POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

R. OUTPATIENT HOSPITAL SERVICES

1. Outpatient services by Georgia hospitals are reimbursed on a determination of allowable costs. The determination of allowable costs is made retrospectively and is based on an appropriate CMS Form 2552 cost report submitted by the hospital and audited by the Department or its agents. Only costs incurred in providing patient care are eligible for reimbursement.

   Allowable costs will not include costs that are in excess of charges. Allowable costs are documented costs that are ordinary and necessary in the delivery of a cost-effective service. Allowable costs shall be determined in accordance with the CMS Provider Reimbursement Manual 15, except as may be modified in this plan or modified in the Department's "Policies and Procedures for Hospital Services" as published on January 1, 2008.

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

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

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

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

4. The maximum allowable payment for outpatient services will be 85.6% of the hospital specific inpatient per case rate for enrolled Georgia hospitals and enrolled non-Georgia hospitals.

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

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

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

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

   b) Memberships in civic organizations;

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

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

   e) Air transport vehicles that are not used to transport patient care staff or patients. If these vehicles are sometimes used for patient care staff or patient transport, the portion of cost that is unrelated to patient care staff or patient transport is nonallowable;

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

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

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

8. The maximum allowable payment for any outpatient hospital services claim will be the hospital's Medicaid-specific inpatient per case rate. When the outpatient cost-based settlements are made, claims for outpatient services which were paid at the per case rate will be excluded from the settlement calculations.

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

10. The Department will limit payment on outpatient Medicare crossover claims as follows: (a) multiply the allowable deductible and coinsurance amount by the hospital-specific percent of charges rate in effect on the date of payment; (b) compare the product from (a) to the hospital's inpatient per case rate in effect on the date of payment; (c) reimburse the lower of the two amounts in (b).

11. A$3.00 recipient co-payment is required on all non-emergency outpatient hospital visits. Pregnant women, recipients under twenty-one years of age,

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nursing home residents, and hospital care recipients are not subject to the co-payment. Emergency services and family planning services are exempt from co-payment. When the outpatient cost-based settlements are made for hospital services, the co-payments plus Medicaid and certain third party payments will be compared to the allowable cost to determine the amount of final settlement.

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

13. Effective for dates of service on and after July 1, 2004, the payment method is modified as follows:
a. For enrolled hospitals other than those identified in items b and c below, the reimbursement rate is 85.6% of costs.
b. For out-of-state enrolled hospitals, payments are made at the statewide average percentage of charges paid to Georgia hospitals that are reimbursed at 85.6% of costs and are not subject to cost settlement. The payment rate for out-of-state enrolled hospitals will not exceed 65% of covered charges.
c. For hospitals that are designated as a Critical Access Hospital, a historically minority-owned hospital, or as a state-owned hospital, the reimbursement rate continues at 100% of costs.

Example settlement calculation for critical access, historically minority owned hospital, or state-owned hospitals:

Percentage of charges paid on interim basis	60%
Charges for services provided during cost report period	$1,000,000
Interim payments	$600,000
Retrospective determination of allowable costs*	$585,000
% of allowable costs reimbursed	100%
Retrospective determination of reimbursable costs	$585,000
Settlement amount due from hospital	$15,000

Example settlement calculation for all other enrolled Georgia hospitals:

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Percentage of charges paid on interim basis	52%
Charges for services provided during cost report period	$1,000,000
Interim payments	$520,000
Retrospective determination of allowable costs*	$585,000
% of allowable costs reimbursed	85.6%
Retrospective determination of reimbursable costs	$500,760
Settlement amount due from hospital	$19,240

* amount would not exceed charges for services

14. Governmental facilities and Critical Access eligible hospitals which meet departmental requirements will be eligible for rate payment adjustments. The rate adjustment payments are intended to provide supplemental funding for Medicaid services to these facilities that based on their governmental status, need sufficient funds for their commitments to meet the healthcare needs of all members of their communities.

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

    - All amounts paid for services provided to Medicaid patients including interim Medicaid claim payments and estimated Medicaid cost report settlement amounts, based on data from cost report worksheet E-3 Part III, and
    - Estimated payment amounts for such services if payments were based on Medicare payment principles. 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

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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 below.

line	Facility Name	comments	XYZ Hospital
1	base period report period beginning date		9/1/xxxx
2	base period report period ending date		8/31/xxxx+1
3	HS&R processing date for Medicaid data		9/6/xxxx+2
4	adjustment factor (if period not equal to 1 year)		1
5	CAH status (1 = yes)		0
	subject to cost settlement		
6	cost of Medicaid covered services		755,769
7	covered charges		2,511,680
8	annual cost of Medicaid covered services	Line 6 x line 4	755,769
9	cost settlement rate		85.60%
10	annual Medicaid payments after cost settlement	Line 8 x line 9	646,938
	fee schedule lab only		
11	covered charges		813,178
12	payments		102,275
13	annual covered charges	Line 11 x line 4	813,178
14	annual interim payments	Line 12 x line 4	102,275

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15	annual cost of services	Line 13 x line 6 / line 7	244,687
	subject to fixed fee payment		
16	covered charges		223,627
17	payments		26,427
18	annual covered charges	Line 16 x line 4	223,627
19	annual interim payments	Line 18 x line 4	26,427
20	annual cost of services	Line 18 x line 6 / line 7	67,290
	subject to limit of inpatient rate		
21	covered charges		137,463
22	payments		48,481
23	annual covered charges	Line 22 x line 4	137,463
24	annual interim payments	Line 23 x line 4	48,481
25	annual cost of services	Line 23 x line 6 / line 7	41,363
	adjustment factors		
26	cost inflation	from cost report to UPL period	1.040

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27	Medicaid fee schedule lab payment rates	from cost report to UPL period	1.030
28	Medicaid payment rates subject to fixed fees	from cost report to UPL period	1.030
29	Medicaid payment rates subject to inpatient limit	from cost report to UPL period	1.030
30	volume allowance	from cost report to UPL period	1.014
31	adjusted Medicaid annual payments	[(Line 10 x line 26) + (line 14 x line 27) + (line 19 x line 28) + (line 24 x line 29)] x line 30	867,288

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32	adjusted annual cost of services	(Line 8 + line 15 + line 20 + line 25) x line 26 x line 30	1,169,622
33	UPL amount	Line 32 – line 33	302,334

Footnotes for UPL Adjustment Factors:

Line 26: Cost Inflation:

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

Line 30: Volume Allowance

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

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