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I. Cost Finding and Cost Reporting

A. Cost Reporting

1. Each hospital participating in the Georgia Medicaid Hospital Program will submit a Uniform Cost Report. The cost reporting period for the purpose of this plan shall be the same as that for the Title XVIII and Title V cost reporting, if applicable. A complete, legible copy of the cost report shall be submitted to the Medicare intermediary and to the Department as appropriate.

2. The cost report must be prepared in accordance the method of reimbursement and cost findings of Title XVIII (Medicare) principles of Reimbursement described in 42 CFR 413, Subparts A, B, C, D, E, F and G, and further interpreted by CMSCMS Publication 15 (HIM-15) except as modified by this plan. Allowable costs will not include reasonable costs that are in excess of customary charges. Only nominal charge providers will be exempt from the lesser of costs or charges principle. A nominal charge provider is a governmental provider which charges patients based on their ability to pay. These are charges which are token in nature and are not intended to be full reimbursement for the items or services furnished.

3. A hospital must furnish its cost report within five months after its fiscal year eud. If the report has not been received after this five-month period and a request for extension has not been granted, a written warning will be issued. This warning will indicate that if, after an additional month (total six months), the cost report has not been received, a one hundred percent reduction will be imposed on all payments made during that period that the cost report is late. These payments will be withheld until an acceptable Medicaid cost report is received. After the cost report is received and is determined to be acceptable, the withheld funds will be released. If the cost report is not received after seven months from the hospital' s fiscal year end, the hospital's agreement of participation will be subject to termination.

4. A hospital which voluntarily or involuntarily ceases to participate in the Georgia Medicaid program or experiences a change of ownership must file a final cost report within five (5) months of the date of termination or change of ownership. For the purpose of this plan, filing a final cost report is not required when: 1) the capital stock of a corporation is sold without change in title to assets or 2) a partnership interest is sold as long as one of the original limited partners becomes a general partner, or control remains

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unchanged. Any change of ownership must be reported to the Department within 45 days after such change of ownership.

5. All hospitals are required to maintain a Medicaid Log and financial and statistical records in accordance with 42CFR413.20 and 413.24.Forpurposesof this plan, statistical records shall include beneficiaries' medical request records. These records must be available upon to representatives, employees or contractors of the Department, State Auditors, the General Accounting Office (GAO) or the United States Department of Health and Services (HHS).

6. Records of related organizations as defined by 42 CFR413.17 must be available upon demand to representatives, employees or contractors of the Department, the Inspector General, GAO, or HHS.

7. The Department shall retain all uniform cost reports submitted for a period of at least three years following the date of submission of such reports and will maintain those reports pursuant to the record keeping requirements of 42 CFR 431.17. Access to submitted cost reports will be in conformity with Georgia law. Unless enjoined by a court of competent jurisdiction, the cost report will be released to the requestor.

B. Reasonable Cost of Inpatient Hospital Services

1. For each hospital also participating in the Health Insurance for the Aged program under Title XVIII of the Social Security Act, the State Agency will apply the same standards, cost reporting period, cost reimbursement principles, and method of cost apportionment currently used in computing reimbursement to such hospital under Title XVIII of the Act.

2. For each hospital not participating in the program under Title XVIII of the Act, the State Agency will apply the standards and principles described in 42 CFR 413.1 through 413.178, either (a) one of the available alternative cost apportionment methods in CFR 413.50, or (b) the "#Gross RCCAC method" of cost apportionment.

3. Allowable costs will be determined using Title XVIII (Medicare) Principles of Reimbursement and the guidelines in the CMS Publication15 (HIM-15) except as modified by Title XIX of the Act, this plan, requirements of licensure and certification and the duration and scope of benefits provided under the Georgia Medicaid Program. These include:

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a. Cost incurred by a hospital in meeting:

- The definition of a hospital contained in 42 CFR440.10 and 42 CFR 440.140 in order to meet the requirements of Section 1902(a)(13) and (20) of the Social Security Act; and
- The requirement established by the State Agency responsible for establishing and maintaining health standards under the authority of 42 CFR 431.610; and
- Any other requirements for licensing under the State law which are necessary for providing inpatient hospital services.

b. Medicaid reimbursement will be limited to an amount, if any, by which the hospital's per case rate exceeds the third party payment amount for each admission.

c. Under this plan, hospitals will be required to accept Medicaid reimbursement as payment in full for services provided. As a result, there will be no Medicaid bad debts generated by patients. Bad debts will not be considered as an allowable expense.

d. The Department does not use Medicare regulations regarding payment for malpractice insurance costs. The methodology that currently is used for Medicaid will continue to be applied in the determination of allowable costs.

e. All procedures or drugs ordered by the patient's physician that result in costs being passed on by the hospital to the Georgia Medicaid Program through the cost report shall be subject to review by the Department. All procedures determined through the Department's or hospital's utilization review committee to be unnecessary or not related to the spell of illness will require appropriate adjustments to the Medicaid Log. Such adjustments for a patient may be rescinded upon a determination made by the hospital utilization review committee or the Department of Medical Assistance as being medically necessary.

f. Reimbursable costs will not include those reasonable costs that exceed customary charges as outlined in CMS Publication 15, Part I, Chapter 26, Section 2614 (Carryover of Unreimbursed Cost).

4. The costs listed below are nonallowable. Reasonable costs used in the establishment of rates will reflect these costs as nonallowable.

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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 of 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 expenses in excess of 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 patient transport, the portion of cost that is unrelated to patient care staff or patient transport is nonallowable;

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 reviews, issuance 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.

C. Audits

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1. Background – To assure that recognition of reasonable cost is being achieved, a comprehensive hospital audit program has been established. The hospital common audit program has been established to reduce the cost of auditing submitted reports under the above three programs and to avoid duplicate auditing effort. The purpose is to have one audit of a participating hospital which will serve the needs of all participating programs reimbursing the hospital for services rendered.

2. Common Audit Program

The Department has entered into a written agreement with the Georgia based Medicare intermediary for participation in a common audit program of Titles VI XVIII and XIX. Under this agreement, the intermediary shall provide the result of Department the result desk review and field audits of those hospitals located in Georgia.

3. Other Hospital Audits

For those hospitals not covered by the common audit agreement with the Medicare intermediary, the Department shall be responsible for the performance of desk reviews and field audits, the Department shall:

a. Determine the scope and format for on-site audits.

b. Contract annually for the performance of desk reviews and audits.

c. Ensure all audits are performed in accordance with generally accepted auditing standards of the AICPA.

d. Ensure that only those expense items that the plan has specified as allowable costs under Section III of this plan have been included by the hospital in the computation of the costs of the various services provided under Title XIX in Georgia;

e. Review to determine the Georgia Medicaid Log is properly maintained and current in those hospitals where its maintenance is required.

4. Retention of Cost Reports

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All audited cost reports received from the Medicare intermediary or issued the Department will be kept in accordance with42 CFR 431.17.

5. Overpayments and Underpayments

The Department may adjust the reimbursement of any provider whose rate is established specifically for it on the basis of cost reporting, whenever the Department determines that such adjustment is appropriate. The provider shall be notified in writing of the Department's intention to adjust the rate, either prospectively, retroactively or both. The terms of payment will be in accordance with the Department's policy. All overpayments will be reported by the Department to CMSCMS as required. Information intentionally misrepresented by a hospital in the cost report shall be grounds to suspend the hospital from participation in the Georgia Medicaid Program.

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II. Rate Setting

Overview - The Georgia Department of Community Health will reimburse qualified providers for inpatient hospital services under the prospective payment system as set forth in this plan.

A. Data Sources and Preparation of Data for Computation of Prospective Rates

The calculation of prospective rates requires the use of claims data, cost data and supplemental expenditure data. The historical claims data is obtained from a chosen base year, with adjustments for inflation. For rates effective July 1, 1998, inflation rates are based on projections as calculated by DRI, reduced by 1% per year; this inflation rate may be updated periodically. The cost data is derived from a cost report year where the majority of hospitals have audited data. For rates effective on July1, 2002, audited data was available for hospital fiscal years ending in 1999 for a majority of hospitals. Hospitals without audited data in the chosen year will have data derived from the hospital's most recently audited cost report; for rates effective July 1, 2002, if audited cost report data is not available for a period ending on or after July 31, 1996, a recent unaudited cost report will be used. The supplemental data is obtained from state supplemental expenditure surveys. The rate components are used in the calculation of the prospective rates as described in Section II of this plan. II.

B. Payment Formulas

Non-Outlier DRG Payment Per Case =(Hospital-Specific Base Rate x DRG Relative Rate) +Capital Add-on +GME Add-on (if applicable)

Outlier DRG Payment Per Case =(Hospital-Specific Base Rate x DRG Relative Rate) + {[(Allowable Charges x Hospital-Specific Operating Cost to Charge Ratio)-(Hospital-Specific Base Rate x DRG Relative Rate)] x A Percentage} +Capital Add-on +GME Add-on (if applicable)

C. Discussion of Payment Components

1. Base Rates

All hospitals are assigned to a peer group in order to develop a base rate that best matches payments to costs for hospitals that provide similar services. The peer group base rate is

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obtained by calculating the average operating cost standardized for case mix of Inlier DRG cases across all cases in a peer group. If a hospital is assigned to the statewide or pediatric peer group, the peer group base rate becomes the hospital-specific base rate. If a hospital is assigned to the specialty peer group and has a sufficient claim volume, the hospital-specific base rate will be the greater of the peer group base rate or the individual hospital's base rate. If a hospital is assigned to the specialty peer group and does not have a sufficient claim volume, the peer group base rate becomes the hospital-specific base rate. For each case paid within the DRG methodology, the hospital specific base rate will be multiplied by the appropriate DRG relative weight to calculate a payment.

2. Calculation of the Capital Add-on Amount

Hospitals receive a hospital-specific add-on based on capital costs from the cost report year, charges from the rate setting base year and supplemental data from the capital expenditure survey.

3. Calculation of the Direct Graduate Medical Education (GME) Add-on Amount

Only hospitals which have GME costs in the cost report year receive the GME add-on amount. The Medicaid portion of GME from the hospital's cost report year is inflated, then divided by the number of cases in the base year to obtain the GME add-on. For rates effective July 1, 1998, inflation rates are based on projections as calculated by DRI, reduced by 1% per year; this inflation rate may be updated periodically.

4. Determination of Capital and Graduate Medical Education (GME) Add-On Amounts

The basis for the determination of capital add-on amounts and GME add-on amounts are described below. All hospital-specific information is based on data from three sources:

(a) the hospital's most recently audited cost report for hospital fiscal year 1999 or before as of February 2002 (for capital and GME add-on amounts)
(b) the hospital's capital surveys from the base year to December 31, 2001 (for capital add-on amounts only)
(c) state fiscal year 2001 Georgia Medicaid and PeachCare paid claims data (for hospitals with a limited number of paid claims, add-on amounts may be determined based on average amounts for other hospitals.)

Part 1 - Calculation of the Capital Add-On Amount

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(a) A Medicaid allocation ratio is used to apportion the Medicaid portion of the hospital's total capital. The allocation ratio is the hospital's Medicaid inpatient costs divided by total hospital costs.
(b) Sum the hospital's capital costs (total building and fixtures) and capital costs (total major movable) from the cost report.
(c) Determine the Medicaid allocation of capital costs from the cost report by multiplying the Medicaid allocation ratio (Item 1 (a)) by total capital costs from the cost report (Item 1 (b)).
(d) Determine the capital CCR by dividing the Medicaid allocation of capital costs (Item 1(c)) by the total allowed Medicaid charges for the cost report period.
(e) Calculate the base year capital costs by multiplying the capital CCR by the base year allowed charges.
(f) Calculate the preliminary capital costs per case by dividing the base year capital costs (Item 1(e)) by the base year number of cases.
(g) Sum the total amounts from the capital expenditure surveys.
(h) Determine the Medicaid allocation of capital costs from surveys by multiplying the Medicaid allocation ratio (Item 1(a)) by total capital from surveys (Item 1(d)).
(i) Determine the survey rate of increase by dividing Item 1(h) by item 1(c).
(j) Calculate the Capital Add-On Amount by multiplying Item 1(f) by one plus Item 1(i).

Part 2 - Calculation of the Direct Graduate Medical Education (GME) Add-On Amount
Only hospitals, which have GME costs in the hospital' s most recently audited Medicare cost report, receive the GME add-on amount.

(a) A Medicaid allocation ratio is used to apportion the Medicaid portion of the hospital's GME. The allocation ratio is the hospital's Medicaid inpatient costs divided by total hospital costs.
(b) Use the hospital's GME costs from the cost report.
(c) Determine the Medicaid allocation of GME costs from the cost report by multiplying the Medicaid allocation ratio (Item 1 (a)) by total GME costs from the cost report (Item 1 (b)).
(d) Determine the GME CCR by dividing the Medicaid allocation of GME costs (Item 1 (c)) by the total allowed Medicaid charges for the cost report period.
(e) Calculate the base year GME costs by multiplying the GME CCR by the base year allowed charges.
(f) Multiply the Medicaid GME amount (Item 1(e)) by the DRI inflation factor. This will yield the inflated Medicaid GME amount.

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(g) Divide the total Medicaid allocation of GME (Item 1(f)) by the Medicaid discharges from the base year. This will yield the Medicaid GME amount per discharge.

