

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



CENTER FOR MEDICAID & CHIP SERVICES (CMCS)

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

SEP -6 2012

Re: Georgia State Plan Amendment 12-005

Dear Mr. Dubberly:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 12-003. Effective July 1, 2012 this amendment proposes to adjust the payment methodology for Long Term Care services. Specifically, this amendment proposes to adjust reimbursement for nursing facilities. Specifically the amendment proposes to increase reimbursement rates resulting from a change to the 2010 cost report from the 2009 cost report as the basis for reimbursement rates. In addition, the amendment proposes to update the property and related per diem established under the FRV system based on the RSMeans Building construction cost data for Nursing Homes. The State estimates that the Federal budget impact of this SPA will be an increase of \$4,805,168 and \$19,220,672 for Fiscal Years 2012 and 2013 respectively.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of July 1, 2012. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Anna Dubois at (850) 878-0916.

Sincerely,

//s//

Cindy Mann
Director, CMCS

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 12-005	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 July 1, 2012	
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:		7. FEDERAL BUDGET IMPACT: FFY 2012 \$ \$0.00 FFY 2013 \$57,579,057	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Section 4.19-D Pages 6,8,9 and 19	
10. SUBJECT OF AMENDMENT: Nursing Home Reimbursement			
11. GOVERNOR'S REVIEW (Check One):			
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED: ☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: //s//		16. RETURN TO: Department of Community Health Medicaid Division 2 Peachtree Street, N.W. Atlanta, Georgia 30303-3159	
13. TYPED NAME: Jerry Dubberly			
14. TITLE :Chief, Medicaid Division			
15. DATE SUBMITTED: 06/08/12			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 06/08/12		18. DATE APPROVED: 09/06/12	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/12		20. SIGNATURE OF REGIONAL OFFICIAL: //s//	
21. TYPED NAME: Cindy Mann		22. TITLE: Director, CMCS	
23. REMARKS: Approved with the following changes to items 7, 8 and 9 as authorized by State Agency. Block #7 changed to read: FFY 12 \$4,805,168; FFY13 \$19,220,672. Block # 8 changed to read: Attachment 4.19-D page 6; Supplement 2 to Attachment 4.19-D pages 6, 9, 10, 14, 15, 17, 19, 20, 21 and Supplement 3 to Attachment 4.19D page 5. Block # 9 Changed to read: Attachment 4.19-D page 6; Supplement 2 to Attachment 4.19-D pages 6, 9, 10, 14, 15, 17, 19, 20, 21 and Supplement 3 to Attachment 4.19D page 5			

of general reimbursement principle, costs with respect to individuals covered by the Medicaid Program will not be borne by those not covered and costs with respect to individuals not covered by the Medicaid Program will not be borne by the Program. The principles of cost reimbursement require that institutions maintain sufficient financial records and statistical data for proper determination of costs payable under the Program. Such records and data must be maintained for a period of at least three years following the date of submission of the cost report

4. Case Mix Index Reports

- a. MDS Data for Quarterly Patient Listing - Using Minimum Data Set (MDS) information submitted by a facility, the Division will prepare a Case Mix Index Report, listing information for patients in a facility on the last day of a calendar quarter. A preliminary version of the report will be distributed to a nursing facility about the middle of the following quarter after each calendar quarter end. The preliminary version of the report will be distributed with instructions regarding corrections to patient payer source information that a nursing facility may submit for consideration before the final version of the report is prepared and distributed.
- b. RUG Classification - For each patient included in the quarterly Case Mix Index Report, the most recent MDS assessment will be used to determine a Resource Utilization Group (RUG) classification. Version 5.12, with 34 grouper and index maximizer, the RUG classification system will be used to determine a patient's RUG category.
- c. Payer Source - For each patient included in the quarterly Case Mix Index Report, a payer source will be identified. As described in section D.4.a, a facility will have the opportunity to submit updated payer source information for changes that may occur by the last day of the calendar quarter.
- d. Relative Weights and Case Mix Index Scores for All Patients - For each patient included in the quarterly Case Mix Index Report, a relative weight will be assigned by the Division. Exhibit D-1 identifies the relative weights for each RUG category. This data will be used to determine a case mix score for all patients in a facility.
- e. Relative Weights and Case Mix Index Scores for Medicaid Patients - For each Medicaid patient included in the quarterly Case Mix Index Report, a Medicaid relative weight will be assigned by the Division. Exhibit D-1 identifies the relative weights for each RUG category. This data will be used to determine a case mix score for Medicaid patients in a facility.
- f. BIMS Scores - For each patient included in the quarterly Case Mix Index Report, the most recent MDS assessment will be used to determine a Brief Interview for Mental Status (BIMS) score.
- g. Corrections to MDS and Payer Source Information Corrections to MDS and payer source information used in payment rate calculations applicable to prior dates of service that result from appeals or audit adjustments may be processed as adjustments to rate calculations in a subsequent period. If the impact of the correction is significant, the Division may elect to process the correction by a retrospective adjustment to prior payments.

