**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**

May 29, 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-23-0009

Dear Director Portman:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Georgia state plan amendment (SPA) to Attachment 4.19-A GA-23-0009, which was submitted to CMS on December 30, 2023. This plan amendment changes the APR grouper from TRICARE DRG v. 35 to APR DRG v. 40. The SPA further sets out the updated calculation of prospective base rates including adjustments for each hospital's Medicaid Inpatient Utilization Rate (MIUR), Indirect Medical Education (IME) if applicable, Peer Group Add-On Amount if applicable, and a stop-loss/stop-gain adjustment if applicable.

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 January 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,

Rory Howe

Rory Howe
Director
Financial Management Group

Enclosures

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES**
**INPATIENT SERVICES**

II. Rate Setting

Overview: The Georgia Department of Community Health will reimburse qualified providers for inpatient hospital services under the prospective payment system as set forth in this plan.

A. Data Sources and Preparation of Data for Computation of Prospective Rates

The calculation of prospective rates requires the use of claims data, cost data, and supplemental expenditure data. The historical claims data is obtained from a chosen base year, with adjustments for inflation and is used to update the factors in the payment formulas detailed in Section B below.

For admissions on and after January 1, 2019, the prospective rates are developed using the following data sources:

- Base Claims Data: Claims Data for CY 2016
- Cost Data: DSH Survey Data filed for the FY2018 DSH Payment Calculation and Medicare Cost Reports for Hospital FYE 2016 when DSH data is not available.
- Medicaid Inpatient Utilization Rate (MIUR): DSH Survey Data filed for the FY2018 DSH Payment Calculation and Medicare Cost Reports for Hospital FYE 2016 when DSH data is not available.
- Direct Graduate Medical Education (GME):
    - Number of Residents: CY 2016 GME Survey FTE Counts s reported by the hospitals that received GME funding from Georgia Medicaid prior to January 1, 2019 from Georgia Medicaid and projected FY 2019 FTE Counts for new GME programs.
    - Medicaid Allocation Ratio (MAR): DSH Survey Data filed for the FY2018 DSH Payment Calculation and Medicare Cost Reports for Hospital FYE in 2016 when DSH data is not available.
- Indirect Medical Education (IME):
    - Number of Residents: CY2016 GME Survey FTE Counts as reported by the hospitals that received GME funding from Georgia Medicaid prior to January 1, 2019 from Georgia Medicaid and projected FY2019 FTE Counts for new GME programs.

For admissions on and after January 1, 2019, the prospective payment model will be updated annually on July 1st as follows:

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- Direct GME allocations will be updated using the most recent resident counts and MAR data.
- IME factors will be updated using the most recent resident counts and bed count data.
- All hospital CCRs will be updated using the most recent cost data.

For admissions on and after January 1, 2024, the prospective rates are developed using the following data sources:

- Base Claims Data:
  - DRG Weights, Outlier Thresholds utilized in CY 2022
  - Stop-Loss/Stop-Gain Calculations utilized January 1, 2023 - July 31, 2023
- Cost Data: DSH Survey Data filed for the SFY2023 DSH Payment Calculation and Medicare Cost Reports for Hospital FYE 2021 when DSH data is not available.
- Medicaid Inpatient Utilization Rate (MIUR): DSH Survey Data filed for the FY2023 DSH Payment Calculation and Medicare Cost Reports for Hospital FYE2021 when DSH data is not available.
- Direct Graduate Medical Education (GME):
  - Number of Residents: CY2024 GME Survey FTE Counts as reported by the hospitals that received GME funding from the Georgia Medicaid prior to January 1, 2024 from Georgia Medicaid and projected FY2024 FTE Counts for new GME programs.
  - Medicaid Allocation Ratio (MAR): DSH Survey Data filed for FY2023 DSH Payment Calculation and Medicare Cost Reports for Hospital FYE in 2021 when DSH data is not available.
- Indirect Medical Education (IME)
  - Number of Residents: CY 2024 GME Survey FTE Counts as reported by the hospitals that received GME funding from Georgia Medicaid prior to January 1, 2024 from Georgia Medicaid and projected FY2024 FTE Counts for new GME programs.
  - Number of Beds: Medicare Cost Reports for Hospital FYE 2021.