D. Special Payment Provisions

1. New Facilities

New facilities under the DRG system will receive payments using the same payment formulas as stated in Section II. However, the components of the formulas will be calculated on a statewide average. A new facility will receive a hospital-specific base rate that is equal to the statewide average rate for the appropriate peer group in which the hospital is classified and a capital add-on payment equal to the statewide average add-on payment for the appropriate peer group.

2. Out-of-State Facilities

Out-of-state facilities under the DRG system will receive payments using the same payment formulas as stated in Section II. However, the components of the formulas will be calculated on a statewide average. An out-of-state facility will receive a hospital specific base rate that is equal to the statewide average rate for the appropriate peer group in which the hospital is classified, a capital add-on payment equal to the statewide average add-on payment for the appropriate peer group, and a cost-to-charge ratio that is equal to the Georgia statewide average of the cost-to-charge ratios.

3. New Medicaid Providers

Prospective payment rates for established facilities which did not submit a hospital-specific Medicare cost report because the facility did not participate in the Medicaid program will be determined in the same manner as a new facility stated in section III.A.

E. DRG Grouper

On or after October 1, 1999, the grouper used to classify cases into DRG categories will be changed from CHAMPUS Grouper version 15.0 to CHAMPUS Grouper version 16.0. The grouper used to assign claims to DRG categories, as well as the corresponding DRG weights and threshold amounts, may be updated periodically.

F. Reviews and Appeals

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In general, providers may submit written inquiries concerning the rate determination process or requests for review of their specific rates. Only the following will be considered under the procedures herein described:

- Evidence that the audited cost report figures used to determine the base rate contained an error on the part of the Department or its agents.
- Evidence that the Department made an error in calculating the prospective rate of payment.
- Evidence that the Department is not complying with its stated policies in determining the base rates, trend factor, or utilization constraints.

Information concerning the base rate and prospective rate will be provided to each hospital prior to the effective date. A hospital will have 30 days from the date on the correspondence to submit a request for adjustment concerning the rate determination process. If no adjustment request is submitted within this time period, a hospital may not contest its rate of payment. There is no time limitation for the Department to reduce a hospital's rate when an error is discovered.

Written requests must be submitted to the Coordinator of the Hospital Reimbursement Unit. Requests for review must include evidence on which the request is being based. Hospitals which do not submit written request or inquiries within thirty days of the date of such information will be considered to have accepted their rates as received. Similarly, failure of the hospital to state the basis for review and to include relevant supporting evidence for the Department's consideration, when requesting an Administrative Review, will also result in a denial of further appeal rights on the rate of payment. The Coordinator of Hospital Reimbursement will have sixty (60) days from the date of receipt to render a decision concerning the written requests or inquiries submitted by a hospital if no additional information is required. The Coordinator may have more than sixty (60) days to render a decision if additional information is requested. If the Coordinator of Hospital Reimbursement requests additional information, the request must be issued within thirty (30) days of receipt, and the hospital must respond within thirty (30) days of receipt of such request. The Coordinator of Hospital Reimbursement will have thirty (30) days from the receipt of the additional information to render a decision in writing. The failure of the Coordinator of Hospital Reimbursement to render a decision within the above-stated time frame will result in a decision in favor of the hospital concerning the issue raised by the hospital on appeal.

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Failure of a hospital to provide information within the specified time frame as requested by the Coordinator of Hospital Reimbursement will result in the denial of the hospital's appeal by the Coordinator of Hospital Reimbursement. A hospital which disagrees with the determination of the Coordinator of Hospital Reimbursement may request a hearing. If the request is not received by the Office of Legal Services within ten (10) days of the date of the Coordinator's decision, the hospital will be deemed to have waived any and all further appeal rights.

G. Co-Payment

A co-payment of $12.50 will be imposed for certain inpatient hospital admissions. Recipients affected by the copayment are limited to adult recipient of Supplemental Security Income (SSI) benefits, certain other adult disabled and aged recipients and parents of children receiving Aid to Families with Dependent Children (AFDC) benefits. Children under age twenty-one, pregnant women, nursing home residents, or hospice care participants are not required to pay this copayment. Emergency services and Family Planning services received by Medicaid recipients do not require a copayment. Services cannot be denied based on the inability to pay these copayments.

H. Administrative Days

Administrative days are those days that a recipient remains in acute care setting awaiting placement in a nursing facility due to the unavailability of a bed. Administrative days may occur in the two situations outlined below.

- Following the physician's written order for discharge on the chart.
- When a utilization review denial letter is given prior to the physician's written order for discharge.

The allowable covered number of administrative days is three or 72 hours for either situation outlined above. Any days greater than three that a recipient remains in the acute care setting awaiting placement in a nursing facility are noncovered days.

I. Hospital Crossover Claims

The maximum allowable payment to enrolled Georgia and non-Georgia hospitals for Medicare inpatient deductibles and coinsurance (crossover claims) will be the hospital-specific Medicaid per case rate. The maximum allowable payment to non-Georgia

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hospitals not enrolled the Georgia Medicaid program for Medicare inpatient crossover claims will be the average hospital-specific inpatient per case rate for enrolled non-Georgia hospitals.

J. Payment In Full

1. Participating in-state providers must accept the amount paid in accordance with the Georgia Title XIX Inpatient Hospital Reimbursement Plan as payment in full for covered services.

2. Settlement
For admissions occurring each calendar year, a comparison of a hospital's total Medicaid payments and its total charges will be made after completion of the calendar year. Except for hospitals receiving designation as a Critical Access Hospital in Georgia, a refund will be due from the hospital for any amount by which total Medicaid payments are in excess of a hospital's total charges for Medicaid patients. Total Medicaid payments included in the comparison shall not include payment adjustments made to Georgia or non-Georgia enrolled disproportionate share hospitals. Total payments will include the appropriate inpatient hospital copayments.

K. Expanded Newborn Screening Program

Effective for services provided on and after January 1, 2007, an additional payment of $40 per newborn admission will be made to fund costs associated with the expansion of the newborn screening program administered by the Georgia Department of Human Resources.

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III. Disproportionate Share Hospitals (DSH)

Federal regulations require that methods and standards used to determine payment rates must take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs. In the month of June of each year, the Department designates enrolled Georgia hospitals as disproportionate share based upon the definition below, a review of annual disproportionate share hospital surveys, review of hospital cost reports, and the requirements of Section 1923 of the Social Security Act. On or around June30 of each year, hospitals will be notified of their designation as disproportionate share and the effective date thereof. A provider will not be designated a disproportionate share hospital at any other time during the year. Should a hospital lose its disproportionate share designation, it must wait until next disproportionate share hospital designation period (June) to be considered again for the designation. A hospital serving a disproportionate number of low income patients with special needs is defined as:

(1) One whose Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments; or

(2) One which has a low-income inpatient utilization rate exceeding25 percent; or

(3) One with total Medicaid charges for paid claims, inpatient and outpatient, exceeding 15 percent of total revenue; or

(4) A non-State hospital with the largest number of Medicaid admissions in its Metropolitan Statistical Area; or

(5) A children's hospital; or

(6) A hospital that has been designated a Regional Perinatal Center by the Department of Human Resources; or

(7) A Georgia hospital that has been designated a Medicare rural referral center and a Medicare disproportionate share hospital provider by its fiscal intermediary; or A Georgia hospital which is a Medicare rural referral center and which has 10% or more Medicaid patient days and 30% or more Medicaid deliveries; or

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no health insurance, or other source of third party coverage, less the amount of non-DSH payments for services provided during the year plus received payments from patients with no insurance, or other third party coverage. Payments made by a state or local government to a hospital for indigent patients shall not be considered a source of third party payment.

Effective for DSH payment adjustments made on or after April 1, 2006, 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 federal allotment and required state matching contribution.
2. Hospitals that meet both federal DSH eligibility criteria and at least one Division of Medical Assistance DSH criterion will be eligible to receive an allocation of available DSH allotment funds.
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 and uninsured patients based on federal definitions.
4. The amount of funds available for DSH payments will be allocated among eligible hospitals.
5. Each hospital's DSH limit will be used as the basis for any allocation, subject to the following adjustments:
   a. For non-governmental hospitals, the allocation basis will be reduced by 0.394.
   b. For hospitals receiving Upper Payment Limit (UPL) rate adjustments, the allocation basis will be increased by the amount of UPL rate adjustments multiplied by 0.394.
   c. For hospitals receiving rate adjustment payments related to medical education, neonatal services or services provided under contract with the Georgia Department of Human Resources, the allocation basis will be increased by the amount of such rate adjustments.
   d. For hospitals meeting either criterion listed below, their allocation will be increased by 10%:
      i. One whose Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments; OR
      ii. One which has a low-income utilization rate exceeding 25 percent.
6. An allocation pool will be established for small rural hospitals, defined as hospitals with less than 100 beds located in rural counties. A county will be considered rural if the county is <u>not</u> in a Metropolitan Statistical Area, as defined by the United States Office of Management and Budget, or if the population of the hospital's county is

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35,000 or less. Total funds available will be based on the share of DSH funds paid to this category of hospitals for FY 2005. The department will calculate the ratio of a hospital's adjusted DSH limit amount to the aggregate of all adjusted DSH limit amounts for all hospitals in the allocation pool. A hospital's DSH payment will be based on its individual ratio applied to the allocation pool. Should the amount calculated for a hospital exceed the hospital's DSH limit, the excess amount will be redistributed to the remaining hospitals in the allocation pool.

7. After the allocation of funds to small rural hospitals, remaining DSH funds will be distributed to all other eligible hospitals. The department will calculate the ratio of a hospital's adjusted DSH limit amount to the aggregate of all adjusted DSH limit amounts for all hospitals in the 2nd allocation pool. A hospital's DSH payment will be based on its individual ratio applied to the 2nd allocation pool. Should the amount calculated for a hospital exceed the hospital's DSH limit, the excess amount will be redistributed to remaining hospitals in the 2nd allocation pool.
8. Total DSH payment amounts for non-governmental hospitals will be compared to the maximum amount of payments that may be made to these facilities, determined by the amount of State matching funds appropriated to the Department for this specific purpose. Should the DSH payment amounts calculated exceed the maximum amount, the excess will be redistributed proportionally from the non-governmental facilities that are not rural hospitals with less than 100 beds, to the governmental non-rural hospitals (i.e., 2nd allocation pool discussed in #7).

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While the fifth and last bullets both use the term "for all other eligible hospitals," the terms refer to different groups of hospitals. As described in the fifth bullet, 50% of the maximum DSH payment adjustment is used as the basis for allocation for hospitals that meet either of the following conditions: non-governmental hospitals in urban areas; non-governmental hospitals in rural areas that have more than 199 beds.

For the fifth bullet, "all other eligible hospitals" are governmental hospitals and non-governmental hospitals in rural areas with less than 200 beds, for which 100% of the maximum DSH payment adjustment is used as the basis for allocation.

As described in the sixth bullet, hospitals with less than 100 beds located in rural counties will receive a payment adjustment for the maximum amount, subject to other limitations described previously in the policy. For the last bullet, "all other eligible hospitals" refers to hospitals meeting either of the following conditions: hospitals located in urban areas; hospitals located in rural counties and with more than 99 beds. For these hospitals, the payment adjustment amount is based on an allocation of remaining available funds.

The last bullet applies to hospitals located in urban areas or located in rural counties and with more than 99 beds. For each of these hospitals, an allocation basis is determined by measuring the unreimbursed cost for services to Medicaid and uninsured patients and applying an adjustment factor of either 50% or 100%. All hospital allocation basis amounts are summed to calculate an aggregate amount. A hospital specific percentage is calculated for each hospital by dividing the hospital's allocation basis amount by the aggregate amount. The hospital specific percentage is then applied to the total amount of funds available to determine the amount of a hospital's payment adjustment. The following example demonstrates how these calculations are applied:

- Hospital A unreimbursed cost for services to Medicaid and uninsured = $20,000,000
- Hospital A adjustment factor =50%
- Hospital A allocation basis =$20,000,000 x 50% =$10,000,000
- Aggregate amount =sum of Hospital A +other allocation basis amounts = $500,000,000
- Hospital A percentage =$10,000,000 / $500,000,000 =2%
- Remaining funds available =$300,000,000
- Hospital A adjustment payment =2% x $300,000,000 =$6,000,000

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IV. Other Rate Adjustments

Upper Payment Limit Rate Adjustments

For payments made for services provided on or after July 1, 2005, the following types of hospitals will be eligible for rate payment adjustments:

- State government-owned or operated facilities;
- Non-State government owned or operated facilities;
- Federally defined Critical Access hospitals;
- Hospitals designated by the Georgia Department of Human Resources as Regional Perinatal Centers;
- Hospitals providing the following program services for the Georgia Department of Human Resources: AIDS Clinic, Poison Control Center, Genetics/Sickle Cell Screening and Maternal and Infant Health Services; and
- Hospitals participating in selected residency grant programs administered by the Georgia Board for Physician Workforce.

The rate adjustment payments are intended to provide supplemental funding for Medicaid services to these facilities that need sufficient funds for their commitments to meet the healthcare needs of all members of their communities and to ensure that these facilities receive financial support for their participation in programs vital to the state' s healthcare infrastructure.

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

- Amounts paid for services provided to Medicaid patients and
- Estimated payment amounts for such services if payments were based on Medicare payment principles. Either cost based or rate payment measures may be used as Medicare payment principles.

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

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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 a monthly, quarterly or 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 on the following page.

