DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Financial Management Group

May 17, 2022

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

RE: State Plan Amendment (SPA) GA-21-0009

Dear Director Rhodes:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State Plan submitted under transmittal number (TN) 21-0009. Effective July 1, 2021, this amendment increases the nursing home reimbursement rates to include updating rates to the 2019 cost report, the general and professional liability, property tax pass through rate, a 5% growth allowance inflation factor and a hold harmless provision, and increases the supplemental quality incentive payments to eligible nursing facilities who demonstrate improvement in certain identified areas.

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.

This is to inform you that Medicaid State Plan Amendment GA-21-0009 is approved effective July 1, 2021. The CMS-179 and the plan pages are attached.

If you have any additional questions or need further assistance, please contact James Francis at james.francis@cms.hhs.gov.

Sincerely,

Rory Howe

Rory Howe
Director

REIMBURSEMENT FOR NURSING FACILITY SERVICES

A facility's Actual Reimbursement Rate is the amount the Division will reimburse to a facility for nursing services rendered to a particular eligible patient for one patient day and is calculated by subtracting Patient Income from Total Allowed Per Diem Billing Rate. In addition, it is subject to retroactive adjustment according to the relevant provisions of Supplement 4 to Attachment 4.19-D.

a. Patient Income is that dollar amount shown on the Summary Notification letter issued by the Division of Family and Children Services (DFCS). The patient's income is deducted in full from the Medicaid reimbursement rate until the income has been exhausted.

b. Total Allowed Per Diem Billing Rate is the amount derived from the rate setting process, as defined on pages 7 through 17 of this Supplement in the sections titled "*Total Allowed Per Diem Billing Rate for Facilities for Which a Cost Report is Used To Set a Billing Rate*" and "*Total Allowed Per Diem Billing Rate for Facilities for Which a Cost Report or Case Mix Score Cannot Be Used to Set a Billing Rate*."

c. A Nursing Facility is an institution licensed and regulated to provide nursing care services or intermediate care services for individuals with intellectual disabilities in accordance with the provisions of this Supplement. For reimbursement purposes, nursing facilities including hospital-based facilities are divided into two types based upon the mix of Medicaid patients residing in the facilities. The type of classification of a nursing facility may change as described in this Supplement. The types are described below:

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1. Nursing Facilities: These facilities provide skilled and intermediate nursing care continuously, but do not provide constant medical and support services available in an acute care facility or hospital.

2. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)-These facilities provide care to patients that have intellectual disabilities.

d. Cost Center refers to one of the five groupings of expenses reported on Schedule B-2 of the "Nursing Home Cost Report Under Title XIX," hereinafter referred to as the Cost Report. Specifically, expenses for the five cost centers are reported in Column 3 of the Schedule as Routine and Special Services (Line 17 and 77), Dietary (Line 89), Laundry and Housekeeping and Operation and Maintenance of Plan (Line 109 and 123), Administrative and General (Line 169), and Property and Related (Line 186). See hospital-based and state institutions cost reports for appropriate cost center expense groupings.

e. Distinct Part Nursing Facilities are facilities in which a portion operates as a nursing facility and another portion operates separately as an intermediate care facility for persons with intellectual disabilities.

f. Total Patient Days are the number of days reported by the facility on Schedule A, Line 13, Column 8 of the Cost Report subject to correction or adjustment by the Division for incorrectly reported data.

g. Hospital-Based Nursing Facilities-A nursing facility is hospital-based when thee following conditions are met:

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1. The facility is affiliated with an acute care hospital that is enrolled with the Division in the Hospital Services Program.
2. The facility is subordinate to the hospital and operated as a separate and distinct hospital division that has financial and managerial responsibilities equivalent to those of other revenue producing divisions of the hospital.
3. The facility is operated with the hospital under common ownership and governance. The long-term care facility, as a division of the hospital, must be responsible to the hospital's governing board.
4. The facility is financially integrated with the hospital as evidenced by the utilization of the hospital's general and support services.
5. A minimum of four services from Section A and two services from Section B below must be shared with the hospital.

Section A

a. Employee benefits
b. Central services and supply
c. Dietary
d. Housekeeping
e. Laundry and linen
f. Maintenance and repairs

Section B

a. Accounting
b. Admissions
c. Collections
d. Data Processing
e. Maintenance of Personnel

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Facilities must provide organizational evidence demonstrating that the above requirements of (4) have been met. This evidence will be used to determine which facilities will be hospital-based.

Evidence that the required number of services in Section A and B are shared with the hospital must be included in the hospital's Medicare cost report.