For admissions on and after January 1, 2024, the prospective payment model will be reviewed and updated annually, contingent upon available state funds, on July 1 as follows:

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- Direct GME allocations will be updated using the most recent resident counts and MAR data.
- IME factors will be updated using the most recent resident counts and bed count data.
- All hospital CCRs will be updated using the most recent cost data.
- The Department may review the other components of the prospective payment model and make updates as needed.

For admissions on and after January 1, 2019:

The Hospital Specific Base Rate will include adjustments for each hospital's Medicaid Inpatient Utilization Rate (MIUR), Indirect Medical Education (IME) if applicable, Peer Group Add-On Amount if applicable, and a stop-loss/stop gain adjustment if applicable.

The Hospital Specific Base Rate is calculated as: [((Statewide Base Rate ) x (1+MIUR Factor) x(1+IME Factor)) + (Peer Group Add-On Amount)] x (1+Stop-Loss/Stop Gain Adjustment)

Non-Outlier DRG Per Case Payment= Hospital Specific Base Rate x DRG Weight

Outlier DRG Per Case Payment={{(Allowable Charges x Hospital Specific Cost-to-Charge Ratio) – DRG Outlier Threshold] x Outlier Payment Percentage} + Non-Outlier DRG Per Case Payment

## METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
## INPATIENT SERVICES

**For Admissions on and after January 1, 2019**

**Examples of Non-Outlier and Outlier DRG Per Case Payments**

| **Hospital Data:** | | **DRG Data:** | |
|---|---|---|---|
| Statewide Base Rate | $5,310.99 | DRG Number | 313 (Chest Pain) |
| MIUR Factor | 6% | DRG Weight | 0.7477 |
| IME Factor | 1.48% | DRG Outlier Threshold | $30,000.00 |
| Peer Group Add-On Amount | $0 | | |
| Stop-Loss/Stop-Gain Adjustment | 1.35% | | |
| Hospital Specific Cost-to-Charge Ratio (CCR) | 0.231 | | |

**Example 1: Calculation of the Hospital Specific Base Rate**

Hospital Specific Base Rate = [((Statewide Base Rate) x (1 + MIUR Factor) x (1 + IME Factor)) + (Peer Group Add-On Amount)] x (1 + Stop-Loss/Stop-Gain Adjustment)

| | | |
|---|---|---|
| 1. Statewide Base Rate | $5,310.99 | |
| 2. MIUR Factor + 1 | 106.00% | |
| 3. IME Factor + 1 | 101.48% | |
| 4. Peer Group Add-On Amount | $0.00 | |
| 5. Stop-Loss/Stop-Gain Adjustment + 1 | 101.35% | |
| 6. Hospital Specific Base Rate | **$5,790.09** | ((Line 1 x Line 2 x Line 3) + Line 4) x Line 5 |

**Example 2: Calculation of Non-Outlier DRG Per Case Payment**

Non-Outlier DRG Per Case Payment = Hospital Specific Base Rate x DRG Weight

| | | |
|---|---|---|
| 1. Hospital Specific Base Rate | $5,790.09 | |
| 2. DRG Weight (Chest Pain) | 0.7477 | |
| 3. Non-Outlier DRG Per Case Payment | **$4,329.25** | (Line 1 x Line 2) |

**Example 3: Calculation of Outlier DRG Per Case Payment**

Outlier DRG Per Case Payment = {[(Allowable Charges x Hospital Specific Cost-to-Charge Ratio) - DRG Outlier Threshold] x Outlier Payment Percentage} + Non-Outlier DRG Per Case Payment

| | | |
|---|---|---|
| 1. Allowable Charges | $225,000.00 | |
| 2. Hospital Specific CCR | 0.231 | |
| 3. Estimated Cost of the Claim | $51,975.00 | (Line 1 x Line 2) |
| 4. DRG Outlier Threshold | $30,000.00 | |
| 5. Estimated Cost Above Threshold | $21,975.00 | (Line 3 - Line 4) |
| ***Qualifies for Outlier Payment Only if Estimated Cost of the Claim is Above the DRG Outlier Threshold*** | | |
| 6. Outlier Payment Percentage | 0.893 | |
| 7. Outlier Payment Amount | $19,623.68 | (Line 5 x Line 6) |
| 8. Non-Outlier DRG Per Case Payment | $4,329.25 | |
| 9. Outlier DRG Per Case Payment | **$23,952.93** | (Line 7 + Line 8) |