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	Facility Name	XYZ Hospital
1	base period report period beginning date	9/1/2003
2	base period report period ending date	8/31/2004
3	HS&R processing date for Medicaid data	9/6/2005
4	adjustment factor (if period not equal to 1 year)	1.00000
5		
6	Medicaid inpatient claims paid at amount >0:	
7	covered charges	3,949,268
8	payments	1,828,506
9	annual covered charges	3,949,268
10	annual payments	1,828,506
11		
12	inpatient CCR	0.446156
13		
14	annual cost of services	1,761,990
15		
16	adjustment factors	
17	claim completion	1.029799
18	inflation	1.073852
19	volume allowance	1.212883
20	combined adjustment factors	1.341269
21		
22	adjusted annual charges	5,297,031
23	adjusted cost of services	2,363,303
24	adjusted Medicaid payments	2,452,518
25	supplemental inpatient rate adjustments	0
26	total Medicaid payments	2,452,518
27		
28	DRG differential	1.176249
29	adjusted Medicare-based annual payments	2,884,772
30	UPL estimate	432,254

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V. Other Information

A. Payment Assurance

The State will pay each hospital for services provided in accordance with the requirements of the Georgia Title XIX State Plan and applicable State and Federal rules and regulations. The payment amount shall be determined for each hospital according to the standards and methods set forth in the Georgia Title XIX inpatient Hospital Reimbursement Plan.

Hospitals will continue to submit claims as they have in the past. All requirements for documented services and charges will remain in effect, and all screens for completeness will continue. Hospital claims will be subject to post-payment review. The Department will be requesting information from the hospitals to substantiate the necessity and appropriateness of services rendered. Any denials for lack of medical necessity, documentation, or other reasons will result in recoupment of monies paid to the provider. A reduced rate for less than acute care is not applicable nor required.

Unlike a per diem or percent or charges system, this reimbursement plan does not provide incentives for prolonging a patient's stay. If a patient remains in the hospital beyond the time of medical necessity, the effect is to reduce the daily reimbursement rate.

B. Provider Participation

This plan is designed to assure adequate participation of hospitals in the Medicaid Program, the availability of hospital services of high quality to recipients, and services within which are comparable to those available to the general public.

C. Swing-bed Services

1. Reimbursement Methodology

Swing-bed providers will be reimbursed a prospective rate per patient day which will be the statewide average Medicaid rate per diem paid to Level I nursing facilities for routine services furnished during the previous calendar year. The per diem rate covers the cost of certain routine services as described in Attachment 3.1A, page lc-3 of the Plan. Ancillary services such as laboratory, radiology, and certain prescription drugs must be billed and reimbursed separately under the appropriate Medicaid program. For example, radiology

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services provided in the outpatient department of the hospital should be billed as outpatient hospital services. Providers must bill on a monthly basis.

Medicaid will reimburse the Medicare Part A coinsurance for skilled level care of swing-bed services provided to Medicaid/Medicare recipients.

Medicaid reimbursement will be reduced by the amount of the recipient's liability (patient income).Patient income is established by the county DFACS office and is the dollar amount shown on Form DMA-59, or the dollar amount shown on Form DMA-286 if the recipient has Medicaid/Medicare coverage. The patient's income is deducted in full from the Medicaid reimbursement rate until the income has been exhausted.

2. Cost Report and Cost Settlement

There will not be a year-end cost settlement process for the swing-bed services program. In addition, there is no swing-bed services cost report. Medicaid Swing-Bed program data should not be included in the Medicaid Hospital program cost report settlement data. The Medicaid routine swing-bed days should be excluded from the hospital's Medicaid routine days on Worksheet D-1, Part I of the cost report.

D. Public Process

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

E. Revisions

The plan will be revised as operating experience data are developed and need for changes is necessary in accordance with Federal and State regulations. If it is found that there are insufficient controls on utilization transfers or cost, or if the Department determines that a different reimbursement methodology is warranted, the Department maintains its right to discontinue this system upon appropriate public notice of the proposed change.

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date specified in the request. These documented costs, related only to buildings and fixed equipment, will be utilized to adjust the depreciation and interest component of base year costs. There will be no adjustment for depreciation and interest on major movable equipment. Costs associated with a revaluation of assets as a result of the sale or lease of a facility which occurred after November 8, 1983, will not be considered for the purpose of determining or adjusting a hospital's rate of payment.

E. Trend Factor

Effective July 1, 1991, the trend factors used to inflate base year operating costs to the reimbursement year is calculated using Data Resources inflation factors of 5.2%, 5.1%, 4.7%, 5.8% and 1.325% for calendar years 1988, 1989, 1990, 1991 and the first quarter of 1992, respectively. The 1988 factor is prorated based on the hospital's fiscal year end. This applies to enrolled Georgia and non-Georgia hospitals.

Effective July 1, 1992, the trend factors used to inflate base year operating costs to the reimbursement year is calculated using Data Resources inflation factors of 5.4%, 4.9%, 4.2%, 4.1% and 2.45% for calendar years 1989, 1990, 1991, 1992 and the second quarter of 1993, respectively. The 1989 factor is prorated based on the hospital's fiscal year end. This applies to enrolled Georgia and non-Georgia hospitals.

In addition, an intensity allowance equal to the total calculated payment adjustment percentage is added to the trend factor for disproportionate share hospitals, effective with dates of admission July 1, 1992, and after. The payment adjustment percentage is one percent (1%) per year of inflation beginning with the first full year that inflation is added. Tnis applies to enrolled Georgia and non-Georgia disproportionate share hospitals.

Effective July 1, 1993, the trend factor used to inflate base year operating costs to the reimbursement year is calculated using the sum of Data Resources inflation factors of 5.1%, 4.7%, 3.7%, 4.9% and 2.7% for calendar

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years 1990, 1991, 1992, 1993 and the second quarter of 1994, respectively. The 1990 factor is prorated based on the hospital's fiscal year end. This applies to enrolled Georgia and non-enrolled hospitals.

In addition, an intensity allowance equal to the total calculated payment adjustment percentage is added to the trend factor for disproportionate share hospitals, effective with dates of admission July 1, 1993, and after. The payment adjustment percentage is one percent (1%) per year of inflation beginning with the first full year that inflation is added. This applies to enrolled Georgia and non-Georgia disproportionate share hospitals.

Effective July 1, 1994, the trend factor used to inflate base year operating costs to the reimbursement year is calculated using the sum of Data Resources inflation factors of 3.7%, 3.1%, 3.0%, 3.6% and 1.85% for calendar years 1991, 1992, 1993, 1994 and the second quarter of 1995, respectively. The 1991 factor is prorated based on the hospital's fiscal year end. This applies to enrolled Georgia and non-Georgia hospitals.

In addition, an intensity allowance equal to the total calculated payment adjustment percentage is added to the trend factor for disproportionate share hospitals, effective with dates of admission July 1, 1994, and after. The payment adjustment percentage is one percent (1%) per year of inflation beginning with the first full year that inflation is added. This applies to enrolled Georgia and non-Georgia disproportionate share hospitals.

Effective with dates of admission of July 1, 1994, and after, one percent per year will be added to the DRI trend factor for Georgia rural (non-MSA) hospitals with less than 100 beds.

Effective July 1, 1995, the trend factor used to inflate base year operating costs to the reimbursement year is calculated using the sum of Data Resources inflation factors of 3.6%, 3.0%, 2.5%, 3.9% and 2.0% for calendar years 1992, 1993, 1994, 1995 and the second quarter of 1996, respectively. The 1992 factor is prorated based on the hospital's fiscal year end. This applies to enrolled Georgia and non-Georgia hospitals.

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In addition, an intensity allowance equal to the total calculated payment adjustment percentage is added to the trend factor for disproportionate share hospitals, effective with dates of admission July 1, 1995, and after. The payment adjustment percentage is one percent (1%) per year of inflation beginning with the first full year that inflation is added. This applies to enrolled Georgia and non-Georgia disproportionate share hospitals.

8/15/96 Effective August 15, 1996, the trend factor used to inflate base year operating costs to the reimbursement year is calculated using the sum of Data Resources inflation factors of 2.0% (proated), 1.5%, 2.4%, 1.9% and 1.0% for calendar years 1993, 1994, 1995, 1996 and the second quarter of 1997, respectively. The 1993 factor is prorated based on the hospital's fiscal year end. This applies to enrolled Georgia hospitals.

In addition, an intensity allowance equal to the total calculated payment adjustment percentage is added to the trend factor for disproportionate share hospitals, effective with dates of admission August 15, 1996, and after. The payment adjustment percentage is one percent (1%) per year of inflation beginning with the first full year that inflation is added. This applies to enrolled Georgia hospitals.

F. Utilization Allowance

In order to discourage inappropriate increases in the utilization of inpatient services, a hospital-specific utilization allowance will be established. For each hospital, the allowance for a calendar year will be calculated as follows: The number of cases admitted during the prior state fiscal year (July 1 through June 30), determined by the Department's paid claims file as of November 15, will be adjusted by the projected change in the statewide recipient utilization for the prior state fiscal year. The recipient utilization projection will be weighted according to the various categories of eligibility. Hospitals will receive full reimbursement at their per case rates for all admissions in the calendar year up to that allowance. From 100% of this allowance, to 103% of this allowance, hospitals will be reimbursed 50% of the per case rate. For admissions beyond 103% of this allowance, hospitals will be

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reimbursed 25% of the per case rate. Effective with dates of admission of January 1, 1989, and after, all admissions to disproportionate share hospitals for deliveries, pregnancy-related diagnoses and children up to 12 months of age will not be counted toward the utilization allowance. These admissions will be paid at 100% of the per case rate.

Effective January 1, 1990, a utilization allowance will no longer be established for each hospital for each calendar year.

G. Disproportionate Share Hospitals (DSH)

Federal regulations require that methods and standards used to determine payment rates must take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs. In the month of June of each year, the Department designates enrolled Georgia hospitals as disproportionate share based upon the definition below, a review of annual disproportionate share hospital surveys, review of hospital cost reports, and the requirements of Section 1923 of the Social Security Act. On or around June 30 of each year, hospitals will be notified of their designation as disproportionate share and the effective date thereof. A provider will not be designated a disproportionate share hospital at any other time during the year. Should a hospital lose its disproportionate share designation, it must wait until the next disproportionate share hospital designation period (June) to be considered again for the designation. A hospital serving a disproportionate number of low income patients with special needs is defined as:

(1) One whose Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments; or

(2) One which has a low-income inpatient utilization rate exceeding 25 percent; or

(3) One with total Medicaid charges for paid claims, inpatient and outpatient, exceeding 15 percent of total revenue; or

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(4) A non-State hospital with the largest number of Medicaid admissions in its Metropolitan Statistical Areas: or

(5) A children's hospital; or

(6) A hospital that has been designated a Regional Perinatal Center by the Department of Human Resources; or

(7) A Georgia hospital that has been designated a Medicare rural referral center and a Medicare disproportionate share hospital provider by its Medicare intermediary; or A Georgia hospital which is a Medicare rural referral center and which has 10% or more Medicaid patient days and 30% or more Medicaid deliveries; or

(8) A State-owned or operated teaching hospital administered by the Board of Regents; or

(9) A public hospital with less than 250 beds located in a non-metropolitan statistical area (non-MSA).

No hospital may be designated a disproportionate share hospital provider unless 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 a hospital 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.

DSH hospitals meeting any of the first eight criteria listed above will have an intensity allowance (payment adjustment) of 1 percent per year added to the trend factor. Hospitals which have a Medicaid inpatient utilization rate at least one standard deviation above the mean statewide rate will have an

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additional payment adjustment calculated and added to the trend factor which is proportional to the percentage by which the hospital's Medicaid utilization rate exceeds one standard deviation above the mean Medicaid statewide inpatient utilization rate for hospitals receiving Medicaid payment. The additional payment adjustment will be a calculated percentage of the 1 percent per year intensity allowance mentioned above. The additional payment adjustment will be computed by subtracting the mean Medicaid statewide utilization rate plus one standard deviation from each hospital's Medicaid inpatient utilization rate. The difference will be divided by the mean Medicaid statewide utilization rate plus one standard deviation, resulting in the percentage by which the hospital's Medicaid utilization rate exceeds one standard deviation above the mean Medicaid statewide inpatient utilization rate. This percentage will be multiplied by 1 percent resulting in the additional payment adjustment percentage. The additional payment adjustment percentage will be added to the base disproportionate share hospital intensity allowance of 1 percent to calculate the increase for one year. The one year factor will be allowed for the number of full years for which inflation is allowed, i.e., if inflation is allowed for two full years. Hospitals whose Medicaid inpatient utilization rate does not exceed the mean Medicaid statewide utilization rate plus one standard deviation, will receive only the base disproportionate share hospital intensity allowance of 1 percent for each year.

Effective with DSH payment adjustments made for admissions on and after July 1, 1995, the DSH provisions below will apply.

(1) No hospital can be deemed or defined as a disproportionate share hospital unless the hospital has a Medicaid inpatient utilization rate of at least 1% in addition to at least one other established DSH criteria as outlined at Section V.G.

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(2) The DSH payments to public and non-public hospitals may not exceed the costs incurred during the year of furnishing hospital services to Medicaid patients and to patients who have no health insurance, or other source of third party coverage, less the amount of non-DSH payments for services provided during the year plus payments received from patients with no insurance, or other third party coverage. Payments made by a state or local government to a hospital for indigent patients shall not be considered a source of third party payment.

All disproportionate share hospitals will have their total calculated payment adjustment percentage added to the trend factor used in calculating their per case rates effective with dates of admission beginning July 1, 1990, and after. Previously, two-thirds (2/3) of the total payment adjustment percentage was included in the trend factor.