Appropriate costs should be allocated to the nursing facility and the Medicare cost report must be approved by the Medicare intermediary.

In making the determination that a long-term care facility is hospital-based, co-location is not an essential factor; however, the distance between the facilities must be reasonable as determined by the Division or its agents.

The Division will recover the monetary difference reimbursed to the facility between hospital-based and freestanding status for any time period the facility does not quality for hospital-based status.

To change classification to hospital-based from another class, or to enroll in the program as a hospital-based provider, the following restrictions apply in addition to the requirements described above:

1. Only one hospital-based nursing facility per hospital is allowed.
2. Any cost increases for the change to the hospital-based classification will be reimbursed when the first filed Medicare

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cost report is used to file the Medicaid cost report to set a per diem rate.

Nursing facilities classified as hospital-based prior to July 1, 1994 will be exempt from the above additional requirements. Hospitals which currently have more than one hospital-based nursing facility will not be allowed to include any additional hospital-based facilities.

h. Property Transaction is the sale of a facility or of a provider; the lease of a facility; the expiration of a lease of a facility; the construction of a new facility; an addition to the physical plant of a facility; or any transaction, other than change of ownership of a provider due solely to acquisition of capital stock, or the merger of a provider with another legal entity (statutory merger). For purposes of reimbursement, a sale shall not include any transaction in which acquisition is less than 51% of a partnership or proprietorship, or accomplished solely by acquisition of the capital stock of the corporation without acquisition of the assets of that corporation. The effective date of any Property Transaction shall be the latest of all of the following events that are applicable to the transaction:

1. The effective date of the sale or the lease.
2. The first day a patient resides in the facility.
3. The date of the written approval by the Office of Health Planning of the relevant proposal.
4. The effective date of licensing by the Division of Healthcare Facility Regulation.
5. The effective date of the Statement of Participation in the Georgia Medical Assistance Program.

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6. The date on which physical construction is certified complete by whichever agency(ies) is/are responsible for this determination.
7. The date of the approval of a Certificate of Need by the Office of Health Planning.

i. Gross Square Footage is the outside measurement of everything under a roof, which is heated and enclosed. When the Division issues the provider a rate under the Fair Rental Value System, it is a tentative rate based upon the data previously submitted to the Division for verification. The data received on gross square footage and age of a facility is subject to audit review (along with other parameters which affect the billing rate calculation). Documentation should include but not be limited to blueprints, architect plans, certified appraisals, etc.

j. Age is defined on page 21 of this Supplement in the section titled "*Property and Related Reimbursement."*

k. Cost is the expense incurred for goods and services used to operate a nursing facility. In the establishment of a per diem billing rate, most costs are allowable while certain other costs are not. A definition of cost and a discussion of allowable and non-allowable costs are contained in the Centers for Medicare and Medicaid Services Provider Reimbursement Manual (CMS-15-1. In addition to those non-allowable costs discussed in the CMS-15-1, *the costs listed below are non-allowable*:

1. Costs related to lobbying and governmental relations, including costs for employees with duties related to lobbying

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and government relations, honorariums and reimbursement of travel or other expenses of elected officials;

2. Memberships in civic organizations;
3. 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;
4. Vehicle depreciation or vehicle lease expense in excess of the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles provided, however, such limits shall not apply to specialized patient transport vehicles (e.g., ambulance);
5. 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. For purposes of this provision, patient care staff includes only those who are transported in order to provide direct medical care to an individual patient.
6. Fifty percent (50%) of membership dues for national, state and local associations;
7. Leal services for an administrative appeal or hearing, or court proceedings involving the provider and the Division or any other state agency when a judgment of relief is not granted to

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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;

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 through June 30, 2021, 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 through June 30, 2021, the basis for reimbursement for the Supplemental Administrative and General-General and Professional Liability Insurance cost

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center will be the June 30, 2018 GL-PL Insurance Supplemental Report. Effective July 1, 2019 through June 30, 2021, the minimum nursing facility per diem billing rate shall be $147.00.

For dates of service beginning July 1, 2021 and thereafter, the June 30, 2019 Medicaid Cost Report is the basis for the nursing facility reimbursement rate. The Department will update the Medicaid Cost Report year used for the nursing facility reimbursement rate at least every two years.

A hold-harmless provision for the first year of the transition period will apply. Nursing facilities whose calculated rate using the June 30, 2019 Medicaid Cost Report is less than their rate on June 30, 2021 will continue to be reimbursed at their June 30, 2021 Medicaid reimbursement rate.