5. Nursing Hours and Patient Day Report

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
NURSING FACILITY SERVICES**

- i. 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; and
- ii. The cost of home office vehicle expense.

A. Methods and Standards for Determining Reasonable Cost-Related Payments

The 2010 cost report, using the reporting format and underlying instructions established by the Department, will be used to determine a facility's allowable cost that will be the basis for computing a rate.

1. Prospective Rates

Payment rates to nursing facilities and ICF/MRs are determined prospectively using costs from a base period. For dates of service beginning February 1, 2012, the 2009 Cost Report is the basis for reimbursement.

2. Determination of Payment Classes

Classes are determined in accordance with Section 1002 of Supplement 2 to Attachment 4.19-D of the State Plan.

B. Payment Assurances

The State will pay each provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the provider under the Plan according to the methods and standards set forth in Section D, above.

In no case shall the payment rate for services provided under the plan exceed the facility's customary charges to the general public for such services.

Advertising costs that are (a) for fundraising 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.

Funds expended for personal purchases.

Rev. 07/01/06

1002.2 Total Allowed Per Diem Billing Rate for Facilities for Which a Cost Report is Used To Set a Billing Rate

Rev. 07/2010

For dates of service beginning July 1, 2012, the 2010 Cost Report is the basis for reimbursement.

Rev. 04/09

For these facilities the following formulas apply:

Total Allowed Per Diem Billing Rate =

Allowed Per Diem + Efficiency Per Diem + Growth Allowance + Other Rate Adjustments.

Summation of the (Net Per Diem or Standard Per Diem, whichever amount is less as to the facility; for Nursing Facilities, the resulting per diem amount for Routine and Special Services is multiplied by a facility's quarterly case mix score as determined by the Division for Medicaid patients during the most recent calendar quarter for which information is available) for each of the four Non-Property Cost Centers plus the Net Per Diem for the Property and Related Cost Center. The Property and Related Cost Center reimbursement for those facilities whose cost reimbursement is limited to the standard (90th percentile) per diem in this cost center will be based upon the standard per diem calculated from the cost reports for the year ending June 30, 1981.

Efficiency Per Diem =

Summation of (Standard Per Diem minus Net Per Diem) x 75% up to the Maximum Efficiency Per Diem for each of the five cost centers.

Rev. 07/01/2010

Growth Allowance =

Rev. 01/01/2008

Summation of 0% of the Allowed Per Diem for each of the four Non-Property and Related cost centers (Routine and Special Services; Dietary;

Historical Dietary, Schedule B, Line 8, Column 4, Divided By Total Patient Days.

Laundry and Housekeeping and Operation and Maintenance of Plant Net Per Diem =

Historical Laundry, Housekeeping, Operation and Maintenance of Plant, Schedule B, Lines 9 plus 10, Column 4, Divided By Total Patient Days.

Administrative and General Net Per Diem =

Historical Administrative and General, Schedule B, Line 11, Column 4, Divided By Total Patient Days.

Property and Related Net Per Diem =

Rev. 07/01/2010

Property and Related net per diem calculated under the Fair Rental Value System..

The Return on Equity Percent is 0% for all facilities.

