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State/Territory Name: Georgia

State Plan Amendment (SPA) #: GA-24-0010

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 S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

December 16, 2024

Stuart Portman
Executive Director
Medical Assistance Plans Division
2 Martin Luther King Jr. Drive SE
East Tower, 19th Floor
Atlanta, Georgia 30334

RE: TN GA-24-0010

Dear Director Portman:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Georgia state plan amendment (SPA) to Attachments 4.19-D GA-24-0010, which was submitted to CMS on September 18, 2024. This plan amendment implements the Patient Driven Payment Model (PDPM) using the nursing acuity component only. The nursing acuity component measures the estimated nursing resource needs a resident may have based on their presenting conditions and functional status.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2) of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact James Francis at 857-357-6378 or via email at James.Francis@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0010

2. STATE: GA

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
7/1/2024

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR § 447.252, 42 CFR 447.253(B)(1)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 24 $ (1,267,177)
b. FFY 25 $ (3,801,531)

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Section 4.19-D, Pages 4-8~~
Section 4.19 D, Supplement 3, Pages 1—8

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
~~Section 4.19-D, Pages 4-8~~
Section 4.19 D, Supplement 3, Pages 1—8

9. SUBJECT OF AMENDMENT
Update SPA to language related to Resource Utilization Group (RUG) and replace with language related to Patient Drive Payment Model (PDPM) and correct grammatical and formatting errors. Update Exhibits D-1 and D-2.

10. 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:

[redacted]

12. TYPED NAME
Lynnette R. Rhodes

13. TITLE
Chief Health Policy Officer

14. DATE SUBMITTED
9/18/2024

15. RETURN TO
Stuart Portman
Executive Director, Medical Assistance Plans Division
Georgia Department of Community Health
2 Martin Luther King Jr. Drive
East Tower, 19th Floor
Atlanta, Geogia 30334
Email: stuart.portman@dch.ga.gov

FOR CMS USE ONLY

16. DATE RECEIVED
9/18/2024

17. DATE APPROVED
December 16, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
7/1/2024

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS

On 11/18/2024, the state provided written permission to make a pen-and-ink change to add the date 9/18/2024 to block 14. (JGF)

On 12/11/2024, the state provided written permission to make a pen-and-ink change to Blocks 7 and 8 as follows: "Section 4.19 D, Supplement 3, Pages 1—8."

Instructions on Back

PART II, POLICIES AND PROCEDURES FOR NURSING FACILITY SERVICES

APPENDIX D

General

This appendix discusses the use of a uniform chart of accounts, the annual submission of a cost report, the principles of reimbursement which comprise the basis for the financial reporting requirements of facilities participating in the Georgia Medicaid Program and other reporting requirements. The Georgia Division of Medical Assistance Uniform Chart of Accounts as comprised on the date of service is incorporated by reference herein. A copy is available from the Division upon request Cost reports and instructions are made available to each facility near the end of the reporting period. The reimbursement principles discussed in this appendix are selected from the Centers for Medicare and Medicaid Services Provider Reimbursement Manual {CMS-15-1). Copies of the Manual, which provide a detailed description of allowable costs, are available from the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

1. Uniform Chart of Accounts

The Georgia Division of Medical Assistance requires that all nursing facilities participating in the Medicaid Program utilize the classification of accounts shown in the Uniform Chart of Accounts in reporting its financial operations in the cost reporting system. While it is not mandatory that books of original entry or ledgers be maintained in accordance with the Uniform Chart of Accounts, facilities are strongly encouraged to do so. The Uniform Chart of Accounts has been designed to meet management needs for budgeting information, information flow, internal control, responsibility accounting and financial reporting. Also, it has been designed in such a manner that accounts may be added or deleted to tailor the financial information to the facility's needs.

Should a facility elect to maintain its books of original entry or ledgers in a manner other than that specified in the Uniform Chart of Accounts, the facility is required to have available a detailed description of how its accounting system differs. This description of differences must be used by the facility for converting the output of its reporting system into the format specified in the Uniform Chart of Accounts. This description of differences and conversion of reporting information into the proper format are considered to be essential components of a facility's accounting records. When such information is needed but not maintained, a facility's cost report will be determined to be unacceptable

for fulfilling reporting requirements and penalties described in Section 2.b and 2.g of this appendix will be imposed.

