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State/Territory Name: Georgia

State Plan Amendment (SPA) #: 18-0010

This file contains the following documents in the order listed:

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

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

November 14, 2018

Blake Fulenwider
Deputy Commissioner, Medicaid Chief
Georgia Department of Community Health
2 Peachtree Street, NW, Suite 36-450
Atlanta, GA 30303

RE: Title XIX State Plan Amendment, GA 18-0010

Dear Mr. Fulenwider:

We have reviewed the proposed State Plan Amendment, GA 18-0010, which was submitted to the Atlanta Regional Office originally on September 19, 2018. This state plan amendment proposes to increase the hospitals triage rate from $50 to $70 for rural hospitals and from $50 to $60 for all other hospitals.

Based on the information provided, the Medicaid State Plan Amendment GA 18-0010 was approved on November 13, 2018. The effective date is July 1, 2018. We are enclosing the approved HCFA-179 and the plan pages.

If you have any additional questions or need further assistance, please contact Amr Ali at (404) 562-7338 or Amr.Ali@cms.hhs.gov.

Sincerely,

/s/

Shantrina D. Roberts, MSN
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

1. TRANSMITTAL NUMBER: 18-0010

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, 2018

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 447.205, 42 CFR 440.10

7. FEDERAL BUDGET IMPACT:
FFY 2018 $954,304
FFY 2019 $2,826,133

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, pages 8.1, 8.2, 8.3, 8.4, 8.5

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, pages 8.1, 8.2, 8.3, 8.4, 8.5

10. SUBJECT OF AMENDMENT: State Plan Amendment 18-0010, Hospital Triage Rate Increase

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/

13. TYPED NAME: BLAKE FULENWIDER

14. TITLE: DEPUTY COMMISSIONER, CHIEF, DIVISION OF MEDICAL ASSISTANCE PLANS

15. DATE SUBMITTED:

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:
09/19/18

18. DATE APPROVED: 11/13/18

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
07/01/18

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
Shantrina D. Roberts

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Operations

23. REMARKS:

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. Fees paid to the Department of Community Health pursuant to the Hospital Medicaid Financing Program Act of 2013 shall be considered allowable cost but will not be included in the retrospective cash settlement and reconciliation of the providers cost report.

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

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

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

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

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

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

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

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

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

5. Emergency room visits to rural hospitals for minor and non-acute illnesses which are not considered as true or potential medical emergencies will be reimbursed at an all-inclusive rate of $70.00. A "rural hospital" shall be defined as a hospital in a Georgia county that has a population of less than 50,000 according to the United States decennial census of 2010, less any military personnel and their dependents.

   Emergency room visits to hospitals that are not a rural hospital for minor and non-acute illnesses which are not considered true or potential medical emergencies will be reimbursed as an all-inclusive rate of $60.00.

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

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

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

   b) Memberships in civic organizations;

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

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

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

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 non-allowable;

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

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

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

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

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

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

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

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

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

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

13. Effective July I, 2013, an adjustment will be added to the hospital outpatient payment rate. Critical Access Hospitals (CAHs) Psychiatric Hospitals and State-Owned / State-Operated Hospitals are exempt from the provider fee and the rate increase. Trauma hospitals will participate in the provider fee but at a lower percentage than other participating hospitals. The table below shows the provider fee and associated rate adjustment for different classes of hospitals.

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

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

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

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

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

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

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

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

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