Effective with dates of admission beginning July 1, 1989, and after, an enrolled hospital designated as disproportionate share by the Department or the Medicaid agency in the state in which it is located will be eligible to receive an outlier payment adjustment for medically necessary inpatient hospital admissions involving exceptionally long lengths of stay for individuals under age six (refer to Item XIII for policy for non-disproportionate share hospitals). To qualify for this day outlier payment, the length of stay for individuals under age six must exceed the hospital-specific threshold, which is defined as the mean length of stay plus three standard deviations. The day outlier payment will equal the number of days in excess of the threshold times the hospital-specific per admission rate per day. This rate per day will be the hospital-specific per case rate divided by the hospital-specific average length of stay for all Medicaid admissions. The base period used for calculation of the threshold and the per admission rate per day will be the period on which the hospital's prospective per case rate is based.

Effective with admissions on and after July 1, 1990,

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the disproportionate share hospital (DSH) providers which directly received grant funds in 1989 from the Department of Human Resources' (DHR) Regionalized Infant Intensive Care Program will have their rates revised to include an additional DSH payment adjustment. These hospitals provide intensive care services to a disproportionate number of high risk neonates and incur significant unreimbursed costs associated with the provision of such services. The payment adjustment will include reported unreimbursed costs of neonatal intensive care and related transportation services as determined by DHR and reviewed and accepted by the Department; no other items are included in this payment adjustment. Effective with admissions on and after July 1, 1991, subject to the availability of funds, these hospitals will receive monthly lump-sum DSH payment adjustments.

Effective with admissions on and after July 1, 1994, the disproportionate share hospital (DSH) provider which was designated the sixth tertiary center to receive grant funds from the Department of Human Resources' (DHR) Regionalized Infant Intensive Care Program, subject to the availability of funds, will receive monthly lump-sum payment adjustments. An illustration of the derivation of the payment is as follows: Annual estimated costs + 12 months = Estimated monthly costs; Estimated monthly costs + Monthly admissions = Estimated monthly cost per admission; and Estimated monthly cost per admission x monthly admissions = Monthly payments. This hospital provides intensive care services to a portionate number of high risk neonates and incurs significant unreimbursed costs associated with the provision of such services. The payment adjustment will include reported unreimbursed costs for neonatal intensive care and related transportation services as determined by DHR and reviewed and accepted by the Department.

The Department will make quarterly payment adjustments to disproportionate share teaching hospitals which participate in the Family Practice and Residency Grants Program administered by the Joint Board of Family Practice (JBFP). These

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hospitals operate post-graduate training programs for physicians preparing to enter family practice and other medical specialties and incur significant unreimbursed graduate medical education costs associated with the operation of such training programs. The payment adjustment amount is determined based on the number of residents in the training programs and the costs incurred in operating such programs, and will not exceed the reported unreimbursed graduate medical education costs for these programs, subject to the availability of funds. The payment adjustment will be reasonably related to cost, volume or proportion of services provided to Medicaid or other low-income patients. An illustration of the derivation of the payment is as follows: Quarterly inpatient admissions (50) x Resident cost per admission ($2,538) = Quarterly payment ($126,900).

Subject to the availability of funds, the Department will make a monthly payment adjustment to disproportionate share hospital providers which contract with the Department of Human Resources (DHR) for services provided in the following programs: AIDS Clinic, Poison Control Center, Genetics/Sickle Cell Screening and Maternal and Infant Health Services. The DSH payments would begin on or after July 16, 1991, and be made to reimburse for significant costs incurred in the provision of program services. Significant costs include costs incurred in operation of the grant programs such as salaries and benefits, supplies and materials, etc. The monthly payment adjustment to the DSH providers which operate these programs is determined based on an expenditure report submitted by the hospital to DHR. The report is reviewed and approved for payment in accordance with contract terms, and forwarded to the Department for payment. The Department reviews the report and makes the payment adjustment not to exceed aggregate reasonable costs incurred by the hospitals. The payments will be reasonably related to cost or volume of services provided by these DSH providers to Medicaid or other low-income patients. An illustration of the derivation of the payment is as follows: Quarterly admissions (300) x cost per

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admission ($1,297) = Quarterly payment ($389,100).

The Department will make a payment adjustment (as described below) effective for dates of admission July 16, 1990, and after, to disproportionate share hospitals which agree to use no less than 15% of the payment adjustment for support of primary care services. The payment adjustment will be made quarterly based on paid admissions and will be determined as outlined below.

1) Calculate a payment adjustment percentage using the steps below:

   Add 3% per year of inflation (beginning with the first full year that inflation is added);

   Add 0-20% for DSH providers whose percentage of Medicaid days is greater than the statewide mean percentage of Medicaid days. Of these providers, the hospital with the highest percentage of Medicaid days gets 20%, and the percentage is factored down accordingly, beginning with the hospital which has the next highest percentage of Medicaid days down to the hospital with the lowest;

   Sum the amounts derived from the steps above to determine the payment adjustment percentage.

2) Multiply the payment adjustment percentage by the inflated hospital specific base year 1987 operating costs. Divide this product by the base year 1987 number of paid admissions to determine the payment adjustment amount per case.

   Add 1%, 2%, 3%, or 4% per year of inflation for hospitals which qualify as DSH by meeting two, three, four or five of the DSH criteria, respectively;

   Add 0-15% based on the percentage of Medicaid admissions for deliveries to total Medicaid admissions for all services;

   Add 1% per year of inflation if the hospital is the only hospital in the county; and

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3) Multiply the payment adjustment amount per case by the number of paid admissions for the quarter; the product is the quarterly payment adjustment specific to each DSH provider. The payment adjustment amount per case is subject to adjustment by the Department.

4) Effective for quarterly payment adjustments made April 1, 1991, and after, subject to availability of funds, adjust the payment amount per case as follows: (1) Increase the payment adjustment amount for fiscal year 1991 by 15% to provide for the establishment and support of primary care programs and services for Medicaid recipients and indigent citizens of Georgia; and (2) increase the DSH payment adjustment percentage by one percent per year of inflation (3.25%) for the DSH providers which are the sole hospital in rural counties.

Multiply the revised payment adjustment amount per case by the number of paid admissions for the quarter; the product is the quarterly payment adjustment specific to each DSH provider which is reasonably related to costs, volume or proportion of services provided to Medicaid or other indigent patients.

Effective with admissions on and after January 1, 1991, subject to the availability of funds, make a payment adjustment for the state-owned and operated disproportionate share teaching hospital in Georgia. The adjustment will be the difference between the hospital's Medicaid per case reimbursement rate, exclusive of the other DSH adjustments, and the hospital calculated per case rate using Medicare principles of reimbursement (the Medicare upper limit rate). This adjustment results in reimbursement of reasonable costs of inpatient hospital services provided to Title XIX patients.

The Department will make a payment adjustment (as described below) effective for dates of admission July 1, 1991, and after, to disproportionate share hospitals which agree to use no less than 15% of the payment adjustment for support of primary care services. The payment adjustment will be based on paid admissions and will be made monthly beginning

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on or around October 31, 1991. The payment adjustment amount will be determined as outlined below.

(1) Calculate a payment adjustment percentage for each DSH using the steps below.

- Add 50% for each DSH provider.
- Add 0-50% proportionally for DSH providers whose percentage of Medicaid days is greater than the statewide mean percentage of Medicaid days.
- Add 12.5% for each additional DSH criterion that a hospital meets.
- Add 0-50% proportionally based on the percentage of Medicaid births to total births for each hospital.
- Add 25% if the hospital is the only Medicaid-enrolled hospital in its county.
- Add 0-100% proportionally for hospitals with calendar year 1990 admissions greater than 1,000.
- Sum the percentages derived from the steps above to determine the payment adjustment percentage.

(2) Multiply the payment adjustment percentage by the inflated hospital-specific base year 1988 operating costs to obtain inflated operating costs for each DSH.

(3) Calculate bad debt and uncompensated services costs by multiplying these total hospital costs by the percentage of Medicaid patient days for each DSH.

(4) Add inflated operating costs and costs of uncompensated services and bad debts and divide by the 1989 discharges to obtain the payment adjustment amount per case for each DSH.

(5) Multiply the payment adjustment amount per case by the estimated number of admissions for each DSH for

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the appropriate period. The product is the estimated DSH payment adjustment. The payment adjustment amount per case is subject to adjustment

by the Department. The payment adjustment is subject to the availability of funds and will be reasonably related to costs, volume or proportion of services provided to Medicaid or other indigent patients.

The Department will make a payment adjustment, (as described below) effective for dates of admission July 1, 1992, and after, to disproportionate share hospitals which agree to comply with Departmental Rule 350-6.03(3): No less than 15% of the payment adjustment will be used for support of primary care services. The payment adjustment will be calculated as outlined below and will be made on or around November 2, 1992, for the period July 1 through October 31; on or around November 30 for the month of November; and on or around December 31 for the month of December.

(1) Calculate a payment adjustment percentage for each DSH using the steps below.

- Add 50% for each DSH provider.
- Add 0-50% proportionally for DSH providers whose percentage of Medicaid days is greater than the statewide mean percentage of Medicaid days.
- Add 12.5% for each additional DSH criterion that a hospital meets.
- Add 0-50% proportionally based on the percentage of Medicaid births to total births for each hospital.
- Add 25% if the hospital is the only Medicaid-enrolled hospital in its county.
- Add 0-100% proportionally for hospitals with calendar year 1990 admissions greater than

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1,000.

- Sum the percentages derived from the steps above to determine the payment adjustment percentage.

(2) Multiply the payment adjustment percentage by the inflated hospital-specific base year 1989 operating costs to obtain inflated operating costs for each DSH.

(3) Calculate bad debt and uncompensated services costs by multiplying these total hospital costs by the percentage of Medicaid patient days for each DSH.

(4) Add inflated operating costs and costs of uncompensated services and bad debts and divide by the 1989 discharges to obtain the payment adjustment amount per case for each DSH.

(5) Multiply the payment adjustment amount per case by the estimated number of admissions for each DSH for the period July 1, 1992, to December 31, 1992. The product is the estimated DSH payment adjustment for the state fiscal year 1993. The payment adjustment amount per case is subject to adjustment by the Department. The payment adjustment is subject to the availability of funds and will be reasonably related to costs, volume or proportion of services provided to Medicaid or other indigent patients.

The Department will make a payment adjustment, (as described below) effective for dates of admission July 1, 1993, and after, to disproportionate share hospitals which agree to comply with Departmental Rule 350-6.03(3): No less than 15% of the payment adjustment will be used for support of primary care services. The payment adjustment will be calculated as outlined below and will be made on or around November 1, 1993, for the period July 1 through October 31; on or around November 30 for the month of November; and on or around December 31 for the month of December.

(1) Calculate a payment adjustment percentage for each DSH using the steps below.

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- Add 50% for each DSH provider.
- Add 0-50% proportionally for DSH providers whose percentage of Medicaid days is greater than the statewide mean percentage of Medicaid days.
- Add 12.5% for each additional DSH criterion that a hospital meets.
- Add 0-50% proportionally based on the percentage of Medicaid births to total births for each hospital.
- Add 25% if the hospital is the only Medicaid-enrolled hospital in its county.
- Add 0-100% proportionally for hospitals with calendar year 1991 admissions greater than 1,000.
- Add 40% to the payment adjustment percentage for all public disproportionate share hospitals prior to multiplication of that percentage by the inflated hospital-specific base year 1990 operating costs. In the event a reduction to this 40% payment adjustment is necessary, such a reduction would be proportional based on estimated Medicaid inpatient admissions.
- Sum the percentages derived from the steps above to determine the payment adjustment percentage.

(2) Multiply the payment adjustment percentage by the inflated hospital-specific base year 1990 operating costs to obtain inflated operating costs for each DSH.

(3) Calculate bad debt and uncompensated services costs by multiplying these total hospital costs by the percentage of Medicaid patient days for each DSH.

(4) Add inflated operating costs and costs of uncompensated services and bad debts and divide by the 1990 discharges to obtain the payment adjustment amount per case for each DSH.

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(5) Reduce the payment adjustment amount per case for non-public hospitals by 50%.

(6) Multiply the payment adjustment amount per case by the estimated number of admissions for each DSH. The product is the estimated DSH payment adjustment. The payment adjustment amount per case is subject to adjustment by the Department. Such an adjustment would be a proportional reduction based on Medicaid inpatient admissions or Medicaid base year inpatient costs.

The Department will make a payment adjustment effective for dates of admission July 1, 1994, and after, to disproportionate share hospitals which agree to comply with Department Rule 350-6-.03(3) See Appendix A. No less than 15% of the payment adjustment will be used for support of primary care services. The payment adjustment will be calculated November 1, 1994, for the period of July 1, through October 31; on or around November 30, for the month of November; and on or around December 31 for the month of December.

(1) Calculate a payment adjustment percentage for each DSH provider using the steps below.

- Add 50% for each DSH provider.
- Add 0-50% proportionally for DSH providers whose percentage of Medicaid days is greater than the statewide mean percentage of Medicaid days.
- Add 12.5% for each additional DSH criterion that a hospital meets.
- Add 0-50% proportionally based on the percentage of Medicaid births to total births for each hospital.
- Add 25% if the hospital is the only Medicaid-enrolled hospital in its county.
- Add 0-100% proportionally for hospitals with calendar year 1992 admissions greater than 1000.
- Add no more than 40% to the payment adjustment

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percentage for all public disproportionate share hospitals prior to multiplication of that percentage b the inflated hospital-specific base year 1991 operating costs. In the event a

reduction to this 40% payment adjustment is necessary, such a reduction would be proportional based on estimated Medicaid inpatient admissions.