This hold-harmless provision will apply to the following quarterly rate setting periods: July 1, 2021, October 1, 2021, January 1, 2022, and April 1, 2022.

Effective July 1, 2021, the basis for reimbursement for the Supplemental Administrative and General -General and Professional Liability Insurance, and Property and Related cost center will be the June 30, 2019 GL-PL Insurance Supplemental Report.

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

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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

Effective July 1, 2021, the growth allowance is the summation of 5% of the Allowed Per Diem for each of the following cost centers: Routine, Dietary, Laundry & Housekeeping, Plan Operations & Maintenance and Admin & General.

Effective July 1, 2019, through June 30, 2021, 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; Laundry and Housekeeping and Operations and Maintenance of Plant; and Administrative 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

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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.

See Supplement 4 to Attachment 4.19-D for appellate procedures to resolve disputes of specific contested adjustments. Specifically, the Net Per Diem for each of the five cost centers is determined as follows (all Schedule reference are to the Cost Report):

See page 20 of this Supplement in the section titled "Property and Related Reimbursement" for additional descriptions of such limitations.

Allowable Home Office salary costs are limited to an appropriate maximum.

Fringe benefits are also limited to an appropriate maximum. (A per bed salary ceiling also is imposed, based on the 70th percentile of costs per the 1988 home office cost reports, plus an allowance for inflation. Home Office salaries and related fringe benefits are subjected toa $100,000 maximum salary for CEO, COO, CFO and other Home Officed personnel. Therefore, in addition to the per bed salary ceiling, we have incorporated a position maximum of $100,000 to be applied only to owners of nursing facilities and related parties.) Reimbursement for the cost of home office vehicles is eliminated, except to the extent that home office vehicle costs can be included with related home office salaries as a fringe benefit, and in total, fall below any designed maximums.

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Routine and Special Services Net Per Diem=

Nursing Facilities Net Per Diem=
(Historical Routine and Special Services (Schedule B, Lines 5 plus 7, Column 4) divided by (Total Patient Days, Schedule A, Line 13, Column 8); for Nursing Facilities, the resulting per diem amount is divided by a case mix index score as determined by the Division for all residents in the facility during the base period, the cost reporting period identified on page 7 of this Supplement titled "*Total Allowed Per Diem Billing Rate for Facilities for Which a Cost Report is Used To Set a Billing Rate*." The method by which a case mix index score is calculated is described in Supplement 3 to Attachment 4.19-D (Uniform Chart of Accounts, Cost Reporting, Reimbursement Principles and other Reporting Requirements) of this Attachment.

ICF-IDD Net Per Diem=
(Historical ICF-IDD Routine and Special Services (Schedule B, Lines 6 plus 7, Column 4) divided by (Total IFC/IDD Patient Days, Schedule A, Line 13, Column 8).

When costs for State Distinct Part Nursing Facilities can be identified, be they routine services or special services, the costs will be allocated as identified. Where costs have not been identified, the patient days method will be used to allocate costs. The example below shows the treatment of these costs:

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Total Routine Services Costs, (Medicaid Cost Report) Schedule B, Line 6 Column 4	$5,000,000	
Patient Days Total Medicaid ICF-IDD Patient Days (Medicaid Cost Report		
Schedule A, Line 13 (Sum of Columns 4, 5, and 6):	$40,000	80%
Total Medicaid NF Patient Days (Medicaid Cost Report)		
Schedule A, Line 13 (Sum of Columns 4, 5, and 6)	$10,000	20%
Total Patient Days:	$50,000	100%

Allocation

Routine Services Cost allocated to ICF-IDD (Schedule B, Line 6, Column 4 is $5,000,000 x 80% = $4,000,000)

Routine Services Cost allocated to NF (Schedule B, Line 6, Column 4 is $5,000,000 x 20% = $1,000,000

Dietary Net Per Diem=

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.

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Administrative and General Net Per Diem=
Historical Administrative and General, Schedule B, Line 11, Column 4, Divided by Total Patient Days.

Supplemental Administrative and General-General and Professional Liability Insurance Net Per Diem
Historical Administrative and General-General and Professional Liability Insurance, Freestanding GL-PL Insurance Supplemental Report, Section C4, Divided by Total Patient Days, Section C5 Hospital-Based GL-PL Insurance Supplemental Report, Section C10, Divided by Total Patient Days, Section C9.

Property and Related Net Per Diem=

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

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

b. Standard Per Diem for each of the five cost centers (Routine and Special Services; Dietary; Laundry and Housekeeping and Operation and Maintenance of Plan; and Administrative and General) 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

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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 thee 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 Intellectual Disabilities group. If the Maximum Percentile does not correspond to a specific value in thee array of net per diem amounts, the maximum percentile is determined by interpolation (i.e., finding the mid-point between whole integers).