For Admissions on and after January 1, 2024:

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The Hospital Specific Base Rate will include adjustments for each hospital's Medicaid Inpatient Utilization Rate (MIUR), Indirect Medical Education (IME) if applicable, Peer Group Add-On Amount if applicable, and a stop-loss/stop-gain adjustment if applicable.

The Hospital Specific Base Rate is calculated as: [((Statewide Base Rate) x (1+MIUR Factor) x (1+IME Factor)) + (Peer Group Add-On Amount)] x (1+ Stop-Loss/Stop Gain Adjustment)

Non-Outlier DRG Per Case Payment = Hospital Specific Base Rate x DRG Weight
Outlier DRG Per Case Payment ={((Allowable Charges x Hospital Specific Cost-to-Charge Ratio)-DRG Outlier Threshold] x Outlier Payment Percentage} + Non-Outlier DRG Per Case Payment

| B | C | D | E | F | G |
|---|---|---|---|---|---|
| 2 | **For Admissions on and after January 1, 2024** | | | | |
| 3 | **This DRG Pricing is an example of estimated DRG payment for inpatient hospital services in Georgia Medicaid** | | | | |
| 4 | | | | | |
| 5 | **Information** | | **Data** | | **Comments or Formula** |
| 6 | **INFORMATION FROM THE HOSPITAL** | | | | |
| 7 | Provider Medicaid ID | | 9999999 | | |
| 8 | Covered Charges | | $250,000.00 | | |
| 9 | Assigned APR-DRG Code | | 120-2 | | |
| 10 | Transfer Claim | | No | | |
| 11 | **HOSPITAL INFORMATION** | | | | |
| 12 | Provider Name | | GA Hospital Example | | |
| 13 | Hospital-specific cost-to-charge ratio | | 0.3300 | | |
| 14 | Statewide Base Rate | | $5,784.88 | | |
| 15 | MIUR Factor | | 6.0% | | |
| 16 | IME Factor | | 25.62% | | |
| 17 | Peer Group Add-On Amount | | $0.00 | | |
| 18 | Stop-Loss/Stop-Gain Adjustment | | 1.35% | | |
| 19 | Final Facility Rate | | $7,807.10 | | [(E14*(1+E15)*(1+E16))+E17]*(1+E18) |
| 20 | **APR-DRG INFORMATION** | | | | |
| 21 | APR-DRG Description | | MAJOR RESPIRATORY AND CHEST PROCEDURES | | |
| 22 | SOI Description | | Moderate | | |
| 23 | DRG Relative Weight | | 2.0221 | | |
| 24 | Cost Outlier Threshold | | $70,217.77 | | |
| 25 | **DRG BASE PAYMENT** | | | | |
| 26 | DRG Base Payment | | $15,786.74 | | E19 * E23 |
| 27 | **OUTLIER PAYMENT** | | | | |
| 28 | Estimated Cost of the Stay | | $82,500.00 | | E8 * E13 |
| 29 | Does this claim require an outlier payment? | | Yes | | If E28 > E24 then "Yes" else "No" |
| 30 | Estimated Cost Above Threshold | | $12,282.23 | | If E29 = "Yes" then E28 - E24 else 0 |
| 31 | Outlier Payment Percent | | 89.30% | | |
| 32 | Total Outlier Payment | | $10,968.03 | | If E29 = "Yes" then E30 * E31 else 0 |
| 33 | **CALCULATION OF DRG AMOUNT** | | | | |
| 34 | Total Payment | | $26,754.77 | | |
| 35 | | | | | |

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES**
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C. Discussion of Payment Components

1. Base Rates

For admissions before January 1, 2019:

All hospitals are assigned to one of three peer groups in order to develop a base rate that best matches payments to costs for hospitals that provide similar services. The three hospital peer groups are: statewide, pediatric and specialty. The specialty peer group consists of long-term acute care and rehabilitation hospitals.