- Sum the percentage derived from the steps above to determine the payment adjustment percentage.

(2) Multiply the payment adjustment percentage by the inflated hospital-specific base year 1991 operating costs for each DSH.

(3) Calculate bad debt and uncompensated services costs by multiplying these total hospital costs by the percentage of Medicaid patient days for each DSH.

(4) Add inflated operating costs and costs of uncompensated services and bad debts and divide by the 1991 discharges to obtain the payment adjustment amount per case for each DSH.

(5) Reduce the payment adjustment amount per case for nonpublic hospitals by 50%.

(6) Multiply the payment adjustment amount per case by the estimated number of admissions for each DSH. The product is the estimated DSH payment adjustment. The payment adjustment amount per case is subject to adjustment by the Department. Such an adjustment would be a proportional reduction based on Medicaid admissions or Medicaid base year inpatient costs.

Public hospitals are limited, by Federal mandate, to a calculated disproportionate share payment cap for the 1995 state fiscal year equal to uncompensated medical care costs. The hospital-specific DSH cap is defined by the following formula:

DSH Cap = Medicaid costs + Costs of services to uninsured patients - non-DSH payments.

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Should a public hospital's DSH payments exceed the hospital-specific DSH limit, the DSH intensity allowance will be reduced, causing the per case rate to decrease. The difference between the original rate and the revised rate will be multiplied by the number of paid admissions for the period to determine the amount of the overpayment. If necessary, other DSH payments will be adjusted or suspended. Public hospitals that qualify as a "high disproportionate share" hospital in accordance with Section 1923 (g)(2)(B) of the Social Security Act may exceed the hospital-specific DSH cap by up to 200%, in state fiscal year 1995 only, if the State certifies that the monies above the cap are used for health services. Such excess payments will be made as DSH payments through the Indigent Care Trust Fund.

For each federal fiscal year, the HCFA places a limit on the aggregate DSH payments that the Department may make. If the Department's estimates indicate that the aggregate limit will be exceeded, the Department will reduce DSH payments to ensure that the limit is not exceeded.

The Department will make a payment adjustment effective for dates of admission July 1, 1995, and after, to disproportionate share hospitals which agree to comply with Department Rule 350-6-.03(3) See Appendix A. No less than 15% of the payment adjustment will be used for support of primary care services. The payment adjustment will be calculated November 1, 1995, for the period of July 1, through October 31; on or around November 30, for the month of November; and on or around December 31 for the month of December.

(1) Calculate a payment adjustment percentage for each DSH provider using the steps below.

- Add 50% for each DSH provider.

- Add 0-50% proportionally for DSH providers whose percentage of Medicaid days is greater than the statewide mean percentage of Medicaid days.

- Add 12.5% for each additional DSH criterion that a hospital meets.

- Add 0-50% proportionally based on the percentage

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of Medicaid births to total births for each hospital.

- Add 25% if the hospital is the only Medicaid-enrolled hospital in its county.

- Add 0-100% proportionally for hospitals with calendar year 1993 admissions greater than 1000.

- Add no more than 40% to the payment adjustment percentage for all public disproportionate share hospitals prior to multiplication of that percentage by the inflated hospital-specific base year 1992 operating costs. In the event a reduction to this 40% payment adjustment is necessary, such a reduction would be proportional based on estimated Medicaid inpatient admissions.

- Sum the percentage derived from the steps above to determine the payment adjustment percentage.

(2) Multiply the payment adjustment percentage by the inflated hospital-specific base year 1992 operating costs for each DSH.

(3) Calculate bad debt and uncompensated services costs by multiplying these total hospital costs by the percentage of Medicaid patient days for each DSH.

(4) Add inflated operating costs and costs of uncompensated services and bad debts and divide by the 1992 discharges to obtain the payment adjustment amount per case for each DSH.

(5) Reduce the payment adjustment amount per case for nonpublic hospitals by 50%.

(6) Multiply the payment adjustment amount per case by the estimated number of admissions for each DSH. The product is the estimated DSH payment adjustment. The payment adjustment amount per case is subject to adjustment by the Department. Such an adjustment would be a proportional reduction based on Medicaid admissions or Medicaid base year inpatient costs.

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Effective with DSH payments made on and after July 1, 1995, all DSH providers are subject to a hospital-specific DSH limit. The limit is defined as outlined below.

(Costs of Medicaid services LESS Medicaid non-DSH payments.) PLUS (Costs of services to individuals with no insurance or other third party coverage LESS payments received from individuals with no insurance or other third-party coverage.)

Subject to the availability of funds, the Department will make a payment adjustment to disproportionate share hospitals which agree to comply with Department Rule 350-6-.03(3). See Appedix A. The payment adjustments will be calculated as outlined below and will be made on or about November 1, 1996, and before December 31, 1996. In the event that guidelines regarding the availability of federal funds used in this program should be subject to change, to better assure that the Department will not expend funds for which federal matching funds are not available, the Department may extend the ending date for making Indigent Care Trust Fund adjustment payments to a date sixty days after federal guidelines are finalized or June 30, 1997, whichever occurs earlier.

(1) Calculate a payment adjustment percentage for each DSH provider using the steps below.

- Add 50% for each DSH provider.
- Add 0-50% proportionally for DSH providers whose percentage of Medicaid days is greater than the statewide mean percentage of Medicaid days.
- Add 12.5% for each additional DSH criterion that a hospital meets.
- Add 0-50% proportionally based on the percentage of Medicaid births to total births for each hospital.
- Add 25% if the hospital is the only Medicaid-enrolled hospital in its county.

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- Add 0-100% proportionally for hospitals with calendar year 1994 admissions greater than 1000.

- Add no more than 100% to the payment adjustment percentage for all public disproportionate share hospitals prior to multiplication of that percentage by the inflated hospital-specific base year 1993 operating costs.

- Sum the percentage derived from the steps above to determine the payment adjustment percentage.

(2) Multiply the payment adjustment percentage by the inflated hospital-specific base year 1993 operating costs for each DSH.

(3) Calculate bad debt and uncompensated services costs by multiplying these total hospital costs by the percentage of Medicaid patient days for each DSH.

(4) Add inflated operating costs, costs of uncompensated services, and bad debts and divide by the 1993 discharges to obtain the payment adjustment amount per case for each DSH.

(5) Reduce the payment adjustment amount per case for non-public hospitals by 60%.

(6) Multiply the payment adjustment amount per case by the estimated number of admissions for each DSH. The product is the estimated DSH payment adjustment. The payment adjustments amount per case is subject to adjustment by the Department.

5/15/97 Subject to the availability of funds, the Department will adjust payments to public hospitals with less than 100 beds located in a non-MSA with an inpatient Medicaid utilization of at least 1% which agree to comply with Department Rule 350-6-.03(3).

The payment adjustment will be calculated as outlined below:

(a) Calculate the Medicaid shortfall.
(b) Calculate the costs of rendering services to individuals with no insurance or other third

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party payer.

(c) Determine Medicaid admissions for each hospital's base fiscal year.

(d) Calculate base year cost per admission by adding (a) and (b) and dividing by (c) above.

(e) Multiply base year cost per admission by estimated Medicaid admissions for the current federal fiscal year.

All DSH providers are subject to the hospital-specific DSH limit and the aggregate statewide DSH limit defined above in Section G of this State Plan.

H. Reviews and Appeals

In general, providers may submit written inquiries concerning the rate determination process or requests for review of their specific rates. Only the following will be considered under the procedures herein described:

- Evidence that the audited cost report figures used to determine the base rate contained an error on the part of the Department or its agents.
- Evidence that the Department made an error in calculating the prospective rate of payment.
- Evidence that the Department is not complying with its stated policies in determining the base rates, trend factor, or utilization constraints.
- Hospitals may appeal for a rate adjustment if they have significant changes in patient care services which resulted in an increase in costs since the base year. The Department will require proof of these increased patient costs, and documentation of the increase in case-mix intensity of Medicaid cases.

Prospective Per Case Rate Appeals

1. Information concerning the base rate and prospective rate will be provided to each hospital prior to the effective date. A hospital will have 30 days from the date on the correspondence to submit a request

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for adjustment concerning the rate determination process. If no adjustment request is submitted within this time period, a hospital may not contest its rate of payment. There is no time limitation for the Department to reduce a hospital's rate when an error is discovered.

2. Written requests must be submitted to the Coordinator of the Hospital Reimbursement Unit. Requests for review must include evidence on which the request is being based. Hospitals which do not submit written request or inquiries within thirty days of the date of such information will be considered to have accepted their rates as received. Similarly, failure of the hospital to state the basis for review and to include relevant supporting evidence for the Department's consideration, when requesting an Administrative Review, will also result in a denial of further appeal rights on the rate of payment. The Coordinator of Hospital Reimbursement will have sixty (60) days from the date of receipt to render a decision concerning the written requests or inquiries submitted by a hospital if no additional information is required. The Coordinator may have more than sixty (60) days to render a decision if additional information is requested. If the Coordinator of Hospital Reimbursement requests additional information, the request must be issued within thirty (30) days of receipt, and the hospital must respond within thirty (30) days of receipt of such request. The Coordinator of Hospital Reimbursement will have thirty (30) days from the receipt of the additional information to render a decision in writing. The failure of the Coordinator of Hospital Reimbursement to render a decision within the above-stated time frame will result in a decision in favor of the hospital concerning the issue raised by the hospital on appeal.

3. Failure of a hospital to provide information within the specified time frame as requested by the Coordinator of Hospital Reimbursement will result in the denial of the hospital's appeal by the Coordinator of Hospital Reimbursement. A hospital which disagrees with the determination of the

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Coordinator of Hospital reimbursement may request a hearing. If the request is not received by the Office of Legal Services within ten (10) days of the date of the Coordinator's decision, the hospital will be deemed to have waived any and all further appeal rights.

I. Adjustments to Rates

The effect of any CON approved capital improvement on depreciation expense for buildings and fixed equipment or changes in cost for services of hospital-based physicians occurring from November 16 through May 15 (inclusive) of any year, will be recognized in a rate change effective the following July 1. Changes occurring from May 16 through November 15 (inclusive) will be effective January 1 of the subsequent year. Costs associated with a revaluation of assets as a result of the sale or lease of a facility which occurred after November 8, 1983, will not be considered for the purpose of determining or adjusting a hospital's rate of payment.

Effective with the establishment of per case rates on and after, July 1, 1991, costs for services of hospital-based physicians (HBP) will no longer be reimbursed by the Hospital program. HBP services must be billed to the Physicians program in order to obtain reimbursement.

VI. Payment Assurance

The State will pay each hospital for services provided in accordance with the requirements of the Georgia Title XIX State Plan and applicable State and Federal rules and regulations. The payment amount shall be determined for each hospital according to the standards and methods set forth in the Georgia Title XIX inpatient Hospital Reimbursement Plan.

Hospitals will continue to submit claims as they have in the past. All requirements for documented services and charges will remain in effect, and all screens for completeness will continue. Hospital claims will be subject to post-payment review. The Department will be requesting information from the hospitals to substantiate the necessity and appropriateness of services rendered. Any denials for lack of medical necessity, documentation, or other reasons will result in recoupment of monies paid to the provider. A reduced rate

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For less that acute care is not applicable nor required.

Unlike a per diem or percent of charge system, this reimbursement plan does not provide incentives for prolonging a patient's stay. If a patient remains in the hospital beyond the time of the medical necessity, the effect is to reduce the daily reimbursement rate.

VII. Provider Participation

This plan is designed to assure adequate participation of hospitals in the Medicaid program, the availability of hospital services of high qualify to recipients, and services within which are comparable to those available to the general public.

VIII. Revisions

The plan will be revised as operating experience data are developed and need for changes is necessary in accordance with Federal and State regulations. If it is found that there are insufficient controls on utilization transfers or cost, or if the Department determines that a different reimbursement method is warranted, the Department maintains its right to discontinue this system upon appropriate public notice of the proposed change.

IX. Payment in Full

A. Participating in-state providers must accept the amount paid in accordance with the Georgia Title XIX Inpatient Hospital Reimbursement Plan as payment in full for covered services.

B. Settlement
For payments occurring each calendar year, a comparison of a hospital's total Medicaid payments and its total charges will be made after completion of the calendar year. Except for hospitals receiving designation as a Critical Access Hospital in Georgia, a refund will be due from the hospital for any amount by which total Medicaid payments are in excess of a hospital's total charges for Medicaid patients.

For enrolled non-Georgia hospitals, the comparison will

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be made beginning with payments and charges for admissions occurring during the calendar year 1990 and after.

Total Medicaid payments included in the comparison shall not include payment adjustments made to Georgia or non-Georgia enrolled disproportionate share hospitals. There

will be no other cash settlement except as outlined in Subsection 1001.3 of the Hospital manual. Total payments will include the appropriate inpatient hospital co-payments.

The Department will review hospital cost reports to verify several rate components. The reimbursement methodology assumes that services in the base year will continue and, therefore, audited cost reports will be reviewed to determine that all services and facilities included in the base year will continue in the reimbursement year on the basis of biannual surveys from the hospital. Additionally, all surveyed items including physician reimbursement will be subject to verification.

An amended audited cost report will not be recognized for the purpose of adjusting reimbursable costs (inpatient and outpatient) if the amended report is received more than three (3) years after the initial audit of the cost report is completed. (For definition purposes, this date is established as the date of initial notification for audit completion to the provider.)

