Table of Contents

State/Territory Name: Georgia

State Plan Amendment (SPA) #: 19-0009

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

December 9, 2019

Lynnette R. Rhodes, Esq.
Executive Director, Medical Assistance Plans
Department of Community Health
2 Peachtree St., 36th Floor
Atlanta, Georgia 30303-3159

RE: Georgia State Plan Amendment 19-0009

Dear Ms. Rhodes:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number 19-0009. This amendment proposes to modify and increase the payments for nursing facility services. Specifically, the SPA proposes to:

1. Increase the growth allowance used in the computation of nursing facility per diem rates to 13.37% as an inflationary adjustment and to recognize additional costs for enhanced background checks;
2. Increase the maximum reimbursement incentive for nursing facilities with 45% or more Medicaid residents during a quarter with Brief Interview for Mental Status (BIMS) scores of less than or equal to 5 from 4.5% to 5.5.%; and
3. Establish a minimum nursing facility reimbursement per diem rate of $147.00 for services provided on or after July 1, 2019.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of July 1, 2019. 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/

Kristin Fan
Director

cc:
Anna Dubois
Dan Yablochnikov

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
0 MB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **19-0009**

2. STATE: GEORGIA

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

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

4. PROPOSED EFFECTIVE DATE
July 1, 2019

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

[ ] NEW STATE PLAN [ ] AMENDMENT TO BE CONSIDERED AS NEW PLAN [X] AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION

42 C.F.R. § 438.6(c), 438.50, 438.52, 438.56, 431.51, 435.145, 435.118

7. FEDERAL BUDGET IMPACT
a. FFY 2019 $7,659,403
b. FFY 2020 $30,492,623

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Supplement 2 to Attachment 4.19-D, Pages 7, 8, 21
Attachment 4.19-D Pages 2, 3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Supplement 2 to Attachment 4.19-D, Pages 7, 8, 21
Attachment 4.19-D Pages 2, 3

10. SUBJECT OF AMENDMENT

This State Plan Amendment will result in an aggregate rate increase for Georgia's nursing facilities based on a. 3.07% inflationary increase and 1% increase in quality incentive payment.

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

[X] OTHER, AS SPECIFIED
Single State Agency
Comments Attached

[redacted]

12. LYNNETTE R. RHODES, ESQ.

13. TITLE
EXECUTIVE DIRECTOR, MEDICAL ASSISTANCE PLANS

15. DATE SUBMITTED 9/29/19

16. RETURN TO

Georgia Department of Community Health
Division of Medical Assistance Plans
2 Peachtree Street, NW, 36th Floor
Atlanta, Georgia 30303-3159

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
09/30/19

18. DATE APPROVED 12/09/19

PLAN APPROVED - ONE COPY ATTACHED

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

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME Kristin Fan

22. TITLE Director, FMG

23. REMARKS state authorized pen and ink changes to blocks 8 and 9

Adding amended page 6 and Adding new page 3a

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
NURSING FACILITY SERVICES

a. All nursing facilities are required to report costs on a uniform cost report form provided by the State Agency. Hospital-Based facilities using Medicare fiscal year ending dates between May 31 and June 30 must submit cost reports on or before November 30. Those using Medicare fiscal year ending dates between July 31 and September must submit cost reports on or before December 31 using the most recent complete fiscal year cost data. All other facilities are required to submit cost reports on or before September 30 of the year in which the reporting period ends.

b. All nursing facilities are required to submit to the Department any changes in the amount of or classification of reported costs made on the original cost report within thirty days after the implementation of the original cost report used to set reimbursement rates. Adjustments to amounts or changes in classification of reported costs in prior years will not be considered.

1. All nursing facilities are required to maintain financial and statistical detail to substantiate the cost data reported for a period of at least three years following the date of submission of the cost report form to the State Agency. These records must be made available upon demand to representatives of the State Agency or the DHHS.

2. The State Agency shall retain all uniform cost reports submitted in accordance with paragraph 2a above for a period of three years following the date of submission of such reports, and will properly maintain those reports.

A. Field Examinations and Desk Reviews

1. The State Agency has, as needed, updated and revised resource materials developed in prior years through the accomplishment of the following tasks:

   a. The development of standards of reasonableness for each major cost center of a nursing facility;

   b. The development of a computerized desk review process for the submitted uniform cost reports; and

   c. The development of a detailed field examination plan, using American Institute of Certified Public Accountants (AICPA) generally accepted auditing standards.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
NURSING FACILITY SERVICES

The standards, desk review, and on-site examinations ensure that only expense items allowable under the Georgia Plan, as detailed under Section C of this attachment, are included in the facility's uniform cost report and that the expense items included are accurately determined and are reasonable.