2. Cost Reporting

Reimbursement of expenses incurred by nursing facilities in the provision of care to Medicaid recipients is accomplished through the mechanism of the cost report. This document reports historical costs and details recipient occupancy data experienced during the fiscal year. The following cost reporting requirements apply to providers of nursing facility services and all home offices who allocate costs to nursing facilities:

a. Each nursing facility must annually file a cost report with the Division of Medical Assistance which covers a twelve-month period ending June 30th. Cost reports must be e-mailed to the Division on or before September 30th. (See Hospital-based facility exception in 2(d) below.)

b. If such cost reports are not filed by September 30th, the Division shall have the option of either terminating the provider agreement upon thirty days written notice or imposing a penalty of $50.00 per day for the first thirty days and a penalty of $100.00 per day for each day thereafter until an acceptable cost report is received by the Division. The only condition in which a penalty will not be imposed is if written approval for an extension is obtained from the Program Manager of Nursing Home Reimbursement Services prior to September 30.

c. If a cost report is received by the Division prior to September 30th but is unacceptable, it will be returned to the facility for proper completion. No penalty will be imposed if the properly completed report is filed by the September 30th deadline. However, the above described penalties may be imposed after the September 30th deadline until an acceptable cost report is received by the Division.

d. Hospital-based facilities using Medicare fiscal year ending dates between July and April must submit cost reports to the Division on or before September 30. Facilities using fiscal year ending dates between May and June must submit cost reports on or before November 30. The financial information to be included on the Medicaid cost report must be taken in total from the provider's most recent Medicare cost report that precedes June 30. The rules regarding unacceptability and timeliness described above in sections b. and c. also apply to hospital-based facilities' cost reports.

Approval for extensions beyond the September 30 or November 30 deadline, where applicable, will be granted only if the provider's operations are "significantly adversely affected" because of circumstances beyond the provider's control (i.e., a flood or fire that causes the provider to halt operations). Each provider must submit a written request specifying the hospital-based facility and the reason for the extension.

To be acceptable, a cost report must be complete and accurate, include all applicable schedules, and be correctly internally cross- referenced. Further, the amount per book column for Schedules B and C must agree with the amounts recorded in the facility's general ledger; however, there may have to be certain groupings of the general ledger amounts to agree with the cost report line items. Estimated amounts used for a conversion to a June 30th year-end are not acceptable. Reported costs of interest paid to non-related parties must be reduced by non-related parties must be reduced by an amount equal to the lesser of: (1) interest paid to non-related parties; or (2) investment income other than the exceptions identified in CMS-15, Section 202.2.

Reported costs of special services must be reduced, as indicated on Schedule B-lA, by an amount resulting from revenue received from sources other than the Division for these services. Adjustments will be based on auditable records of charges to all patients as required by cost report instructions.

Any changes to the amount of or classification of reported costs and patient day information must be made within 30

days after the applicable September 30th November 30th or approved extended submission deadline. Amended cost reports submitted after these deadlines will not be accepted unless they have been requested by the Division. If the original cost report is used to set reimbursement rates, the provider has up to 30 days from the implementation of the original cost report to request changes to the amount of or classification of reported costs and patient day information in accordance with the appeal procedures outlined in Appendix I (Billing rate and Disallowance of Cost from the Cost Report), Adjustments to amounts or changes in classification of reported costs in prior years will not be considered.

Late cost report penalties will be invoiced through the Accounting Section of the Division for the total amount of the assessed penalty. The provider must submit payment to the Division. Penalties not properly paid will be deducted from the monthly reimbursement check. The assessments will not be refunded.

e. New facilities, which have less than twelve but not less than six months of actual operating cost experience, will only submit cost data for their actual months of operation as of June 30. New facilities that have less than six months of actual operating cost experience are not required to submit a cost report. Facilities in which there has been a change of ownership must submit a separate report for each owner. The subsequent owner will be reimbursed based on the previous owner's cost report (with an adjustment in the property cost center only) until a new cost report is received from the new owner and determined reliable and appropriate. The Division will determine whether each submitted cost report is appropriate and reliable as a basis for computing the Allowed Per Diem billing rate and may calculate a facility's Allowed Per Diem billing rate in accordance with Section 1002.3.