X. Reimbursement for Cost Outlier Cases (Enrolled Hospitals)

A hospital which has an unusually costly admission (or admissions) during the reimbursement year may obtain additional reimbursement for the admission under circumstances described below. This additional reimbursement, determined on a case-by-case basis, may be granted if the cost of the admission in question exceeds the threshold established for the hospital.

To obtain additional reimbursement for an unusually expensive admission (outlier), a hospital must make a request to the Coordinator or the Hospital Reimbursement Unit and provide the following information:

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1. Itemized charges for the admission.

2. Utilization review notes, physician's orders and discharge summary.

3. A copy of UB-92 claims on the admission.

4. A copy of the paid remittances on the admission.

After utilization review, the Department will use the following methodology to determine the amount of any additional reimbursement to be allowed:

(a) For all hospitals, except freestanding children's hospitals in the State of Georgia, the threshold amount will be computed using an average of charges for the five (5) most expensive inpatient admissions in the hospital's base year, trended to the reimbursement year using inflation factors. Effective July 1, 1989, and after the cost outlier threshold for freestanding children's hospital's in the State of Georgia is $50,000.

(b) If the hospital's base year costs-to-charges ratio is less than the reimbursement year to date payments-to-charges ratio, the appeal for additional reimbursement will be denied. Quarterly payment adjustments made to disproportionate share hospital providers will <u>not</u> be considered when determining the payments-to-charges ratio during outlier review.

(c) If the hospital's base year costs-to-charges ratio exceeds the reimbursement year to date payments-to-charges ratio, the Department will pay the total covered charges for outlier minus threshold, to which the base year costs-to-charges ratio (maximum of 75%) is applied less any adjustment and the regular per case amount already paid.

Allowable Outlier Charges
MINUS [<u>Threshold</u>]
EQUALS Excess Charges
TIMES <u>C/C Ratio</u> (Max. 75%)
EQUALS Excess Charges Reduced to Cost
MINUS [<u>Adjustment</u>]
MINUS [<u>Regular Per Case Rate</u>]

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EQUALS Additional Payments

(d) Hospitals with a base year cost-to-charges ratio of 100% or more will receive excess charges as computed in (c) above, without application of the cost-to-charges ratio.

(e) The hospital's per case payment and charges for the outlier in question will be included in the ratio computed in (c) and (d) above.

Day outlier reimbursement for enrolled Georgia hospital is explained at Section IV.G. above. Outlier reimbursement for enrolled non-Georgia hospitals is explained at Section IV.A.2. above.

XI. Swing-Bed Services

A. Reimbursement Methodology

Swing-bed providers will be reimbursed a prospective rate per patient day which will be the statewide average Medicaid rate per diem paid to Level I nursing facilities for routine services furnished during the previous calendar year. The per diem rate covers the cost of certain routine services as described in Attachment 3.1A, page 1c-3 of the Plan. Ancillary services such as laboratory, radiology, and certain prescription drugs must be billed and reimbursed separately under the appropriate Medicaid program. For example, radiology services provided in the outpatient department of the hospital should be billed as outpatient hospital services. Providers must bill on a monthly basis.

Medicaid will reimburse the Medicare Part A coinsurance for skilled level of care swing-bed services provided to Medicaid/Medicare recipients.

Medicaid reimbursement will be reduced by the amount of the recipient's liability (patient income). Patient income is established by the county DFACS office and is the dollar amount shown on Form DMA-59, or the dollar amount shown on Form DMA-286 if the recipient has Medicaid/Medicare coverage. The patient's income is deducted in full from the Medicaid reimbursement rate until the income has been exhausted.

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B. Cost Report and Cost Settlement

There will not be a year-end cost settlement process for the swing-bed services program. In addition, there is no swing-bed services cost report. Medicaid Swing-Bed program data should not be included in the Medicaid Hospital program cost report settlement data. The Medicaid routine swing-bed days should be excluded from the hospital's Medicaid routine days on Worksheet D-1, Part I of the cost report.

XII. Hospital Crossover Claims

Effective with dates of payment of October 1, 1990, and after, the maximum allowable payment to enrolled Georgia and non-Georgia hospitals for Medicare inpatient deductibles and coinsurance (crossover claims) will be the hospital-specific Medicaid per case rate. The maximum allowable payment to non-Georgia hospitals not enrolled in the Georgia Medicaid program for Medicare inpatient crossover claims will be the average hospital-specific inpatient per case rate for enrolled non-Georgia hospitals.

XIII. Nonallowable Costs

The costs listed below are nonallowable. Reasonable costs used in the establishment of rates effective on and after July 1, 1991, will reflect these costs as nonallowable.

1) 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;

2) Memberships in civic organizations;

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

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4) Vehicle depreciation or vehicle lease expenses in excess of 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);

5) 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 patient transport, the portion of cost that is unrelated to patient care staff or patient transport is nonallowable;

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

7) Legal services for an administrative appeal or hearing, or court proceeding involving the provider and the Department or any other state agency when judgement 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

8) 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.

XIV. Day Outliers

Effective with dates of admission beginning July 1, 1991, and after, all non-disproportionate share hospitals will be eligible to receive an outlier payment adjustment for medically necessary inpatient hospital admissions involving exceptionally long lengths of stay for individuals under age one. To qualify for this day outlier payment, the length of stay for individuals under age one must exceed the hospital-

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specific threshold, which is defined as the mean length of stay plus three standard deviations. The day outlier payment will equal the number of days stay in excess of the threshold times the hospital-specific per admission rate per day. This rate per day will be the hospital-specific per case rate divided by the hospital-specific average length of stay for all Medicaid admissions. The base period used for calculation of the threshold and the per admission rate per day will be the period on which the hospital's prospective per case rate is based.

XV. Co-Payment

Effective with dates of admission of July 1, 1994, and after, a co-payment of $12.50 will be imposed for certain inpatient hospital admissions.

Recipients affected by the copayment are limited to adult recipient of Supplemental Security Income (SSI) benefits, certain other adult disabled and aged recipients and parents of children receiving Aid to Families with Dependent Children (AFDC) benefits. Children under age twenty-one, pregnant women, nursing home residents, or hospice care participants are not required to pay this copayment. Emergency services and Family Planning services received by Medicaid recipients do not require a copayment. Services cannot be denied based on the inability to pay these copayments.

XVI. Administrative Days

Administrative days are those days that a recipient remains in acute care setting awaiting placement in a nursing facility due to the unavailability of a bed. Administrative days may occur in the two situations outlined below.

- Following the physician's written order for discharge on the chart.
- When a utilization review denial letter is given prior to the physician's written order for discharge.

The allowable covered number of administrative days is three or 72 hours for either situation outlined above. Any days greater than three that a recipient remains in the acute care setting awaiting placement in a nursing facility are noncovered days.

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XVII. DRG Prospective Payment System

1. Effective October 9, 1997, the Georgia Department of Medical Assistance (DMA) will reimburse qualified providers for inpatient hospital services under the prospective payment system as set forth in this plan.

2. All inpatient services associated with admissions occurring on or after October 9, 1997, furnished by hospitals, are subject to the "Hybrid DRG Prospective Payment System" (hereafter referred to as the Hybrid DRG System).

3. Payment for all inpatient hospital services (as defined by the DMA Policy Manual) are reimbursed through the Hybrid DRG system either:

   (a) an amount per discharge (per case) for a diagnosis related group (hereafter referred to as the DRG system or DRG portion of the hybrid system), or

   (b) an amount per discharge (per case) based on claim-specific allowable charges multiplied by a hospital-specific cost-to-charge ratio (hereafter referred to as the cost-to-charge (CCR) system or CCR portion of the hybrid system).

4. The DRG portion of the hybrid system consists of DRG categories whose cases have sufficient volume, are relatively homogeneous, and are not considered to be highly specialized in nature. The CCR portion of the hybrid system consists of DRG categories whose cases are infrequent or highly variant.

5. Under both the DRG and CCR portions of the hybrid system, the DRG and CCR payments reflect reimbursement for operating costs. Capital costs and direct graduate medical education costs (when applicable) are paid based on a hospital-specific prospective per case basis. These per case add-on rates are uniform for a given hospital regardless of whether the operating portion of the case is paid under the DRG or CCR portion of the system.

6. For discharges paid under the DRG system, Georgia-specific relative weights and base rates are used. The Health Care Financing Administration (HCFA) Grouper version 14.0 is used to classify cases into DRG categories. For each DRG, relative weights are calculated by dividing the average operating cost for a specific DRG by the overall average operating cost across all cases included in the DRG system.

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7. As provided for in Section III of this plan, outlier payments are available under the DRG system for cases exhibiting unusually high costs for the hospital stay. In addition to unusually high cost cases, special payment provisions are made for cases involving a patient transfer from one facility to another or readmission of patients after an early discharge. Reimbursement for outlier cases are paid according to the reimbursement methodology set forth in Section III.

8. Payments for short stay cases, where a patient is discharged within one day of their admission to a facility, will be made based on DMA's policy regarding the definition of inpatient and outpatient cases.

9. DRG per discharge operating base rates will be adjusted according to the percentage of estimated non-outlier payments above or below a hospital's non-outlier operating costs per case. For DRG per discharge cases, on a per case average, losses will be limited to 90 percent of non-outlier operating costs and gains limited to 110 percent of non-outlier operating costs.

10. Reimbursement for disproportionate share hospitals will be made outside of the Hybrid DRG System.

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I. Data Sources and Preparation of Data for Computation of Prospective Rates

The calculation of prospective rates requires the use of historical claim and cost data and the calculation of rate components. These rate components are used in the calculation of the prospective rates as described in Section II of this plan.

A. Data Sources

The following describes the data sources that are used for the development of the necessary prospective rate components:

1. Historical Claims Data

Hospital inpatient claims data for dates of service July 1, 1994 through June 30, 1995 were utilized for the calculation of the base rates and the DRG relative weights.

2. Cost Report Data

The most recently audited HCFA Medicare cost report (through hospital fiscal year 1994) was used. This data was utilized for the calculation of the hospital-specific cost-to-charge ratios, the capital add-on rates and the direct graduate medical education (GME) add-on rates.

3. Capital Survey Data

The capital survey has historically been used by the Georgia Department of Medical Assistance (DMA) to collect information about hospital capital expenditures that have occurred in the time period since the most recent cost reporting period. For the purpose of calculating the hospital-specific capital add-on rate within the Hybrid DRG system, the capital survey information was used to supplement the cost report information by incorporating capital expenditures that occurred more recently than the base year. Therefore, capital survey data was collected for the period after the hospital cost report period to the present.

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4. Certified Registered Nurse Anesthetist (CRNA) Survey Data

DMA reimburses hospitals for CRNA costs using rates outside of the inpatient hospital reimbursement rates. Therefore, it is necessary to remove CRNA costs from the cost report data prior to calculating the rate components within the Hybrid DRG system. The survey data collected by DMA coincides with the cost reporting period utilized and provides the information necessary to identify and remove CRNA costs as necessary.

B. Preparation of Data

The following describes the general preparation of historical claims and cost data and the subsequent calculations of the necessary components used to compute rates:

1. Data Quality Analysis

An assessment is made of the quality of the data and the following exclusions are made from the historical claims database used to calculate the prospective rates:

(a) Cases with unusually low charges
(b) One day or same day discharges
(c) Medicare crossover claims
(d) Denied claims or claims with paid amounts equal to 0

2. Determination of Claim Costs

Allowable costs for each claim are computed by multiplying the hospital cost-to-charge ratio by the allowable charges from the claim. Using the hospital cost reports, overall operating cost-to-charge ratios are computed for each hospital. These cost-to-charge ratios are applied to the historical allowed claim charges to compute the allowable claim costs. Total facility cost-to-charge ratios exceeding 1.0 are limited to a value of 1.0.

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3. **Inflation**

Since inflation indices are necessary to adjust costs so that they more accurately reflect costs for the rate year, both direct graduate medical education add-ons and claim costs used in the calculation of the DRG system rate components were inflated to the midpoint of the rate year. Georgia has historically used the DRI inflation factor minus one percent as the inflation adjustment factor. Therefore, the DRI Type Hospital Market Basket minus one percent is used as the inflation factor. This one percent, annualized over the period equals 3.3 percent. The inflation factors used to inflate costs from state fiscal years 1995 through 1998 are as follows:

Period	DRI Type Hospital Market Basket (minus 1% annually)
7/1/94 - 6/30/95	2.1 %
7/1/95 - 6/30/96	2.2 %
7/1/96 - 6/30/97	1.1 %
7/1/97 - 7/30/98	1.4 %

Each claim is inflated to the midpoint of the rate year (February 18, 1998). Because the historical claims data covers the period of July 1, 1994 through June 30, 1995, the inflation of claim costs requires different inflation factors for the different dates of service. For example, a claim with a service date falling in July 1994 requires a larger inflation adjustment than a claim that falls in May 1995 (closer to the rate year). Each facility's graduate medical education costs were also inflated in the same manner in order to compensate for the different fiscal year ends.

In addition, an intensity allowance equal to the total calculated payment adjustment percentage is applied to the projected cost of services for Georgia Medicaid patients for disproportionate share hospitals, effective with admissions October 9, 1997 and after.

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4. DRG Assignment

DRG values are determined using HCFA Grouper version 14.0. Each claim is assigned a DRG value that is the basis for categorizing claims into DRG groups.