The peer group base rate is obtained using cost report data and by calculating the average operating cost standardized for case mix of Inlier DRG cases across all cases in a peer group, with an adjustment factor applied to maintain budget neutrality. Effective for admissions on or after July 1, 2015 the base rate calculation, including the case mix standardization and budget neutrality adjustment, will incorporate hospital capital costs that were previously included in a separate capital add-on payment If a hospital is assigned to the statewide or pediatric peer group, the peer group base rate becomes the hospital-specific base rate. If a hospital is assigned to the specialty peer group, the hospital specific base rate is assigned.

**Specialty Peer Group Base Rates**

For admissions on and after January 1, 2008:

If a hospital is assigned to the specialty peer group and has a sufficient claim volume, the hospital-specific base rate will be the hospital's base rate. If a hospital is assigned to the specialty peer group and does not have a sufficient claim volume, the peer group base rate becomes the hospital-specific base rate. For each case paid within the DRG methodology, the hospital specific base rate will be multiplied by the appropriate DRG relative weight to calculate a payment.

For admissions on and after January 1, 2019:

All hospitals are assigned to one of two peer groups in order to develop a hospital specific base rate that best matches payments to costs for hospitals that provide similar services. The two hospital peer groups are: statewide and pediatric.

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Hospitals in the statewide peer group have hospital specific base rates calculated from the statewide base rate with adjustments for Medicaid utilization (MIUR), medical education (IME) if applicable, and a stop-loss/stop-gain factor if applicable.

Hospitals in the pediatric peer group have hospital specific base rates calculated from the statewide base rate with adjustments for Medicaid utilization (MIUR), medical education (IME) if applicable, the Pediatric Peer Group Add-On Amount, and a stop-loss/stop gain factor if applicable.

The statewide base rate is the average cost of claims in the base data for hospitals in the statewide peer group, adjusted for budget neutrality.

The Pediatric Peer Group Add-On Amount is the difference between the average cost of claims in the pediatric peer group, adjusted for budget neutrality and the average cost of claims in the statewide peer group, adjusted for budget neutrality.

The stop-loss/stop-gain factor adjusts hospital specific base rates such that the hospital does not experience a loss due to the rebasing and does not experience a gain greater than 4.01% due to the rebasing.

For admissions on or after January 1, 2024, the stop-loss/stop-gain factor adjusts hospital specific base rates such that the hospitals estimated reimbursement using the data and logic found on page 4.19a, page 6a is budget neutral to the reimbursement as of December 31, 2023.

2. Hospital Provider Fee Add-On Amount

For admissions on or after July 1, 2013 through June 30, 2025:

Effective July 1, 2013, an adjustment to hospital inpatient base rates, capital add-on and GME add-on rates will be added to hospitals' inpatient rates. Critical Access Hospitals (CAHs), Psychiatric Hospitals and State-Owned / State-Operated Hospitals are exempt from the provider fee and the rate adjustment. Trauma hospitals will participate in the provider fee but at a lower percentage than other participating hospitals. The table below shows the provider fee and associated rate increase for different classes of hospitals.

Effective on or after July 1, 2015 an adjustment to the Graduate Medical Education (GME) Supplemental Payments (see Section D1) will be made for participating GME hospitals that are not exempt from the provider fee and rate adjustment and as detailed in the table below.

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| Provider Type | Provider Fee Percent | *Rate Increase Percent |
|---|---|---|
| Participating Acute Care and Specialty Hospitals | 1.45% | 11.88% |
| Trauma Hospitals | 1.40% | 11.88% |
| Critical Access Hospitals | N/A | N/A |
| Psychiatric Hospitals | N/A | N/A |

When calculating the Final DRG Payment Per Case, the addition of this new Base Rate Change will be the final step before any cutbacks are considered. The dollar amount will be calculated as a percentage (stored in the new System Parameter) of the DRG Payment Per Case at that point in adjudication.