For ownership changes effective with at least six months of patient day data on the applicable June 30 fiscal year cost report, the initially submitted cost report will be used to establish the new owner's rate when the comparable cost reports are used to set rates. For the periods prior to the use of the new owner's cost report, the new owner will receive rates based on the previous owner's approved cost report data, with the appropriate Fair Rental Value property reimbursement rate. If the new owner's initial cost report contains less than six months of patient day data, when the initial cost report period reports are used to set rates, the new owner will receive a rate based on the previous owner's last approved cost report inflated to current costs, as determined by the Division, or the costs from the new owner's initial cost report, whichever is lower. If the ownership change is between related parties, when the initial cost report period reports are used to set rates, the old owner's cost report and new owner's cost report for the year of the ownership change may be combined and considered in determining the minimum rate for the new owner.

f. Reported costs must conform to Divisional instructions, or in the absence of specific instructions, to the allowable costs discussed in CMS-15-1. Reported costs are subject to audit verification by the Division, State or Federal auditors or their agents. Providers using computerized information systems for accounting or other purposes must make this information available in a suitable electronic format if requested by the Division or its agents. Where such audit verifications determine that the cost report was prepared based upon inadequate accounting records, the facility will be required to correct its records and submit a corrected cost report. A penalty will be imposed on the facility for the costs incurred by the Division for any additional audit work performed with the corrected cost report.

g. For audit examinations described in (i) above, it is expected that a facility's accounting records will be available within the State. Should such records be maintained at a location outside the State, the facility will be required to pay for travel costs incurred for any examination conducted at the out-of-state location.

h. Should a cost report submitted to the Nursing Home Unit for review need explanation or clarification, appropriate work papers or letters of explanation should be attached.

l. All cost reports and supporting documentation must be emailed to nhcostreport@dch.ga.gov. Correspondence concerning the cost reports may be mailed to the following address:

Department of Community Health
2 Martin Luther King Jr. Dr. SE
East Tower, 17th Floor
Atlanta, GA 30034

3. Reimbursement Principles

The objective of a system of reimbursement based on reasonable costs is to reimburse the institution for its necessary and proper expenses incurred related to patient care. As a matter 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 ends. 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. PDPM Classification - For each patient included in the quarterly Case Mix Index Report, the most recent MDS assessment will be used to determine a Patient Driven Payment Model (PDPM classification. Version 2.2001, with 34 grouper and index maximizer, the PDPM value assigned by CMS will be used for the PDPM Case Mix value.

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 PDPM 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 PDPM category. This data will be used to determine a case mix score for Medicaid patients in a facility.

f. CPS Scores - For each patient included in the quarterly Case Mix Index Report, the most recent MOS assessment will be used to determine a Cognitive Performance Scale (CPS) score.

g. Corrections to MDS and Payer Source Information Corrections to MOS 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.

A detailed description of all data elements in the Case Mix Index Report is presented in Exhibit D-2.

5. Nursing Hours and Patient Day Report

Except for ICF-MR's, each nursing facility must submit a Nursing Hours and Patient Day Report for each calendar quarter, within one month after the end of the quarter. The required information will be submitted in accordance with a format and instructions as distributed by the Division. A facility's request to correct or amend a nursing home provider fee report will be limited to a 30 day period following the report's due date. Corrections to nursing hours and patient day data 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.

If a facility does not submit a report or does not submit a report when due, a late fee of $10 per day may be assessed.