5. Determination of DRGs paid within the DRG

A list of DRGs to be paid within the DRG portion of the system and a list to be paid within the CCR portion of the system is established using the following criteria:

a. Frequency of Cases

DRGs that have insufficient case volume to set a reliable DRG relative rate are assigned to the CCR portion of the hybrid system. The formula for determining the minimum number of cases is as follows:

$$N = \frac{(Z \times S)^2}{(R)}$$

where N = Minimum Sample Size
S = Standard Deviation
R = Error Level
Z = Confidence Level (90 %)

For any particular DRG, if the actual number of cases is greater than the minimum sample size, N, the DRG is paid on a per discharge basis.

b. High Variance

DRG categories with unusually high variation are paid on a CCR basis. High variation DRGs are defined as categories where a large percentage of the cases are widely scattered from the mean. This high variation creates an unreliable average per case amount.

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6. DRG Relative Weights

Relative weights are computed for the per discharge DRGs and are computed from Georgia claims data. For each DRG, the weight is calculated by taking the average operating cost per case and dividing it by the average operating cost per case across all DRG cases.

7. Hospital Case-Mix Index

This value is computed for each hospital that has cases falling within the per case DRG categories. The case-mix index is computed for each hospital by multiplying the number of cases for each per case DRG by the appropriate DRG relative weight. After this value is computed for each DRG and summed, this amount is then divided by the total number of per discharge DRG cases for the hospital. The resulting calculation is the case-mix index, which represents the average resource intensity of the per case DRG cases for a hospital.

8. Hospital Average Cost per Case

For each hospital, the average operating cost per case is calculated by summing the total operating costs for DRG cases and dividing by the total number of cases.

9. Peer Groups

Each hospital is assigned to one of the four peer groups (urban, rural, pediatric, or special care) according to:

a. The hospital's Medicare classification as either a facility in an MSA (urban) or not in an MSA (rural) or

b. An identifiable set of unique hospital attributes

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II. Payments for Non-Outlier Cases

A. Payment Formulas

Non-Outlier DRG Payment Per Case = (Hospital-Specific Base Rate x DF Relative Rate) + Capital Add-on + GME Add on (if applicable)

Outlier DRG Payment Per Case = (Allowable Charges x Hospital Specific Operating Cost-to-Charge Ratio) + Capital Add-on GME Add-on (if applicable)

B. Operating Payment

Under the Hybrid DRG System, all cases are reimbursed on a per case basis. Operating costs are reimbursed in one of two ways:

- Within the DRG portion of the system
- Within the CCR portion of the system

An additional, or add-on, payment for capital and direct medical education is described in Section II.B.3.

1. DRG Base Rates

For each case, the computation of the total DRG payment for non-outlier DRG cases is computed as follows. This section focuses on the calculation of the Base Rate payment component.

a. Case-Mix Adjusted Average Costs

Each hospital's average DRG non-outlier operating cost per case is divided by the hospital's case-mix index, resulting in an average cost per case without the effect of case-mix.

b. Peer Group Base Rates

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The case-mix adjusted total DRG inlier operating cost is calculated for each facility by multiplying the case-mix adjusted average cost for each hospital by the total number of DRG cases. The total case-mix adjusted cost is summed across hospitals for each peer group and divided by the number of cases within each peer group. The resulting value for each peer group is the peer group base rate. Each facility is assigned their appropriate base rate based upon the hospital's peer group classification.

c. Hospital-Specific Base Rates

Peer group Base Rates are adjusted according to the percentage of estimated DRG non-outlier operating payments above or below a hospital's average cost per case. For DRG cases, estimated losses will be prospectively limited to 90 percent of non-outlier operating costs and estimated gains prospectively limited to 110 percent of non-outlier operating costs.

d. Adjustment to Rural Hospital-Specific Base Rates

The hospital-specific base rates for hospitals in the rural peer group will be adjusted upwards by 3.3 percent. This adjustment reinstates the one percent that was removed from the inflation factors in Section I.B.3. The reason for a 3.3 percent increase was that when DMA modeled the DRG system, costs were inflated by a nationally standardized inflation rate minus one percent for every year. For example, if the inflation rate for the state fiscal year was 3.4 percent, costs were inflated by 2.4 percent. This is standard DMA practice since it was found that hospital costs in Georgia were growing at a slower pace than the national rate. The 3.3 percent increase reinstates the one percent reduction (compounded from the base year to the payment year).

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2. Cost-to-Charge Operating Payment

As specified in Section I.A.2 operating cost-to-charge ratios are computed from hospital cost reports. Any cost-to-charge ratio exceeding 1.0 is set to 1.0. These cost-to-charge ratios are used to determine reimbursement for cases that do not classify into one of the DRG reimbursement categories. The operating cost-to-charge ratio was calculated in the following manner.

a. Divide Medicaid Inpatient Charges from the cost report by the Total Patient Revenue from the cost report to obtain the Medicaid Charge-to-Revenue Ratio.

b. Subtract the Total CRNA Costs reported on the cost report from the Total CRNA Costs reported on the CRNA survey to obtain the CRNA Reduction.

c. Multiply the Medicaid Charge-to-Revenue Ratio by CRNA Reduction amount to obtain the Medicaid Portion of the CRNA Reduction.

d. Subtract the Medicaid Portion of the CRNA Reduction from the Medicaid Inpatient Costs from the cost report to obtain the Medicaid Inpatient Costs Adjusted for CRNA.

e. Divide Medicaid Inpatient Operating Costs Adjusted for CRNA by the Medicaid Inpatient Charges from the cost report to obtain the Cost-to-Charge Ratio.

3. Hospital Specific Add-on Payment

For both DRG and CCR cases, reimbursement for non-operating costs is made through a hospital-specific add-on payment. Add-on amounts include capital and applicable GME costs per discharge.

a. Capital cost per discharge represents all capital costs reported on the Medicare cost reports or collected by DMA through the capital surveys. The capital portion of the add-

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on is computed by dividing capital costs by the hospital cost report Medicaid discharges.

1. Divide the Medicaid Inpatient Costs from the cost report by the Total Costs from the Cost Report to obtain the Medicaid Allocation Ratio.

2. Sum the Total Buildings and Fixtures capital costs and the Total Major Movable capital costs from the cost report to obtain the Total Capital Costs.

3. Multiply the Medicaid Allocation Ratio by the Total Capital Costs to obtain the Medicaid Allocation of Capital Costs.

4. Divide the Medicaid Allocation of Capital Costs by the Medicaid Discharges to obtain the Cost Report Capital Cost Per Case.

5. Multiply the Total Capital Expenditures from the Capital Expenditure Survey by the Medicaid Allocation Ratio to obtain the Medicaid Allocation of Survey Capital Costs.

6. Divide the Medicaid Allocation of Survey Capital Costs by the Medicaid Discharges to obtain the Survey Capital Cost Per Case.

7. Sum the Cost Report Capital Cost Per Case and the Survey Capital Cost Per Case to obtain the Capital Add-on.

b. The GME add-on is calculated for the applicable hospitals in the following manner.

1. Multiply the Total Graduate Medical Education Costs from the cost report by the Medicaid

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Allocation Ratio to obtain the Medicaid Allocation of GME.

2. Divide the Medicaid Allocation of GME by the Medicaid Discharges to obtain the Medicaid GME per case.

3. Multiply the Medicaid GME per case by the DRI inflation factor (from the midpoint of the cost report year to the midpoint of the payment year) minus 1 to obtain the GME Add-on.

C. Coding Adjustment Factor

A two percent reduction in the hospital base-rate and cost-to-charge ratio is made to account for improvements in hospital coding practices resulting from the implementation of a prospective DRG system. The application of the adjustment to the base rate applies to the base-rate amount that is unaffected by the stop loss or stop gain adjustment described in Section II.B.1.c of this plan.

III. Payments for Outlier Cases

Special treatment is made for cases that have unusually high costs under the prospective payment system. For both DRG and CCR cases, special payment methods have been developed.

A. DRG Cases

DRG cases with operating costs meeting both of the following conditions will be considered for outlier reimbursement:

1. The operating costs exceed the DRG cost threshold for this DRG, where the threshold equals three standard deviations above the geometric mean cost for DRG cases.

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2. The operating costs exceed the overall cost threshold for all cases, where the threshold equals two standard deviations above the geometric mean costs for all cases (per discharge and percent of allowed charge).

The additional payment for DRG outlier cases equals the DRG payment amount plus 80 percent of costs above the DRG base payment amount. (the base-rate multiplied by the relative weight)

B. CCR Cases

CCR cases with operating costs meeting both of the following conditions will be considered for outlier reimbursement:

1. The operating costs exceed the MDC cost threshold for this DRG, where the threshold equals three standard deviations above the MDC geometric mean cost for DRG cases.

2. The operating costs exceed the overall cost threshold for all cases, where the threshold equals two standard deviations above the geometric mean costs for all cases (per discharge and percent of allowed charge).

Payment for CCR cases equals the MDC outlier operating cost threshold plus 80 percent of costs above the MDC outlier threshold.

IV. Special Payment Provisions

A. New Facilities

1. Payments for new facilities will be determined as follows:

a. Facilities under the DRG system will receive a hospital-specific base rate that is equal to the statewide average rate for the appropriate peer group in which the hospital is classified.

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b. Facilities under the DRG system will receive a capital add-on payment equal to the statewide average add-on payment for the appropriate peer group.

2. New facilities will receive payments described in Sections II and III once a recalculation of the base year is performed by DMA for all facilities.

3. New facilities currently operating under the previous DMA three year cost settlement policy will continue to be cost settled until the end of their three year period.

B. Out-of-State Facilities

1. Inpatient prospective rates will be determined as follows:

a. Facilities under the DRG system will receive a hospital specific base rate that is equal to the statewide average rate for the peer group in which the hospital is classified.

b. Facilities under the DRG system will receive a capital add-on payment equal to the statewide average add-on payment.

2. Outlier Case

Payments for outlier cases will be calculated in the same manner as described in Section III except that the cost-to-charge ratio for all out-of-state facilities will be set at the Georgia statewide average of the cost-to-charge ratios.

C. New Medicaid Providers

Prospective payment rates for established facilities which did not submit a hospital-specific Medicare cost report because the facility did not participate in the Medicaid program will be determined in the same manner as a new facility stated in section IV.A.

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XVIII. Public Process

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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XIX. Transition from Regional to Statewide Payment Rates

In order to allow for a transition from payment rates based on region (urban or rural) to statewide payment rates, the following changes are effective for admissions occurring on or after April 10, 1998:

1. Hospitals previously assigned to rural or urban peer groups are combined into one statewide peer group.
2. For the statewide peer group, an adjustment to compensate for expected increases in the accuracy of coding for diagnoses and procedures is changed from a 2% reduction to 0%.
3. For the statewide peer group, payment rates for each hospital is determined by the use of the base rate for the statewide peer group or by the hospital's initial rural or urban peer group rate, whichever is greater.

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XX. Revisions

Due to revisions to the methods and standards for establishing payment rates for inpatient services, the following identifies previous methods and standards which are no longer in effect:

section	page(s)	date no longer effective
I.E - I.G	1-2	on or before October 9, 1997
II.B	2	on or before October 9, 1997
II.D	3 (lines 14-29) only	on or before October 9, 1997
V.A.1	8	on or before October 9, 1997
V.A.2 line 6-line 40	9	on or before October 9, 1997
V.B	10-16	on or before October 9, 1997
V.C	17-24	on or before October 9, 1997
V.E-F	25-28	on or before October 9, 1997
V.G	31 (line 13)-34 (line 1) only	on or before December 1, 1999
V.G	34 (line 10)- 42 (line 15) only	on or before December 1, 1999
V.G	42 (line 21)-43 only	on or before October 9, 1997
V.H	46 (lines 26-32) only	on or before October 9, 1997
V.I	48 (lines 18-19) only	on or before October 9, 1997
X	50-52	on or before October 9, 1997

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section	page(s)	date no longer effective
XIV	54-55	on or before October 9, 1997
XVII	56-69	on July 1, 1998
Not applicable	71	page number omitted
XIX	72	on July 1, 1998

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

Overview

Effective with dates of service on or after July 1, 1998, the Division of Medical Assistance (DMA) will reimburse qualified providers for inpatient hospital services under the prospective payment system as set forth in this plan.

I. Data Sources and Preparation of Data for Computation of Prospective Rates

The calculation of prospective rates requires the use of claims data, cost data and supplemental expenditure data. The historical claims data is obtained from a chosen base year, with adjustments for inflation. For rates effective July 1, 1998, inflation rates are based on projections as calculated by DRI, reduced by 1% per year; this inflation rate may be updated periodically. The cost data is derived from a cost report year where the majority of hospitals have audited data. For rates effective on July 1, 2002, audited data was available for hospital fiscal years ending in 1999 for a majority of hospitals. Hospitals without audited data in the chosen year will have data derived from the hospital's most recently audited cost report; for rates effective July 1, 2002, if audited cost report data is not available for a period ending on or after July 31, 1996, a recent unaudited cost report will be used. The supplemental data is obtained from state supplemental expenditure surveys. The rate components are used in the calculation of the prospective rates as described in Section II of this plan.