Rev. 07/2010

Rev 07/2004

b. Standard Per Diem for each of the five cost centers (Routine and Special Services; Dietary; Laundry and Housekeeping and Operation and Maintenance of Plant; Administrative and General; and Property and Related) is determined after facilities with like characteristics concerning a particular cost center are separated into distinct groups. Once a group has been defined for a particular cost center, facilities in a group shall be ordered by position number from one to the number of facilities in the group, arranged by Net Per Diem from the lowest (Number "1") to the highest dollar value Net Per Diem. The number of facilities in the applicable group shall be multiplied by the Maximum Percentile, or a median net per diem may be chosen, with

the Maximum Cost per day being determined as a percentage of the median.

The Maximum Cost per day for the Administrative and General costs of all nursing facilities eligible for an efficiency incentive payment is 105% of the median cost per day within each peer group. The Maximum Percentile is the eighty-fifth for Laundry and Housekeeping and Operation and Maintenance of Plant cost centers. The Maximum Percentile is the ninetieth percentile for the Routine Services and Special Services, and the Property and Related cost centers. For the Dietary cost center, the Maximum Percentile is the sixtieth percentile for the Hospital-Based Nursing Facility group and the ninetieth percentile for the Free Standing Nursing Facility group and the Intermediate Care Facility for the Mentally Retarded group. If the Maximum Percentile does not correspond to a specific value in the array of net per diem amounts, the maximum percentile is determined by interpolation (i.e., finding the mid-point between whole integers).

Rev. 07/06

Rev. 07/2010

Rev. 07/06

The grouping will be done using Net Per Diem for each cost center that has been reported by the facility, and calculated by the Division .. Standards effective July 1, 2012, will not be recalculated based upon changes in rates due to subsequent determination of additional allowable cost, disallowance of previously allowable cost or any change in the Net Per Diem in any cost center. The following examples show groupings by Net Per Diem:

Routine and Special Services Maximum Percentile at 90%

Nursing Home Net Per Diem for 10 nursing homes from lowest to highest:

\$90, \$95, \$95, \$100, \$115, \$120, \$120, \$130, \$135, \$140

Maximum Percentile Standard Determination

(10 net per diems) X (90th percentile) = 9th position or \$135

Administrative and General Maximum Cost at 105% of Median

Nursing Home Net Per Diems for 11 nursing homes from lowest to highest:

\$90, \$95, \$95, \$100, \$115, \$120, \$120, \$130, \$135, \$140, \$150

Maximum Cost Standard Determination at 105% of Median

Rev. 07/01/2010

The Property and Related Net Per Diem referred to in subsections (a) through (c) above is equal to either the Fair Rental Value Rate as determined under Section 1002.5(a) through (g)

Rev 07/05

- d. In all other instances where the Division determines that a cost report cannot be used to set a reimbursement rate, the Total Allowed Per Diem Billing Rate will be resolved as described in the provisions discussed below for unauditable cost reports. If the Division determines that a cost report which was to be used to set a reimbursement rate is unauditable (i.e., the Division's auditors cannot render an opinion using commonly accepted auditing practices on the filed cost report, either on the desk review or on-site audit), or unreliable (See Supplement 3 to Attachment 4.19-D), the Division may reimburse the facility the lower of the following:
- The last Total Allowed Per Diem Billing Rate issued prior to the reimbursement period to be covered by the unauditable cost report;
 - The Total Allowed Per Diem Billing Rate calculated from the unauditable cost report; or
 - The Total Allowed Per Diem Billing Rate calculated according to 90% of the four Non-Property and Related Standard Per Diem amounts plus the appropriate growth allowance and Property and Related Net Per Diem.

Once a cost report becomes auditable and appropriate, the Total Allowed Per Diem Billing Rate will then be calculated using the audited cost report as a basis. The resulting reimbursement rate will then be applied to the appropriate period.

- e. If a case mix score cannot be determined for a facility, the average score for all facilities may be used in a rate calculation. If a facility's number of MDS assessments for Medicaid patients in a quarter is limited so as to make the resulting average case mix score unreliable for rate calculations, the Department may elect to use the average score for all facilities.