EXHIBITD-1

Category	PDPM Code	PDPM Nursing Component	PDPM Index for All Patients	PDPM Index for Medicaid Patients
Extensive Services	ES3	A	3.95	4.03
Extensive Services	ES2	B	2.99	3.05
Extensive Services	ES1	C	2.85	2.91
Special Care High/Low	HDE2	D	2.33	2.38
Special Care High/Low	HDE1	E	1.94	1.98
Special Care High/Low	HBC2	F	2.18	2.22
Special Care High/Low	HBC1	G	1.81	1.85
Special Care High/Low	LDE2	H	2.02	2.06
Special Care High/Low	LDE1	I	1.68	1.71
Special Care High/Low	LBC2	J	1.67	1.70
Special Care High/Low	LBC1	K	1.39	1.42
Cognitive Impairment	CDE2	L	1.82	1.86
Cognitive Impairment	CDE1	M	1.58	1.61
Cognitive Impairment	CBC2	N	1.51	1.54
Cognitive Impairment	CA2	O	1.06	1.08
Cognitive Impairment	CBC1	P	1.3	1.33
Cognitive Impairment	CA1	Q	0.91	0.93
Behavior Issues	BAB2	R	1.01	1.03
Behavior Issues	BAB1	S	0.96	0.98
Physical Functioning	PDE2	T	1.53	1.56
Physical Functioning	PDE1	U	1.43	1.46
Physical Functioning	PBC2	V	1.19	1.21
Physical Functioning	PA2	W	0.69	0.70
Physical Functioning	PBC1	X	1.1	1.12
Physical Functioning	PA1	Y	0.64	0.65

EXHIBIT- 2

Detailed Description of Data Presented in Case Mix Index Reports

Selection criteria for quarterly "Listing of Residents" reports – Residents are determined by identifying individuals for whom an MDS assessment has been received and for whom no subsequent discharge tracking document has been received. It is assumed that residents for whom a periodic assessment is more than 3 months past due have been discharged and these individuals are not included in this report. The following data elements are selected from the most recent assessment data for patients residing in the nursing home on the last day of a calendar quarter:

A0310a – Reasons for assessment as reported in section A0310 of the MDS Section

1 = admission assessment

2 = quarterly review assessment

3 = annual assessment

4 = significant change in status

5 = significant change to prior comprehensive assessment

6 = significant correction to prior quarterly assessment

99 = not OBRA required assessment

Section b, PPS Unscheduled Assessment for a Medicare Part A Stay

8 = Interim Payment assessment
99 = not PPS assessment

Resident Name – Self explanatory

Completion Date (ZO500b) – For assessments, this is the date completed as reported in section ZO500b of the MDS. For discharge tracking, this is the date of discharge. For re-entry tracking, this is the date of re-entry.

PDPM Code – PDPM classification code (see "PDPM Index for All Patients" in Exhibit D-1) provided by CMS PDPM calculation. If CMS is unable to calculate a PDPM value due to missing PDPM items, the default PDPM value "Z" will be assigned.

PDPM Category – Description of PDPM classification (see Exhibit D-1)

PDPM CMI and PDPM CMI Add-on – see "PDPM Mix Index for all Patients".

Resident ID – Identification number assigned to resident by MDS reporting system.

Medicaid Cognitive Add-On – Identifies residents with Brief Interview for Mental Status (BIMS) scores less than or equal to 5. In the absence of BIMS scores, identifies residents with Cognitive Performance Scale (CPS) scores of moderately severe to very severe.

Payment Source – Primary source of payment for services to residents based on information included in MDS assessment data. If the MDS data includes a Medicaid identification number or Medicaid pending designation, Medicaid is assumed to be the resident's payment source. If a Medicaid identification number is not present and a Medicare identification number is present, Medicare is assumed to be the payment source. If neither a Medicaid nor Medicare identification number is present, the payment source is identified as "other." A facility may submit a correction entry to the Division to note any changes to a patient's payment source that may not be reflected in MDS data. Such correction entries for payment status will be assumed to be permanent unless a subsequent correction entry is submitted for a resident.

Number of Residents, Overall CMI Averages and Medicaid CMI Average – The number of residents and average case mix index score, based on relative weights for "PDPM Index for All Patients" in Exhibit D-1, are listed for 3 categories of residents by payment source – Medicaid, Medicare, and Other. For Medicaid patients, an average case mix index score, based on relative weights for "Case Mix Index for Medicaid Patients," is also listed.

Number and % of Residents Included in Cognitive Add-On – The number and percentage of Medicaid residents with BIMS scores less than or equal to 5 and residents with Cognitive Performance Scale scores of moderately severe to very severe.