbying.

8. When the outpatient cost-based settlements are made, claims for outpatient services which were paid at the per case rate will be excluded from the settlement calculations.

9. Hospital-based physicians services will not be reimbursed if billed to the Hospital program. These services must be billed to the Physician program in order to be reimbursed by the Department.

10. The Department will limit payment on outpatient Medicare crossover claims as using the following steps:

(a) multiply the allowable deductible and coinsurance amount by the hospital-specific percent of charges rate in effect on the date of payment;
(b) compare the dollar amount from (a) to the hospital's inpatient per case rate in effect on the date of payment and,
(c) reimburse the lower of these two amounts.

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11. A $3.00 recipient co-payment is required on all non-emergency outpatient hospital visits. Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospital care recipients are not subject to the co-payment. Emergency services and family planning services are exempt from co-payment. When the outpatient cost-based settlements are made for hospital services, the co-payments plus Medicaid and certain third party payments will be compared to the allowable cost to determine the amount of final settlement.

12. The Department shall exclude from paid claims data used to calculate settlement claims for which a third party paid at or in excess of the amount Medicaid would pay. Third party payments which were below the Medicaid payment amount will be included in the interim payment amounts that are compared to reimbursable costs. The paid claims data used in the initial determination of outpatient settlements will be used when such settlements are adjusted.

13. Effective July 1, 2013, an adjustment will be added to the hospital outpatient payment rate. Critical Access Hospitals (CAHs) Psychiatric Hospitals and State-Owned / State-Operated Hospitals are exempt from the provider fee and the rate increase. 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 adjustment for different classes of hospitals.

| **Provider Type** | Provider Fee Percent | Rate Increase Percent |
|---|---|---|
| Participating Acute Care Hospitals and Specialty Hospitals | 1.45% | 11.88% |
| Trauma Hospitals | 1.40% | 11.88% |
| Critical Access Hospitals, State-Owned and State-Operated Hospitals, Out-of-State Hospitals | N/A | N/A |

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This new base rate change will be a multiplier, which will be expressed as a constant percentage of the Allowed Charge. There will be three different values for this Base Rate Change factor. One will be used for Inpatient Medicare Crossover claims. The second will apply to Outpatient Medicare Crossover claims. The Third will apply to non-Crossover Hospital claims.

When calculating the Final Allowed Charge, the addition of this new Base Rate Change Add-on will be the final step before any cutbacks are considered. The dollar amount will be calculated as a percentage of the Allowed Charge at that point in adjudication.

**Outpatient Cost-to-Charge Ratio Base Payment is Calculated as:**

CCR Base Payment = Total Calculated Allowed Charge** x Cost-To-Charge Ratio (CCR)* percent

CCR Base Payment + Cap/GME Add-on + Newborn Add-on = Allowed Charge
Allowed Charge x .1188 Base Rate Change Factor)= Base Rate Change Add-on
Allowed Charge + Base Rate Change Add-on – deductions (Copay, COB, Patient Liability) = Reimbursement Amount
The payment is the lower of the reimbursement amount or the inpatient per case rate plus Base Rate Change add on.

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*The system finds the provider's Cost-To-Charge Ratio (CCR) percent on the reference institutional rate table using the provider number and the claim's admission date.

**Calculation of the Allowed Charge occurs for each claim line. The total of the claim line Allowed Charges is used to calculate the cost-to-charge ratio (CCR) base payment.

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Effective for dates of service on and after July 1, 2013, through June 30, 2017, the payment method is modified as follows:

a. For enrolled hospitals other than those identified in items b and 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,

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need sufficient funds for their commitments to meet the healthcare needs of all members of their communities.

The rate payment adjustments will be subject to federal upper payment limits. For the appropriate groupings of State governmental facilities, non-State governmental facilities and non-governmental facilities, aggregate rate adjustment payments available without exceeding upper payment limits will be determined by measuring the difference between:

- All amounts paid for services provided to Medicaid patients including interim Medicaid claim payments and estimated Medicaid cost report settlement amounts, based on data from cost report worksheet E-3 Part III, and
- Estimated payment amounts for such services if payments were based on Medicare payment principles. Cost based and rate payment measures (for clinical diagnostic lab services) will be used to determine Medicare payment amounts.