3. Calculation of the Capital Add-on Amount

For admissions before July 1, 2015, hospitals receive a hospital-specific add-on based on reimbursable capital costs from the cost report year, charges from the rate setting base year and supplemental data

from the capital expenditure survey. See page 6 under “A. Data Sources and Preparation of Data for Computation of Prospective Rates” for detailed cost report reference.

4. Calculation of the Direct Graduate Medical Education (GME) Add-on Amount

For admissions before July 1, 2015, hospitals which have reimbursable GME costs in the cost report year receive the GME add-on amount. The Medicaid portion of GME from the hospital's cost report year is adjusted for inflation, then divided by the number of cases in the base year to obtain the GME add-on. See page 6 under “A. Data Sources and Preparation of Data for Computation of Prospective Rates” for detailed cost report reference.

5. Determination of Capital and Graduate Medical Education (GME) Add-On Amounts

The basis for the determination of capital add-on amounts and GME add-on amounts that were in place for admissions before July 1, 2015 is described below. All hospital-specific information is based on data from three sources and may be updated periodically:

(a) The hospital's cost report (for capital and GME add-on amounts)
(b) The hospital's capital surveys, if utilized (for capital add-on amounts only)

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(c) Georgia Medicaid and PeachCare paid claims data (for hospitals with a limited number of paid claims, add-on amounts may be determined based on average amounts for other hospitals.)

Part 1 - Calculation of the Capital Add-On Amount

(a) A Medicaid allocation ratio is used to apportion the Medicaid portion of the hospital's total capital. The allocation ratio is the hospital's Medicaid inpatient costs divided by total hospital costs.
(b) Sum the hospital's reimbursable capital costs (total building and fixtures) and capital costs (total major movable) from the cost report.
(c) Determine the Medicaid allocation of capital costs from the cost report by multiplying the Medicaid allocation ratio (Item (a)) by total capital costs from the cost report (Item (b)).
(d) Determine the capital CCR by dividing the Medicaid allocation of capital costs (Item (c)) by the total allowed Medicaid charges for the cost report period.
(e) Calculate the base year capital costs by multiplying the capital CCR by the base year allowed charges.
(f) Calculate the preliminary capital costs per case by dividing the base year capital costs (Item (e)) by the base year number of cases.
(g) Sum the total amounts from the capital expenditure surveys, if utilized.
(h) Determine the Medicaid allocation of capital costs from surveys by multiplying the Medicaid allocation ratio (Item (a)) by total capital from surveys (Item (d)).
(i) Determine the survey rate of increase by dividing Item (h) by item (e).
(j) Calculate the Capital Add-On Amount by multiplying Item (f) by one plus Item (i).

Part 2 - Calculation of the Direct Graduate Medical Education (GME) Add-On Amount

Only hospitals, which have GME costs in the base period cost report, receive the GME add-on amount.

(a) A Medicaid allocation ratio is used to apportion the Medicaid portion of the hospital's GME. The allocation ratio is the hospital's Medicaid inpatient costs divided by total hospital costs.
(b) Use the hospital's reimbursable GME costs from the cost report.
(c) Determine the Medicaid allocation of GME costs from the cost report by multiplying the Medicaid allocation ratio (Item (a)) by total GME costs from the cost report (Item (b)).
(d) Determine the GME CCR by dividing the Medicaid allocation of GME costs (Item (c)) by the total allowed Medicaid charges for the cost report period.
(e) Calculate the base year GME costs by multiplying the GME CCR by the base year allowed charges, adjusted for inflation.
(f) Divide the total Medicaid allocation of GME (Item (e)) by the Medicaid discharges from the base year. This will yield the Medicaid GME amount per discharge.

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6. Indirect Medical Education

For admissions on and after July 1, 2015, hospitals with medical education will receive a hospital specific base rate adjustment in the form of a rate factor for Indirect Medical Education (IME) based on the number of interns and residents and the number of hospital beds indicated on their Medicare cost report.

7. Calculation of the Indirect Medical Education (IME) rate factor

Determine IME cost factor for the claims used in the fiscal period using Medicare cost report factors concurrent with the claims period.