Rev. 07/01/07

1002.4 Other Rate Adjustments

Quality Improvement Initiative Program

Facilities must enroll in the Quality Improvement Program to receive the following incentives:

- a. A staffing adjustment equal to 1% of the Allowed Per Diem for Routine and Special Services may be added to a facility's rate. To qualify for such a rate adjustment, a facility's Nursing Hours and Patient Days Report must demonstrate that the facility meets the minimum staffing requirements presented in section 1003.1
- b. For the most recent calendar quarter for which MDS information is available, Brief Interview for Mental Status (BIMS) scores for Medicaid patients will be measured, as determined by the Division. An adjustment factor may be applied to a facility's Routine and Special Services Allowed Per Diem based on the percentage of Medicaid patients whose BIMS scores are less than or equal to 5. The adjustment factors are as follows:

% of Medicaid Patients	Adjustment Factor
<20%	0%
20% - <30%	1%
30% - <45%	2.5%
45% - 100%	4.5%

Rev. 07/01/2010

- c. A quality incentive adjustment may be added to a facility's rate utilizing the following set of indicators.

1. Clinical Measures:

The source of data is the Center for Medicare and Medicaid Services (CMS) website. Each measure is worth 1 point if the facility-specific value is in excess of the statewide average.

- (a) Percent of High Risk Long-Stay Residents Who Have Pressure Sores.
- (b) Percent of Long-Stay Residents Who Were Physically Restrained.
- (c) Percent of Long-Stay Residents Who Have Moderate to Severe Pain.
- (d) Percent of Short-Stay Residents Who had Moderate to Severe Pain.
- (e) Percent of Residents Who Received Influenza Vaccine.
- (f) Percent of Low Risk Long-Stay Residents Who Have Pressure Sores.

2. Alternative Clinical Measures:

Rev 4/08

NOTE: Facilities placed on the Special Focus List generated by CMS will not earn the DCH 1% Quality Incentive until the following conditions have been met:

- **The facilities next standard survey and/or compliant survey ,after being placed on the list, does not have a deficiency cited over Level E scope and severity; and**
- **The facilities second standard survey and /or compliant survey , after being placed on the list, does not have a deficiency cited over Level E scope and severity; or**
- **If the facility is removed from the special focus list by CMS for any other reason**

Rev. 07/01/2010

1002.5 Property and Related Reimbursement

1. Effective for dates of service on and after July 1, 2012, the Property and Related Net Per Diem shall be the amount computed using the Fair Rental Value (FRV) reimbursement system described below. Under a FRV system, a facility is reimbursed on the basis of the established current value of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest, and rent/lease expenses. The FRV system shall establish a nursing facility's bed value based on the age of the facility, its location, and its total square footage.
2. The Property and Related Net Per Diem established under the FRV System shall be calculated as follows:
 - (a) Effective for dates of service on and after July 1, 2012 the value per square foot shall be based on the \$146.08 construction cost for nursing facilities, as derived from the 2010 RSMeans Building Construction cost data for Nursing Homes (national index for open shop construction). The Value per Square Foot shall be adjusted by using the RSMeans Location factors based on the facility's zip code as well as by a Construction Cost Index which is set at 1.0708. The resulting product is the Adjusted Cost per Square Foot.

Example Calculation of Initial Fair Rental Value Per Diem

Ref.	Data Element	Example Data	Source of Data
A	Facility Name	XYZ Nursing	
B	Medicaid Provider ID	Home	Department Data
C	Rate Setting Year	12345678A	Department Data
D	Adjusted Base Year	2012	Department Criteria
E	Licensed Nursing Facility Beds	1989	Department Data
F	Nursing Facility Square Footage	138	Department Data
G	Nursing Facility Zip Code	68,857	Department Data
H	Total Patient Days	30312	Department Data
I	Per Bed Square Footage Limit	48,552	Department Data
J	Maximum Allowed Square Footage	700	Department Criteria
K	Allowed Total Square Footage	96,600	E x I
		68,857	lesser of F or J
L	Rate Year RSMeans Cost per Square Foot	\$146.08	RSMeans lookup based on Rate Year
M	RSMeans Location Factor	0.9	RSMeans lookup based on Zip Code (G)
N	Construction Cost Index	1.0708	Department Criteria
O	Adjusted Cost per Square Foot	\$140.78	L x M x N
P	Facility Replacement Value	9,693,688	K x O
Q	Equipment Allowance	6,000	Department Criteria
R	Equipment Cost Index	1	Department Criteria
S	Equipment Value	\$828,000.00	E x Q x R
T	Facility Value Excluding Land	\$10,521,688	P + S
U	Bed Additions and Facility Renovations	0	Separate calculations affecting the Nursing Facility (see D and V) C - D (D is based on initial age adjusted by additions/renovations per U)
V	Nursing Facility Age	21	
W	Maximum Years for FRV Age	25	Department Criteria