Comparisons of amounts paid for services provided to Medicaid patients and estimated payment amounts for such services if payments were based on Medicare payment principles will also be made for each facility to determine facility-specific rate adjustment payments. If an individual facility cannot be paid a portion of its full rate adjustment payment due to a facility-specific charge limit, this rate adjustment amount can be allocated to other facilities that are eligible to receive additional rate adjustment payments without exceeding facility-specific charge limits. These rate payment adjustments will be made on quarterly or, at least, annual basis and will be determined in a manner that will not duplicate compensation provided from payments for individual patient claims. A sample of how a rate adjustment payment is calculated is presented below.

| line | Facility Name | comments | XYZ Hospital |
|---|---|---|---|
| 1 | base period report period beginning date | | 9/1/xxxx |
| 2 | base period report period ending date | | 8/31/xxxx+1 |
| 3 | HS&R processing date for Medicaid data | | 9/6/xxxx+2 |
| 4 | adjustment factor (if period not equal to 1 year) | | 1 |

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| | | | |
|---|---|---|---|
| | | | |
| 5 | CAH status (1 = yes) | | 0 |
| | | | |
| | subject to cost settlement | | |
| 6 | cost of Medicaid covered services | | 755,769 |
| 7 | covered charges | | 2,511,680 |
| 8 | annual cost of Medicaid covered services | Line 6 x line 4 | 755,769 |
| 9 | cost settlement rate | | 95.77% |
| 10 | annual Medicaid payments after cost settlement | Line 8 x line 9 | 721,382 |
| | | | |
| | fee schedule lab only | | |
| | | | |
| 11 | payments | | 102,275 |
| | | | |
| 12 | annual interim payments | Line 11 x line 4 | 102,275 |
| 13 | estimated payments for fee schedule lab services if paid on Medicare Lab fee schedule | | 244,687 |
| | | | |
| | subject to fixed fee payment | | |
| 14 | covered charges | | 223,627 |
| 15 | payments | | 26,427 |
| 16 | annual covered charges | Line 14 x line 4 | 223,627 |
| 17 | annual interim payments | Line 16 x line 4 | 26,427 |

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| | | | |
|---|---|---|---|
| 18 | annual cost of services | Line 16 x line 6 / line 7 | 67,290 |
| | | | |
| | subject to limit of inpatient rate | | |
| 19 | covered charges | | 137,463 |
| 20 | payments | | 48,481 |
| 21 | annual covered charges | Line 20 x line 4 | 137,463 |
| 22 | annual interim payments | Line 21 x line 4 | 48,481 |
| 23 | annual cost of services | Line 21 x line 6 / line 7 | 41,363 |
| | | | |
| | adjustment factors | | |
| 24 | cost inflation | from cost report to UPL period | 1.040 |
| | | | |
| | | | |
| | | | |

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| | | | |
|---|---|---|---|
| 28 | volume allowance | from cost report to UPL period | 1.014 |
| | | | |
| 29 | adjusted Medicaid annual payments | [(Line 10 x line 24) + (line + ] x line 28 | 763,290 |
| 30 | adjusted annual cost of services | (Line 8 + line 13 + line 18 + line 23) x line 24 x line 28 | 1,169,622 |
| 31 | UPL amount | Line 30 – line 29 | 406,332 |

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**Footnotes for UPL Adjustment Factors:**

Line 26: Cost Inflation:

DCH uses Global Insight Hospital Market Basket (Table 6.3), as adopted by CMS, for all inflation-related hospital cost estimates. This quarter-by-quarter index provides a breakout of all relevant categories of hospital cost.

Line 30: Volume Allowance

This is primarily eligibility growth. DCH currently predicts Medicaid fee-for-service eligibility in the Aged, Blind and Disabled (ABD) population to grow annually at 1.4%.

15. Effective for dates of service April 1, 1991, and after, the Department will provide payment to enrolled hospitals which offer, either directly or through contract, birthing and parenting classes to Medicaid-eligible pregnant women. Reimbursement will be the lesser of the amount billed for revenue code 942 or the maximum allowable payment amount established by the Department. When the outpatient cost-based settlements are made, claims for outpatient services for birthing and parenting classes will be excluded from the settlement calculations as reimbursement is at a fixed payment rate.