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 in each facility's rate sheet. Effective July 1, 2018, the Administrative and General cost center standard per diem will be recalculated in the rate sheet by removing general and professional liability insurance cost and determining a new Net Per Diem amount. General and professional liability insurance costs will be recorded in the rate sheet in the Supplemental Administrative and General-General and Professional Liability Insurance cost center which will not have a per diem calculated. Subsequent to the recalculation of the Administrative and General cost center standard, there will not be any recalculation of standards based upon the changes in rats due to subsequent determination of additional allowable cost, disallowance of previously allowable cost or any

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change in the Net Per Diem in any cost enter. 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 (90^{th} percentile) = 9^{th} 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
Median Net Per Diem is the per diem amount that falls in the middle of the group or $120
$120 x 105%= $126

Administrative and General Maximum Cost at 105% of Median (Interpolation)

Nursing Home Net Per Diems for 10 nursing homes from lowest to highest:
$90, $95, $95, $100, $115, $120, $120, $130, $135, $140

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Maximum Cost Standard Determination at 105% of Median

Median Net Per Diem is the average of the two middle net per diem amounts that fall in the middle of the group ($115 + $120/2=$118)

$118 x 105% =$124

There are several instances where a facility could fall in more than one group. Intermediate care facilities for Individuals with Intellectual Disabilities which are also nursing facilities are classified as intermediate care facilities for the Intellectually Disabled and not grouped with other nursing facilities.

For the purpose of determining the Standard Per Diem and the Allowed Per Diem for each cost center, a facility is grouped according to the type facility (e.g., nursing facility, hospital-based nursing facility, or intermediate care facility for the Intellectually Disabled) it is as of the date the Standard Per Diem is calculated.

If a facility changes classification to hospital-based or grouping on January 1 through June 30 of any calendar year, it will be grouped into its new category for reimbursement purposes for dates of services July 1 of that year and thereafter. If a facility changes classification as described above on July 1 through December 31 of ay calendar year, regrouping will occur from January 1 of the following year.

Routine and Special Services Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

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Nursing Facility

Intermediate Care Facility for the Intellectually Disabled

Dietary Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

Free Standing Nursing Facility
Hospital-Based Nursing Facility
Intermediate Care Facility for the Intellectually Disabled

Laundry and Housekeeping and Operation and Maintenance of Plan Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

Nursing Facility
Intermediate Care Facility for the Intellectually Disabled

Administrative and General Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

Nursing Facility
Intermediate Facility for the Intellectually Disabled

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Property and Related Standard Per Diem

Costs for property taxes and property insurance as defined in the Uniform Chart of Accounts, are calculated separately and are not subject to property-related cost center Standard Per Diem.

Supplemental Administrative and General-General and Professional Liability Insurance Standard Per Diem

Costs for property taxes and property insurance as defined in the Uniform Chart of Accounts, are calculated separately and are not subject to property-related cost enter Standard Per Diem.

c. The Efficiency Per Diem represents the summation of the Efficiency Per Diem for each of the five cost centers. If the Net Per Diem is equal to or exceeds the Standard Per Diem in any cost center, or if the Net Per Diem is equal to or less than 15% of the Standard Per Diem, the Efficiency Per Diem for the cost center is zero ($0.00). If the Net Per Diem is less than the Standard Pere Diem in any cost center, and if the Net Per Diem is more than 15% of the Standard Per Diem, the Efficiency Per Diem for the cost center is calculated by subtracting the Net Per Diem from the Standard Per Diem for that cost center and then multiplying the difference by .75. The product represents the Efficiency Per Diem for that cost center subject to the following maximums which have been established through legislative authority:

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Routine and Special Services	
Maximum Efficiency Payment	$0.53
Dietary Maximum Efficiency Payment	$0.22
Laundry and Housekeeping and Operation and Maintenance of Plant Maximum	
Efficiency Payment	$0.41
Administrative and General Maximum	
Efficiency Payment	$0.37
Property and Related Maximum	
Efficiency Payment	$0.40

Total Allowed Per Diem For Facilities Purchased From An Unrelated Party Between January 1, 2012 and June 30, 2014

Facilities purchased from a party not related to the new owner between January 1, 2012 and June 30, 2014 will have their per diem rates effective

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July 1, 2015 determined based on the cost of the new owner. Related parties shall be defined to include the following:

(1) Immediate family members including the previous owner's spouse, child, sibling, parent, grandparent, or grandchild. Related parties shall also include stepparents, stepchildren, stepsiblings, and adoptive relationships; and

(2) A business corporation, general partnership, limited partnership, limited liability company, joint venture, nonprofit corporation, or any other for profit or not for profit entity that owns or controls, is owned or controlled by, or operates under common ownership or control of the previous owner.