For admissions on or after January 1, 2019, the IME calculation methodology is as follows:

(a) Calculate the total FTE residents.
(b) Sum the number of beds at the hospital and sub providers from the cost report, Worksheet S-3, Column 2, Line 14 plus Line 16 plus Line 17.
(c) Determine total number of inpatient beds by subtracting nursery beds from total beds on the cost report (Item (b) minus Worksheet S-3, Colum 2, Line 13).
(d) Calculate ratio of residents to beds by dividing the total FTE residents (Item (a)) by the total number of inpatient beds (Item (c)).
(e) Use the CMS Medicare formula in place on July 1 2015 to determine Indirect Medical Education Factor: 1.35 * ([1 + ratio of interns & residents to bed (Item (d))]$^{0.405}$ - 1).

For admissions on or after January 1, 2024, the IME calculation methodology is as follows:

(a) Calculate the total FTE residents.
(b) Sum the number of beds at the hospital and sub providers from the cost report, Worksheet S-3, Column 2, Line 14 plus Lin 16 plus Line 17.
(c) Determine total number of Inpatient beds by subtracting nursery beds from total beds on the cost report (Item (b) minus Worksheet S-3, Column 2, Line 13)
(d) Calculate ratio of residents to beds by dividing the total FTE residents (Item (a)) by the total number of inpatient beds (Item (c)).
(e) Use the CMS Medicare formula in place on July 1, 2023 to determine indirect Medical Education Factor: 1:35* ([1+ ratio of interns & residents to bed (Item (d))]$^{0.405}$ -1).

8. Calculation of the Medicaid Inpatient Utilization Rate (MIUR) Factor:

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Hospitals will receive a hospital specific base rate adjustment determined from the percentage of Medicaid patients versus overall patients. The Medicaid Utilization Percentage is estimated from Disproportionate Share Hospital (DSH) survey data and the corresponding Medicare cost report data from the most recently completed DSH survey. For facilities that do not supply DSH survey data, equivalent cost report data from the DSH period is substituted for DSH data.

For admissions on or after January 1, 2019, the MIUR factor is calculated as follows:

(a) For facilities completing DSH surveys:
1. Determine total Medicaid inpatient days from DSH Survey Pt. II, Sec. H, Line 18.
2. Determine total inpatient days from DSH Survey Pt. II, Sec. G, Line 18.
3. Calculate MIUR from total Medicaid inpatient days (Step 1) divided by total inpatient days (Step 2).

(b) For facilities without DSH surveys:
1. Determine total Medicaid fee for service and managed care days from cost report Worksheet S-3, Part I, Column 7, Line 14 plus Line 2.
2. Determine total inpatient days from Medicare cost report Worksheet S-3, Part I, Column 8, Line 14.
3. Calculate MIUR from Medicaid days (Step 1) divided by total inpatient days (Step 2).

The Medicaid Utilization percentages are grouped into six bands, each of which has a corresponding rate factor percentage which is applied to the base rate. The MIUR bands are as follows:

| | | |
|---|---|---|
| Band 0-10.9%: | MIUR is less than 11% | 0% rate increase |
| Band 11-20.9%: | MIUR at least 11% but less than 21% | 2% rate increase |
| Band 21-30.9%: | MIUR at least 21% but less than 31% | 4% rate increase |
| Band 31-40.9%: | MIUR at least 31% but less than 41% | 6% rate increase |
| Band 41-50.9%: | MIUR at least 41% but less than 51% | 8% rate increase |
| Band 51+%: | MIUR is 51% or higher | 10% rate increase |

For admissions on or after January 1, 2024, the MIUR factor is calculated as follows:

- For facilities completing DSH surveys:
  - Determine total Medicaid Inpatient days from DSH Survey Pt. II, Sec. H, Line 18.
  - Determine total inpatient days from DSH Survey Pt. II, Sec. G, Line 18

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- Calculate MIUR from total Medicaid Inpatient days (Step 1) divided by total inpatient days (Step 2)

- For facilities without DSH surveys:
  - Determine total Medicaid fee for service and managed care days from cost report Worksheet S-3, Part I, Column 7, Line 14, plus Line 2.
  - Determine total inpatient days from Medicare cost report Worksheet S-3, Part I, Column 8, Line 14.
  - Calculate MIUR from Medicaid days (Step 1) divided by total inpatient days (Step 2).