2. The State Agency will conduct analyses of the uniform cost reports for the reporting year ending the previous June 30th to verify that the facility has complied with paragraphs 2 and 3 above in Section A.

3. Where the analyses conducted, as specified in paragraph B 2 above, reveal that a facility has not complied with requirements, further examination of the facility's financial and statistical records and other documents will be conducted as needed.

4. On-site examinations of the financial and statistical records will be performed annually in at least 15 percent of participating facilities, with desk reviews completed for the remaining facilities. The independent accountant reports will be submitted for the Department's approval by September 30 of the year following the reporting year of the cost reports. Such on-site examinations of financial and statistical records will be sufficiently comprehensive in scope to ascertain whether, in all material respects, the uniform cost report complies with Section B, Paragraph 1 above.

5. The on-site examinations conducted in accordance with Section B, paragraph 4 above shall produce an independent accountant report which shall meet AICPA generally accepted auditing standards. The report shall declare the accountant's opinion as to whether, in all material respects, the uniform cost report includes only expense items allowable under the Georgia Plan, as detailed under Section C of this attachment, and that the expense items included are accurately determined, and are reasonable. These independent accountant reports shall be kept by the State Agency for at least three years following the date of submission of such reports, and will be properly maintained.

6. Any overpayments found in the field examinations and desk reviews under this paragraph will be accounted for on Form HCFA-64 no later than 60 days from the date that the final rate notification is sent to the nursing facility.

B. Allowability of Costs

The Department uses the Centers for Medicare and Medicaid Services Manual (CMS 15-1) Medicare principles, as a guide to determine allowable and non-allowable costs. However, in situations where warranted, the Department has developed policy regarding cost allowability outsold of CMS 15-1. In addition to the use of the CMS 15-1 as a guide, the Department describes specific cost allowability in Supplement 2 of Attachment 4.19-D. The following paragraphs address the allowability of costs:

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.

C. 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.

D. 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.

REIMBURSEMENT FOR NURSING FACILITY SERVICES

8. 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.

9. Funds expended for personal purchases.

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

For dates of service beginning July 1, 2018, the June 30, 2012 Medicaid Cost Report is the basis for reimbursement for all nursing facilities except those nursing facilities reimbursed in accordance with the rules applicable to nursing facilities purchased from an unrelated party between January 1, 2012 and June 30, 2014. For those facilities, the June 30, 2013, June 30, 2014 or December 31, 2014 cost report is the basis for reimbursement. Effective July 1, 2018, the basis for reimbursement for the Supplemental Administrative and General- General and Professional Liability Insurance cost center will be the June 30, 2018 GL-PL Insurance Supplemental Report. Effective July 1, 2019, the minimum nursing facility per diem billing rate shall be $147.00.

For these facilities the following formulas apply:

Total Allowed Per Diem Billing Rate =

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

REIMBURSEMENT FOR NURSING FACILITY SERVICES

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 (including the Supplemental Administrative and General-General and Professional Liability Insurance cost center) plus the Net Per Diem for the Property and Related Cost Center. The Property and Related Cost Center reimbursement is the facility's computed Fair Rental Value per diem.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.

Growth Allowance =

Summation of 13.37% of the Allowed Per Diem for each of the four Non-Property and Related cost centers (Routine and Special Services; Dietary; Landry and Housekeeping and Operations and Maintenance of Plant; and Administrative and General).

Further explanation of these terms is included below:

a. In general, the Net Per Diem is determined from the costs of operation of the individual facility in which eligible patients reside. These reports are determined by utilizing the information submitted by the facility on its Cost Report.

   All amounts and supporting data submitted on the Cost Report are subject to verification and adjustment by the Division. These modifications concern: mathematical calculation errors; limitations placed on allowable costs, and the documents, principles, and criteria referenced therein; reasonableness limitations placed on salaries paid employees of the facility; reasonableness limitations using the principles contained in CMS-15-1; or other parameters placed on reasonable cost by the Division. These modifications basically concern what expenses are attributable to the care received and the reasonableness of the amounts of expenses that are attributable to care.

30% - <45%	2.5%
45% - 100%	5.5%

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 Centers 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 Sever 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:

Facilities that do not generate enough data to report on the CMS website (due to not meeting the minimum number of assessments for a reporting in a quarter) will use the following measures from the My InnerView (MIV) Quality Profile. The values used from MIV Quality Profile will be compared to the MIV Georgia average values for those measures. Each measure is worth 1 point if the facility-specific value is in excess of the MIV Georgia average.

(a) Chronic Care Pain – Residents without unplanned weight loss/gain.
(b) PAC Pain – Residents without antipsychotic medication use.