The new owner's rate effective July 1, 2015 will be determined as follows:

a. The first cost report ending June 30th that contains at least six months of cost under the new owner will be used to establish the provider's rate effective July 1, 2015.

b. If there is not a cost report ending June 30th that contains at least six months of cost under the new owner available when establishing the July1, 2015 rate, cost report information covering from the date of change in ownership through December 31, 2014 will be used.

c. Rates determined based on cost report information subsequent to June 30, 2014 will be reconciled and retroactively adjusted upon review of the information.

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d. The cost ceilings used when establishing the rate effective July 1, 2015 will be determined using the same June 30th year end used for determining cost. The June 30, 2014 cost reports will establish ceilings for cost data submitted for the period ending December 31, 2014.

e. Providers will continue to receive rates based on the new owner's cost report until a later cost report is approved for rebasing.

f. Effective April 1, 2017 through June 30, 2017, the growth allowance is 12% for 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.

Total Allowed Per Diem Billing Rate For Facilities For Which A Cost Report or Case Mix Score Cannot Be Used To Set A Billing Rate

If the Division determines that a cost report cannot be used to set a billing rate the per diem rate will be established as follows:

a. When changes in ownership occur, new owners will receive the prior owner's per diem until a cost report basis can be used to establish a new per diem rate. (See Supplement 3 to Attachment 4.19-D)
b. Newly enrolled facilities will be reimbursed the lower of: projected costs; or 90% of the appropriate cost center ceilings, plus a growth allowance and the appropriate Property and Related Net Per Diem until a cost report is submitted which can be used to establish a rate.
c. In all other instances (except as noted below for newly constructed facilities) where the Division determines that a cost report cannot be used to set a reimbursement rate, the Total Allowed Per Diem Billing Rate

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will be resolved as described in the provisions discussed below for unauditable cost reports.

The Total Allowed Per Diem Billing Rate for facilities with more than 50 beds determined by the Division to be newly constructed facilities is equal to 95% of the four Non-Property and Related Standard Per Diem amounts plus the appropriate growth allowance and Property and Related Net Per Diem.

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 on page 20 of this Supplement in the section titled "*Property and Related Reimbursement."*

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), 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,

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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/GL-PL Insurance Supplemental Report becomes auditable and appropriate, the Total Allowed Per Diem Billing Rate will then be calculated using the audited cost report/GL-PL Insurance Supplemental 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 less than 10% of the MDS assessments for all patients, the Department may elect to use the average case mix score for facilities.

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 on page 24 of this Supplement in section titled "*Additional Care Services, Required Nursing House*."

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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%	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 Severe Pain.

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(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.
(c) High Risk Pressure Ulcer – Residents without acquired pressure ulcers.
(d) Physical Restraints – Residents without acquired restraints.
(e) Vaccination: Flu – Residents without falls.
(f) Low Risk Pressure Ulcer – Residents without acquired catheters.

3. Non-Clinical Measures:

Each measure is worth 1 point as described.

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a. Participation in the Employee Satisfaction Survey.
b. Most Current Family Satisfaction Survey Score for "Would you recommend this facility?" Percentage of combined responses either "excellent" or "good" to meet or exceed the state average of 85% combined.
c. Quarterly average for RNs/LVNs/LPNs Stability (retention) to meet or exceed the state average.
d. Quarterly average for CNAs/NA Stability (retention) to meet or exceed the state average.
e. AHCA Active Bronze Quality Award Winner per the AHCA Active Bronze Quality Award Winner list.

4. Additional Quality Points Available

The following measures are worth the specified number of points as described in the two criteria below in addition to the 1% or 2% available incentive.

(a) AHCA Active Silver Quality Award winner per the AHCA Active Silver quality Award Winner List will earn an additional incentive equal to 1%.
(b) AHCA Active Gold quality Award winner per the AHCA Active Gold Quality Award Winner List will earn an additional incentive equal to 2%.
(c) A Nursing Center who has earned and is currently accredited as a Joint Commission Accredited Nursing Care Centers will earn an additional incentive equal to 2%.

