DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244--1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid, CHIP, and Survey & Certification

JUN 1 1 2010

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

RE: State Plan Amendment 10-006

Dear Dr. Dubberly:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number l0-006. Effective April 1, 2010 this amendment modifies the State's reimbursement methodology for setting payment rates for inpatient hospital services. Specifically, the State proposes remove obsolete language regarding retrospective settlement of supplemental payments based on the upper payment limit. After April 1, 20l0 the payments will be made prospectively and no settlements will be completed.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), l902(a)(30), 1903(a), 1923, and l932(b)(2)(C) of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of April 1, 2010. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Stanley Fields at (502) 223-5332 or Venesa Day at 410-786-8281.

Sincerely

//s//

Cindy Mann
Director, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 10-006

2. STATE: GEORGIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2010

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250t

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 $0
FFY 2011 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, pp. 18-20

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, pp. 18-22

10. SUBJECT OF AMENDMENT:
INPATIENT HOSPITAL UPPER PAYMENT LIMITS

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//s//

13. TYPED NAME: Jerry Dubberly

14. TITLE: Chief, Division of Medicaid

15. DATE SUBMITTED:04-22-10

16. RETURN TO:
Department of Community Health
Division of Medicaid
2 Peachtree Street, NW, 36th Floor
Atlanta, Georgia 30303-3159

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 04-22-10

18. DATE APPROVED: 06-11-10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 04-01-10

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME:
Cindy Mann

22. TITLE: Director, CMCS

23. REMARKS:

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

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 determined in accordance with 42 CFR 413s or based on Medicare Prospective payment methods determined in accordance with 42 CFR 412.

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

TN No. 10-006
Supersedes
TN No.. 07-011
Approval Date JUN 1 1 2010
Effective Date APR - 1 2010

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

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.

Line	Field Descripiton	Comments	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
5	Medicaid inpatient claims paid at amount > 0:		
6	covered charges	From HS&R	3,949,268
7	payments	From HS&R	1,828,506
8	annual covered charges	From HS&R	3,949,268
9	annual payments	From HS&R	1,828,506
10	Cost of Medicaid Services	Worksheets C, Part 1 and D-1, Part II	1,661,931
11	Covered Charges for Medicaid Services	Worksheets C, Part 1 and D-1, Part II	3,725,000
12	inpatient CCR	Line 14 / Line 9	0.446156

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

13	annual cost of services	Line 4 X Line 6 X Line 12	1,761,990
15			
16	adjustment factors		
17	claim completion		1
18	inflation		1.073852
19	volume allowance		1.014000
20	combined adjustment factors	Line 17 X Line 18 X Line 19	1.088886
21	supplemental inpatient rate adjustments		0
22	adjusted annual charges	Line 4 X Line 6 X Line 20	4,300,302
23	adjusted Medicaid payments	Line 4 X Line 9 X Line 20	1,991,034
24	adjusted cost of services	Line 13 X Line 20	1,918,606
25	total Medicaid payments	Line 21 + Line 23	1,991,034

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

26	DRG differential		1.176249
27	adjusted Medicare-based annual payments	Line 23 X Line 26	2,341,952
28	UPL estimate	Line 27 - Line 25	350,918