The Medicaid Utilization percentages are grouped into six bands, each of which has a corresponding rate factor percentage which is applied to the base rate. The MIUR bands are as follows:

| | | |
|---|---|---|
| Band 0-10.9%: | MIUR is less than 11% | 0% rate increase |
| Band 11-20.9%: | MIUR at least 11% but less than 21% | 2% rate increase |
| Band 21% -30.9%: | MIUR at least 21% but less than 31% | 4% rate increase |
| Band 31-40.9%: | MIUR at least 31% but less than 41% | 6% rate increase |
| Band 41-50.9% | MIRU at least 41% but less than 51% | 8% rate increase |
| Band 51+% | MIRU is 51% or higher | 10% rate increase |

D. Special Payment Provisions

1. Graduate Medical Education (GME) Supplemental Payments

Effective July 1, 2015 through December 31, 2018, hospitals which have GME costs in the base period cost report, receive a GME payment as a Graduate Medicaid Education Supplemental Payment. GME is paid in at least four quarterly equal payments or more frequently if funds are available.

(a) A Medicaid allocation ratio is used to apportion the Medicaid portion of the hospital's GME. The allocation ratio is the hospital's Medicaid inpatient costs divided by total hospital costs.
(b) Use the hospital's reimbursable GME costs from the cost report.
(c) Determine the Medicaid allocation of GME costs from the cost report by multiplying the Medicaid allocation ratio (Item 1 (a)) by total GME costs from the cost report (Item 1 (b)).
(d) Determine the GME CCR by dividing the Medicaid allocation of GME costs (Item 1 (c)) by the total allowed Medicaid charges for the cost report period.
(e) Calculate the base year GME costs by multiplying the GME CCR by the base year allowed charges, adjusted for inflation.
(f) Divide the total Medicaid allocation of GME (Item 1(e) by the number of payments

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Effective January 1, 2019, hospitals with accredited GME programs receive a Graduate Medical Education Supplemental Payment. GME supplemental payments are made in quarterly installments. The annual amount of each GME supplemental payment is determined as follows:

(a) Determine the number of FTE residents.
(b) Determine the Medicaid Allocation Ratio (MAR). For facilities with DSH surveys, the Medicaid Allocation Ratio is Total Medicaid Hospital Revenue divided by Net Hospital Revenue. For facilities without DSH surveys, the Medicaid Allocation Ratio is Total Medicaid Inpatient Cost (Medicare Cost Report Worksheet E-3, Part VII, Title XIX, Line 1.00, Column 1.00) divided by Total Inpatient and Outpatient Cost (Medicare Cost Report Worksheet B, Part I, Line 118, Column 24).
(c) Determine the hospital's base GME funding as follows: $49,000 x (FTE resident count determined in step (a)) x (MAR determined in step (b))
(d) Hospitals with FTE residents in the residency programs listed below will receive additional funding above the base funding allocation.
    a. Family Medicine: $33,000/FTE Resident
    b. OB/GYN: $33,000/FTE Resident
    c. General Pediatrics: $28,500/FTE Resident
    d. Pediatric Specialty Programs: $13,500/FTE Resident
    e. General Surgery: $10,000/FTE Resident

2. New Facilities

New facilities under the DRG system will receive payments using the same payment formulas as stated in Section II. However, the components of the formulas will be calculated on a statewide average. A new facility will receive a hospital-specific base rate that is equal to the statewide average rate for the appropriate peer group in which the hospital is classified, a capital add-on payment equal to the statewide average add-on payment for the appropriate peer group and a cost-to-charge ratio that is equal to the Georgia statewide average of the cost-to-charge ratios. For dates of admission on or after July 1, 2015, capital costs will be reimbursed as part of the statewide average base rate instead of via the capital add-on payment.

For dates of admissions on or after January 1, 2024, new facilities will be reimbursed at the statewide base rate and the Georgia statewide average of cost-to-charge ratios. New facilities will be eligible for a hospital specific cost-to-charge ratio as soon as a filed DSH Survey and/or Medicare Cost Report is available prior to the annual IPPS updates.