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To qualify for a quality incentive adjustment equal to 1% of the Allowed Per Diem for Routine and Special Services for the most recent calendar quarter, the facility must obtain a minimum of three (3) points in the following combination: One (1) point must come from clinical measures, one (1) point from the non-clinical measure, and a third point from either the clinical or non-clinical measures.

To qualify for a quality incentive adjustment equal to 2% of the Allowed Per Diem for Routine and Special Services, for the most recent calendar quarter, the facility must obtain a minimum of six (6) points in the following combination: Three (3) points must come from the clinical measures, one (1) point from the non-clinical measures, and two (2) points from either the clinical or non-clinical measures.

An additional 1% incentive, not to exceed a total quality add-on of 4% can be earned by a facility that is an active AHCA Silver Award Winning Center. An additional 2% incentive, not to exceed a total quality add-on of 5% can be earned by a facility that is an active AHCA Gold Award Winning Center of Joint Commissioner Accredited.

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:

1. The facilities next standard survey and/or complaint survey, after being placed on the list, does not have a deficiency cited over Level E scope and severity; and

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

Supplemental Quality Incentive Payments

Effective August 13, 2021, the Division will provide supplemental quality incentive payments to eligible skilled nursing facilities that demonstrate improvement in the quality of care rendered to members. Utilizing calendar year 2020 data as the baseline, nursing facilities that demonstrate improvement in the four categories identified below will be eligible for a supplemental payment. Nursing facilities must demonstrate improvement in at least one or more of the areas noted below in order to receive the supplemental payment. The supplemental payment will be based on the percentage of improvement ranked by decile for each of the four categories listed below.

- High-Risk Long Stay Residents with pressure ulcers
- Long-stay residents who received an antianxiety or hypnotic medication
- Long-stay residents who received an antipsychotic medication
- Long-stay residents with a urinary tract infection

Supplemental payments will be distributed to eligible nursing facilities twice per year. However, in year one (SFY2022), eligible nursing facilities will only receive one payment. For each subsequent year after calendar year 2020, the base year will be adjusted annually to reflect improvement against the prior year. For example, CY2021 would be paid out against improvement against CY2020, CY2022 would be paid out against CY2021, and CY2023 against improvement in CY2022. Only

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those facilities who demonstrate improvement will be eligible for the add on payment.

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, 2014 the value per square foot shall be based on the $187.12 construction cost for nursing facilities, as derived from the 2012 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 1.0. The resulting product is the Adjusted Cost per Square Foot.

   (b) A Facility Replacement Value is calculated by multiplying the Adjusted Cost per Square Foot by

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(c) the Allowed Total Square Footage. The latter figure is the lesser of a nursing facility's actual square footage (computed using the gross footage method) compared to the number of licensed beds times 700 square feet (the maximum allowed figure per bed).

(d) An Equipment Value is calculated by multiplying the number of licensed beds by $6,000 (the amount allowed per bed) and by an initial Equipment Cost Index of 1.000.

(e) A Depreciation Replacement Value is calculated by depreciating the sum of the Facility Replacement Value and the Equipment Value. The amount depreciated is determined by multiplying the Adjusted Facility Age discussed in this Supplement by a 2% Facility Depreciation Rate. The Initial Adjusted Facility Age will be the lesser of the calculated facility age or 25 years.

(f) The Land Value of a facility is calculated by multiplying the Facility Replacement Value by 15% to approximate the cost of the land.

(g) A Rental Amount is calculated by summing the facility's Depreciated Replacement Value and the Land Value and multiplying the figure by a Rental Rate which is 9.0% effective July 1, 2009.

(h) The Annual Rental Amount is divided by the greater of the facility's actual cumulative resident days during the 2012 cost reporting period or 85% of the licensed bed capacity of the facility multiplied by 365. The resulting figure constitutes

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(i) the Property and Related Net Per Diem established under the FRV system.

An example of how the Property and Related Net Per Diem is calculated is presented in the following table. Example Calculation of Initial Fair Rental Value Per Diem:

Ref.	Data Element	Example Data	Source of Data
A	Facility Name	XYZ Nursing Home	Department Data
B	Medicaid Provider ID	12345678A	Department Data
C	Rate Setting Year	2012	Department Criteria
D	Adjusted Base Year	1989	Department Data
E	Licensed Nursing Facility Beds	138	Department Data
F	Nursing Facility Square Footage	68,857	Department Data
G	Nursing Facility Zip Code	30312	Department Data
H	Total Patient Days	48,552	Department Data
I	Per Bed Square Footage Limit	700	Department Criteria
J	Maximum Allowed Square Footage	96,600	E x I