II. Payment for Inpatient Hospital Services

A. Payment Formulas

Non-Outlier DRG Payment Per Case = (Hospital-Specific Base Rate x DRG Relative Rate) + Capital Add-on + GME Add-on (if applicable)

Outlier DRG Payment Per Case = (Hospital-Specific Base Rate x DRG Relative Rate) + {[(Allowable Charges x Hospital-Specific Operating Cost to Charge Ratio) – (Hospital-Specific Base Rate x DRG Relative Rate)] x A Percentage} + Capital Add-on + GME Add-on (if applicable)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

B. Discussion of Payment Components

1. Base Rates

All hospitals are assigned to a peer group in order to develop a base rate that best matches payments to costs for hospitals that provide similar services. The peer group base rate is obtained by calculating the average operating cost standardized for case mix of Inlier DRG cases across all cases in a peer group. If a hospital is assigned to the statewide or pediatric peer group, the peer group base rate becomes the hospital-specific base rate. If a hospital is assigned to the specialty peer group and has a sufficient claim volume, the hospital-specific base rate will he the greater of the peer group base rate or the individual hospital's base rate. If a hospital is assigned to the specialty peer group and does not have a sufficient claim volume, the peer group base rate becomes the hospital-specific base rate. For each case paid within the DRG methodology, the hospital specific base rate will be multiplied by the appropriate DRG relative weight to calculate a payment.

2. Calculation of the Capital Add-on Amount

Hospitals receive a hospital specific add-on based on capital costs from the cost report year, charges from the rate setting base year and supplemental data from the capital expenditure survey.

3. Calculation of the Direct Graduate Medical Education (GME) Add-on Amount

Only hospitals which have GME costs in the cost report year receive the GME add-on amount. The Medicaid portion of GME from the hospital's cost report year is inflated, then divided by the number of cases in the base year to obtain the GME add-on. For rates effective July 1, 1998, inflation rates are based on projections as calculated by DRI, reduced by 1% per year; this inflation rate may be updated periodically.

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4. Marginal Payments for Outliers

If the cost of a case exceeds the outlier threshold established by DMA, the case qualifies as an outlier and receives an additional payment of a percentage of the difference between the operating cost of the case and the operating portion of the non-outlier DRG payment amount (Hospital-Specific Base Rate x DRG Relative Rate). For rates effective on July 1, 1998, the percentage rate applied is 90%; this percentage rate may be updated periodically.

III. Special Payment Provisions

A. New Facilities

New facilities under the DRG system will receive payments using the same payment formulas as stated in Section II. However, the components of the formulas will be calculated on a statewide average. A new facility will receive a hospital-specific base rate that is equal to the statewide average rate for the appropriate peer group in which the hospital is classified and a capital add-on payment equal to the statewide average add-on payment for the appropriate peer group.

B. Out-of-State Facilities

Out-of-state facilities under the DRG system will receive payments using the same payment formulas as stated in Section II. However, the components of the formulas will be calculated on a statewide average. An out-of-state facility will receive a hospital specific base rate that is equal to the statewide average rate for the appropriate peer group in which the hospital is classified, a capital add-on payment equal to the statewide average add-on payment for the appropriate peer group, and a cost-to-charge ratio that is equal to the Georgia statewide average of the cost-to-charge ratios.

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C. New Medicaid Providers

Prospective payment rates for established facilities which did not submit a hospital-specific Medicare cost report because the facility did not participate in the Medicaid program will be determined in the same manner as a new facility stated in section III.A.

IV. DRG Grouper

On or after October 1, 1999, the grouper used to classify cases into DRG categories will be changed from CHAMPUS Grouper version 15.0 to CHAMPUS Grouper version 16.0. The grouper used to assign claims to DRG categories, as well as the corresponding DRG weights and threshold amounts, may be updated periodically.

V. Other Rate Adjustments

For payments on or after December 1, 1999, subject to the availability of funds, hospitals designated by the Georgia Department of Human Resources as Regional Perinatal Centers will be eligible for rate payment adjustments. These hospitals provide intensive care to high risk neonatal patients and incur significant unreimbursed costs associated with the provision of such services. Rate adjustment amounts for neonatal services provided to Medicaid patients will be determined:

- For non-public hospitals, subject to the upper payment limit for inpatient services, by measuring the incremental difference in aggregate payments if Medicaid payment rates were set equal to a measure of current market rates. For fiscal year 2000, rate adjustment payments will be approximately 45% of the difference between Medicaid and current market rate. The identification of market rates will be based on payment rates used by the Department of Community Health for services provided to those covered by the State Health Benefit Plan.
- For public hospitals, subject to the upper payment limit for inpatient services, by the difference between each hospital's charges and DRG-based payments for inpatient services provided to Medicaid patients.

These rate payment adjustments will be made on a monthly, quarterly or annual basis for lump-sum amounts and will be determined in a manner that will not duplicate compensation provided from payments for individual patient claims.

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For payments on or after December 1, 1999, subject to the availability of funds, hospitals will be eligible for rate payment adjustments for providing the following program services for the Georgia Department of Human Resources: AIDS Clinic, Poison Control Center, Genetics/Sickle Cell Screening and Maternal and Infant Health Services. Hospitals can incur significant unreimbursed costs associated with the provision of such services. Subject to the upper payment limit for inpatient services, rate adjustment payments will be based on the difference between each hospital's charges and DRG-based payments for inpatient services provided to Medicaid patients. These rate payment adjustments will be made on a monthly, quarterly or annual basis for lump-sum amounts and will be determined in a manner that will not duplicate compensation provided from payments for individual claims.

For payments on or after December 1, 1999, subject to the availability of funds, hospitals participating in the residency grant programs administered by the Georgia Board for Physician Workforce will be eligible for rate payment adjustments. These hospitals operate post-graduate training programs for physicians preparing to enter family practice and other medical specialties and incur significant graduate medical education costs associated with the operation of such training programs. The payment adjustments will be calculated as described below:

- For non-public hospitals, using the Medicaid share of indirect medical education costs, using Medicare principles of reimbursement.
- For public hospitals, subject to the upper payment limit for inpatient services, based on the difference between each hospital's charges and DRG-based payments for inpatient services provided to Medicaid patients.

These rate payment adjustments will be made on a monthly, quarterly or annual basis for lump-sum amounts and will be determined in a manner that will not duplicate compensation provided from payments for individual patient claims.

For payments on or after December 1, 1999, subject to the availability of funds, any state-owned or operated teaching hospital will be eligible for an inpatient rate payment adjustment. Such a hospital can incur significant unreimbursed medical education and other operating costs. The payment adjustment will be the difference between the hospital's Medicaid reimbursement rate per admission, exclusive of any DSH payment adjustments, and the hospital's calculated rate per admission using Medicare principles of reimbursement. The adjustment results in reimbursement of reasonable cost of inpatient hospital services provided to Medicaid patients and will be made on a monthly, quarterly

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or annual basis for lump-sum amounts and will be determined in a manner that will not duplicate compensation provided from payments for individual patient claims.

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For payments made for services provided on or after March 29, 2001, subject to the availability of funds in the year in which the interim and final rate is paid, State government-owned or operated facilities, non-State government owned or operated 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 status as government owned or operated, need sufficient funds for their commitments to meet the healthcare needs of all members of their communities. A facility's status as government owned or operated will be based on its ability to make direct or indirect intergovernmental transfer payments to the State. If sufficient funds are not available to provide maximum allowable payment amounts, rate adjustment payments may be reduced proportionally among facilities eligible to receive payment.

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

- Amounts paid for services provided to Medicaid patients and
- Estimated payment amounts for such services if payments were based on Medicare payment principles. Either cost based or rate payment measures may be used as Medicare payment principles.

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 a monthly, quarterly or annual basis and will be determined in a manner that will not duplicate compensation provided from payments for individual patient claims.

An example of how a rate adjustment payment could be calculated is presented on the following page.

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	Facility Name	XYZ Hospital
1	Payments for services provided to Medicaid patients during calendar year 2000 as of March 31, 2001	756,620
2	Total charges for services provided to Medicaid patients during calendar year 2000 as of March 31, 2001	1,218,489
3	Statewide adjustment factor for additional calendar year 2000 services paid after March 31, 2001	117.443%
4	Adjustment for inflation between base period (calendar year 2000) and payment period (CY2001)	103.0%
5	Estimated Medicaid payments for patient services in CY 2001 (line 1 x line 3 x line 4)	915,255
6	Estimated current rate adjustment payments for funding from the Georgia Department of Human Resources or the Georgia Board for Physician Workforce	0
7	Estimated total Medicaid payments for CY 2001 (line 5 + line 6)	915,255
8	Estimated total Medicaid charges for CY 2001 (line 2 x line 3 x line 4)	1,473,961
9	Statewide adjustment factor for difference between Medicare and Medicaid DRG rates	131.2%
10	Estimated payments for services to Medicaid patients based on Medicare DRG rates (line 5 x line 9)	1,200,815
11	Facility-specific limit at 150% of payments based on Medicare DRG rates (line 10 x 150%)	1,801,223
12	Lower of total charges or 150% of payments based on Medicare DRG rates (< of line 8 or line 11)	1,473,961
13	Maximum facility-specific annual upper payment limit rate adjustment (line 12 - line 7)	558,706

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METHODS AND STANDARDS FOR ADDITIONAL DSH EXPENDITURES

Effective for DSH payment adjustments made on or after December 1, 1999, the following methodology will be used for determining payment amounts:

- For each federal fiscal year, the amount of DSH allotment funds available for DSH payment adjustments will be determined.
- Hospitals that meet federal DSH criteria and that meet at least one Division of Medical Assistance DSH criterion will be eligible to receive an allocation of available DSH allotment funds.
- The maximum amount of all DSH payments to each hospital will not exceed a hospital's unreimbursed costs for services to Medicaid and uninsured patients.
- The maximum amount of all DSH payments to each hospital will be reduced by any DSH payments for other uses or purposes to determine an amount for the maximum DSH payment adjustment.
- The amount of DSH allotment funds available for DSH payment adjustments will be allocated among eligible hospitals. For non-public hospitals that are in urban areas or that have more than 99 beds (or 199 beds for payments made after December 15, 2000), 50% of the maximum DSH payment adjustment will be used as the basis for any allocation. For all other eligible hospitals, 100% of the maximum DSH payment adjustment will be used as the basis for any allocation.
- Hospitals with less than 100 beds located in rural counties will receive a payment adjustment for the maximum amount, subject to maximum limitations described above.
- For all other eligible hospitals, the payment adjustment will be determined as follows:
  - An aggregate amount of maximum DSH payment adjustments for use as an allocation basis will be calculated.
  - Hospital-specific percentages will be calculated by dividing each hospital's allocation basis by the aggregate amount. The hospital-specific percentage will be applied to the amount of DSH allotment funds available for payment adjustments to determine the amount of funds that may be paid to each hospital, subject to maximum limitations described above.

While the fifth and last bullets both use the term "for all other eligible hospitals," the terms refer to different groups of hospitals. As described in the fifth bullet, 50% of the maximum DSH payment adjustment is used as the basis for allocation for hospitals that meet either of the following conditions: non-public hospitals in urban areas; non-public hospitals in rural areas that have more than 99 beds (or 199 beds for payments made after December 15, 2000).

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METHODS AND STANDARDS FOR ADDITIONAL DSH EXPENDITURES

For the fifth bullet, "all other eligible hospitals" are public hospitals and non-public hospitals in rural areas with less than 100 beds (or 200 beds for payments made after December 15, 2000), for which 100% of the maximum DSH payment adjustment is used as the basis for allocation.

As described in the sixth bullet, hospitals with less than 100 beds located in rural counties will receive a payment adjustment for the maximum amount, subject to other limitations described previously in the policy. For the last bullet, "all other eligible hospitals" refers to hospitals meeting either of the following conditions: hospitals located in urban areas; hospitals located in rural counties and with more than 99 beds. For these hospitals, the payment adjustment amount is based on an allocation of remaining available funds.

The last bullet applies to hospitals located in urban areas or located in rural counties and with more than 99 beds. For each of these hospitals, an allocation basis is determined by measuring the unreimbursed cost for services to Medicaid and uninsured patients and applying an adjustment factor of either 50% or 100%. All hospital allocation basis amounts are summed to calculate an aggregate amount. A hospital specific percentage is calculated for each hospital by dividing the hospital's allocation basis amount by the aggregate amount. The hospital specific percentage is then applied to the total amount of funds available to determine the amount of a hospital's payment adjustment. The following example demonstrates how these calculations are applied:

Hospital A unreimbursed cost for services to Medicaid and uninsured = $20,000,000
Hospital A adjustment factor = 50%
Hospital A allocation basis = $20,000,000 x 50% = $10,000,000
Aggregate amount = sum of Hospital A + other allocation basis amounts = $500,000,000
Hospital A percentage = $10,000,000 / $500,000,000 = 2%
Remaining funds available = $300,000,000
Hospital A adjustment payment = 2% x $300,000,000 = $6,000,000

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

The following changes will be effective for DSH payment adjustments made on or after December 15, 2001:

- Division of Medical Assistance DSH criteria measuring Medicaid inpatient utilization, Medicaid charges and Medicaid admissions will be modified so that a hospital's services to both Medicaid and PeachCare patients will be considered.
- Medicaid intensity rate adjustment payments will be reclassified to DSH payments from the Indigent Care Trust Fund.

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The following changes will be effective for DSH payment adjustments made on or after December 15, 2004:

- If a hospital's county is not in a Metropolitan Statistical Area, as defined by the United States Office of Management and Budget, or if the population of the hospital's county is 35,000 or less, the hospital will be treated as a rural hospital.
- 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:
    - The hospital must have two or more physicians with staff privileges that are:
        - Enrolled in the Medicaid program;
        - Credentialed to provide OB services at the hospital in family practice, general practice, or obstetrics; and
        - 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
    - 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.