Ref.	Data Element	Example	Source of Data
X	FRV Adjusted Facility Age	23	lesser of V or W
Y	Facility Depreciation Rate	2.00%	Department Criteria
Z	Depreciation Using FRV Adjusted Age	\$4,839,976	$T \times X \times Y$
AA	Depreciated Replacement Value	\$5,681,712	$T - Z$
AB	Land Percentage	15.00%	Department Criteria
AC	Land Value	\$1,454,053	$P \times AB$
AD	Depreciated Replacement Value & Land	\$7,135,765	$AA + AC$
AE	Rental Rate	9.00%	Department Criteria
AF	Rental Amount	\$642,218	$AD \times AE$
AG	Minimum Occupancy Percentage	85.00%	Department Criteria
AH	Bed Days at Minimum Occupancy	42,815	$E \times 365 \times AG$
AI	Total Allowed Patient Days	48,552	Higher of H or AH
AJ	Fair Rental Value per Diem	\$13.22	AF / AI

3. The Property and Related Net Per Diem may be updated annually on July 1, effective for dates of service on or after July 1, 2010 as follows:

- (a) The value per square foot shall be based on the construction cost for nursing facilities, as derived from the most recent RSMeans Building Construction cost data available on June 1st of each year. The Value per Square Foot shall be adjusted by using the RSMeans Location factors based on the facility's zip code and by using a cost index to correspond to annual state appropriations.
- (b) A complete facility replacement, which includes either relocating to a newly constructed facility or gutting a complete facility and rebuilding it, will result in a new base year correlating to the date in which the facility went into operation. All partial replacements will be treated as renovations and will have their base year adjusted based on the methodology proscribed for a renovation.

4. A Renovation Construction Project shall mean a capital expenditure (as defined in Section 1002.5(4a)) that exceeds \$500 per existing licensed bed and has been filed with the Office of Health Planning as a New Construction Project under the authority of Ga. Comp. R. & Regs. r. 290-5-8:

- a. Allowable capital expenditures include the costs of buildings, machinery, fixtures, and fixed equipment (see Table 5 in Estimated Useful Lives of Depreciable Hospital Assets) Revised 2008 Edition), published by Health Forum, Inc., for a complete listing of allowable items) constituting any New Construction Project as referenced in paragraph 4 above. The exception, to this requirement is for telemedicine terminals, solar panels, tankless water heaters, and low flow toilets. Capital expenditures are asset acquisitions that meet the criteria of §108.1 of the Provider Reimbursement Manual (CMS-15-1) or are betterments or improvements which meet the criteria of §108.2 of the Provider Reimbursement Manual (CMS-15-1) or which materially (a) expand the capacity, (b) reduce the operating and maintenance costs, (c) significantly improve safety, or (d) promote energy conservation.
5. For purposes of the FRV calculation, the age of the facility shall be determined as follows:
- (a) The age of each facility shall be determined as of July 1, 2012 by comparing the 2012 rate setting year to the later of the facility's year of construction or the year the building was first licensed as a nursing facility; provided, however, that such age will be reduced for Construction Projects, or bed additions that occurred subsequent to the initial construction or conversion of the facility, but prior to July 1, 2012.
 - (b) For periods subsequent to July 1, 2012, the FRV adjusted age determined in Section 1002.5(5a) of a facility will be reduced on a quarterly basis to reflect new Renovation Construction Projects or bed additions that were completed after July 1, 2012, and placed into service during the preceding quarter. The rate adjustment for Renovation Projects or bed additions will be effective the first day of the calendar quarter subsequent to such project being completed and placed into service.
 - (c) Once initial rates are established under the FRV reimbursement system, subsequent calculations of the FRV adjusted age will be determined by subtracting the adjusted base year (derived by calculating the impact of bed additions and facility renovations) from the rate setting year.. The FRV adjusted age may be recalculated each July 1 to make the facility one year older, up to the maximum age of 25 years and will be done in concert with the calculations of the Value per Square Foot as determined in