K	Allowed Total Square Footage	68,857	Lesser of F or J
L	Rate year RS Means Cost per Square Foot	$146.08	RS Means lookup based on Rate Year
M	RS Means Location Factor	0.9	RS Means 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
V	Nursing Facility Age	21	(see D and V) C-D (D is based on initial age adjusted by additions/renovations per U)
W	Maximum Years for FRV Age	25	Department Criteria
X	FRV Adjusted Facility Age	23	Lesser V or W

Y	Facility Depreciation Rate	2.00%	Department Criteria
Z	Depreciation Using FRV Adjusted Age	$4,839,976	T x X x Y
AA	Depreciated Replacement Value	$5,681,712	T – Z
AB	Land Percentage	15.00%	Department Criteria
AC	Land Value	$1,454,053	P x AB
AD	Depreciated Replacement Value & Land	$7,135,765	AA + AC
AE	Rental Value	9.00%	Department Criteria
AF	Rental Amount	$642,218	AD x AE
AG	Minimum Occupancy Percentage	85.00%	Department Criteria
AH	Bed Days at Minimum Occupancy	42.815	E x 365 x AG
AI	Total Allowed Patient Days	48,552	Higher of H or AH
AJ	Fair Rental Value per Diem	$13.22	AF/AI

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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 this Supplement 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

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b. 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, 2014 by comparing the 2014 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, 2014.

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(b) For periods subsequent to July 1, 2014, the FRV adjusted age as determined by the provisions in this Supplement will be reduced on a quarterly basis to reflect new Renovation Construction Projects or bed additions that were completed after July 1, 2014, and placed into service during the preceding quarter. The rate adjustment for Renovation Projects or bad additions will be effective the first day of the calendar quarter subsequent to final approval of the completed project by the Department. Bed reductions will not be used to determine a facility's adjusted age. 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 in this Supplement in the section titled "*Property and Related Reimbursement*." Age adjustments and Rate adjustments are not synonymous.

(c) If a facility has added beds, the age of these additional beds will be averaged in with the age of the remaining beds, and the weighted average age of all beds will be used as the facility's age. An example of how an addition would reduce the age of the facility is presented in the following table:

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Example Calculation of the Impact of an Addition on a Nursing Facility's Base Year

Ref	Data Element	Example	Source of Data
A	Facility Name	XYZ Nursing Home	Department Data
B	Medicaid Provider ID	12345678A	Department Data
C	Year Bed Additions Were Completed	1981	Department Criteria
D	Base Year Prior to Additions	1970	Based on Initial Age adjusted by Prior Bed Additions and Facility Renovations
E	Existing Beds prior to Bed Additions	130	Department Data
F	Number of Beds Added	8	Department Data
G	Age of Existing Beds when Additions Were Completed	11	C-D
D	Adjust Base Year	1989	Department Data
E	Licensed Nursing Facility Beds	138	Department Data
F	Nursing Facility Square Footage	68857	Department Data
G	Nursing Facility Zip Code	30312	Department Data

H	Weighted Average of Existing Beds	1430	E x G
I	Total Beds After Bed Additions were Completed	138	E + F
J	Base Year Age Adjustment	10.36	H/I
K	New Base Year	1,971.00	C- J (rounded)

(d) If a facility performed a Renovation Construction Project as defined in this Supplement on page 17 in the section titled "*Property and Related Reimbursement*" the cost of the Project will be converted to an equivalent number of replacement beds by dividing the value of the renovation by the depreciable bed replacement value.

i. The renovation completion date will be used to determine the year of the renovation.

ii. An Age Index factor will be used to calculate a bed replacement cost for any renovation occurring prior to July 1, 2009. The Age Index factor is derived by using the 2009 Edition of the RSMeans and dividing the Historical Cost Index for 2009.

iii. To determine the accumulated depreciation per bed, 2 percent per year will be used for a maximum number of 25 depreciable years.

In no case will the consideration of a Renovation Construction Project reduce the age of the facility to a number less than zero.

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An example of how the cost of a Renovation Construction Project would be converted to an equivalent number of replacement beds and a new base year is presented in the following table:

Example Calculation of the Impact of a Renovation on a Nursing Facility's Base Year

Ref	Data Element	Example	Source of Data
A	Facility Name	XYZ Nursing Home	Department Data
B	Medicaid Provider ID	12345678A	Department Data
C	Rate Setting Year	2009	Department Data
D	Year Renovation was Completed	2003	Department Data
E	Base Year Prior to Renovation	1981	Based on Initial Age Adjusted by Prior Bed Addition and Facility Renovations
F	Licensed Number Facility Beds	138	Department Data
G	Facility Square Footage	40,060	Department Data
H	Nursing Facility Zip Code	30442	Department Data

I	Renovation Amount	$372,662.00	Department Criteria
J	Renovation Year RS Means Cost Index	132.00	RS Means lookup based on Year Renovation Completed
K	Rate Year RS Means Cost Index	185.90	RSMeans lookup based on Rate year
L	Facility Age Index Factor	0.7101	J/K
M	Rate Year RS Means Cost per Square Foot	$141.10	RS Means lookup based on Rate Year
N	Maximum Square Feet per Bed	700	Department Criteria

O	Allowed Facility Square Footage	40,060	Lesser of G or (F x N)
P	Facility Cost Prior to Adjustments	$5,652,446.00	M x O
Q	RS Means Location Factor	0.77	RS Means lookup based on Zip Code (H)
R	Adjusted Facility cost	$3,090,461.00	P x L x Q
S	Age of Beds at Time of Renovation	22	D – E
T	Maximum Bed Replacement Years	25	Department Criteria

U	Allowed Age of Beds	22	Lesser of S or T
V	Initial Aging Depreciation Rate	2.00%	Department Criteria
W	Allowed Facility Depreciation	$1,359,803.00	R x U x V
X	Adjusted Bed Replacement Cost	$12,541.00	(R-W)/F
Y	New Bed Equivalents	29.72	I/X (but limit is F)
Z	Total beds to be Weighed	108.28	F – Y
AA	Weighted Average of Beds	2,382.26	Z x S
AB	Base Year Age Adjustment	17.26	AA/F
AC	New Base Year	1986	D – AB (rounded)

Overall Limitations on Total Allowed Per Diem Billing Rate

In no case shall the Total Allowed Per Diem Billing Rate, whether determined pursuant to the provisions of this Supplement or the Nursing Facility manual, exceed the facility's customary charges to the general public for those services reimbursed by the Division.

Payment in Full for Covered Services

The facility must accept as payment in full for covered services the amount determined in accordance with Section 1002, Nursing Facility Manual.

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Adjustments to Rates

Payment rates for state-owned nursing facilities will be adjusted to 100% of service costs. This provision will apply in addition to all others in this chapter and will supersede those that are in direct conflict only to the extent that they are not capable of simultaneous application.

Additional Care Services

Required Nursing Hours

The **minimum required** number of nursing hours per patient day for all nursing facilities is 2.00 actual working hours. The **minimum expected** nursing hours are 2.50 to qualify for the 1% add-on. (See 1002.4)

Failure to Comply

a. The **minimum standard** for nursing hours is **2.00**.
b. Facilities found not in compliance with the 2.00 nursing hours will be cited for being out of compliance with a condition of participation. This will lead to imposition of a civil monetary penalty, denial of reimbursement for newly admitted patients, or suspension or termination whichever is appropriate as determined by the Division.

c. The **minimum expected** for nursing hours is **2.50** for participation in the Quality Improvement Program.

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Medicare Crossover Claims

The maximum allowable payment for Medicare nursing facility coinsurance (crossover) claims will be the nursing facility's Medicaid specific per diem rate in effect for the dates of service of the crossover claims. The crossover claims will not be subsequently adjusted due to subsequent per diem rate adjustments. This section is also included in Chapter 1100 of the Manual.

Upper Payment Limit Rate Adjustments for Government Owned or Operated Nursing Facilities

For payments on or after January 1, 2001, State government –owned or operated facilities and non-State government owned or operated facilities will be eligible for rate payment adjustments, subject to the availability of funds. The rate payment adjustments will be subject to federal upper payment limits and will be based on amounts that would be paid for services under Medicare payment principles. These rate payment adjustments will be made on a quarterly basis in a manner that will not duplicate compensation provided from payments for individual patient claims.

Payments Rates for Patient Leave Days or Bed Hold Days

Effective for dates of service on and after July 1, 2004, payments for patient leave days or for bed hold days during a patient's hospitalization will be made at 75% of the rate paid for days when a

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patient is onsite at a facility. Because patient leave days and bed hold days are not subject to the nursing home provider fee, the payment rate for patient leave days and bed hold days will exclude any compensation for the provider fee.

Nurse Aide Training and Testing Costs

The Division will reimburse nursing facilities, on a full time equivalent (FTE) basis, up to $738 for each individual who has completed a state-approved training and competency program for nurse aides. At the facilities request, Interim payments of $.25 per Medicaid patient day will be made quarterly to the facility to cover the cost of providing nurse aide testing and training.