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3. Out-of-State Facilities

For dates of admissions on or after January 1, 2019, out-of-state enrolled facilities will be reimbursed at the statewide base rate and the Georgia statewide average of cost-to-charge ratios.

4. New Medicaid Providers

Prospective payment rates for established facilities which did not submit a hospital-specific Medicare cost report because the facility did not participate in the Medicaid program will be determined in the same manner as a new facility stated in section D.2.

E. DRG Grouper

For admissions on and after January 1, 2019, the grouper used to classify cases into DRG categories will be TRICARE Grouper version 35.0. The grouper used to assign claims to DRG categories, as well as the corresponding DRG weights and threshold amounts, may be updated periodically.

For admissions on and after January 1, 2024, the grouper used to classify cases into DRG categories will be the APR-DRG Grouper version 40.0. The grouper used to assign claims to DRG categories, as well as the corresponding DRG weights and outlier threshold amounts, may be reviewed and updated periodically for budgetary considerations.

F. Reviews and Appeals

In general, providers may submit written inquiries concerning the rate determination process or requests for review of their specific rates. Only the following will be considered under the procedures herein described:

- Evidence that the audited cost report figures used to determine the base rate contained an error on the part of the Department or its agents.
- Evidence that the Department made an error in calculating the prospective rate of payment.
- Evidence that the Department is not complying with its stated policies in determining the base rates, trend factor, or utilization constraints.

Information concerning the base rate and prospective rate will be provided to each hospital prior to the effective date. A hospital will have 30 days from the date of the correspondence to submit a request for adjustment concerning the rate determination process. If no adjustment request is submitted within this

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time period, a hospital may not contest its rate of payment. There is no time limitation for the Department to reduce a hospital's rate when an error is discovered.

Written requests must be submitted to:

Director of Reimbursement
Department of Community Health
2 Martin Luther King Jr. Drive SE
East Tower, 16th Floor
Atlanta, Georgia 30334

Requests for review must include evidence on which the request is being based.

Hospitals which do not submit written requests or inquiries within thirty days of the date of such information will be considered to have accepted their rates as received. Similarly, failure of the hospital to state the basis for review and to include relevant supporting evidence for the Department's consideration, when requesting an Administrative Review, will also result in a denial of further appeal rights on the rate of payment. The Director of Reimbursement will have sixty (60) days from the date of receipt to render a decision concerning the written requests or inquiries submitted by a hospital if no additional information is required. The Director of Reimbursement may have more than sixty (60) days to render a decision if additional information is requested. If the Director of Reimbursement requests additional information, the request must be issued within thirty (30) days of receipt, and the hospital must respond within thirty (30) days of receipt of such request. The Director of Reimbursement will have thirty (30) days from the receipt of the additional information to render a decision in writing. The failure of the Director of Reimbursement to render a decision within the above-stated time frame will result in a decision in favor of the hospital concerning the issue raised by the hospital on appeal.

Failure of the hospital to provide information within the specified time frame as requested by the Director of Reimbursement will result in the denial of the hospital's appeal by the Director of Reimbursement. A hospital which disagrees with the determination may request a hearing. If the request is not received by the Office of Legal Services within ten (10) days of the date of the Director's decision, the hospital will be deemed to have waived any and all further appeal rights.

G. Co-Payment

A co-payment of $12.50 will be imposed for certain inpatient hospital admissions. Recipients affected by the copayment are limited to adult recipients of Supplemental Security Income (SSI) benefits, certain

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other adult disabled and aged recipients and parents of children receiving Temporary Assistance for Needy Families (TANF). Children under age twenty-one, pregnant women, nursing home residents, or hospice care participants are not required to pay this co-payment. Emergency services and Family Planning services received by Medicaid recipients do not require a copayment. Services cannot be denied based on the inability to pay these copayments.

H. Administrative Days

Administrative days are those days that a recipient remains in an acute care setting awaiting placement in a nursing facility due to the unavailability of a bed. Administrative days may occur in the two situations outlined below.

- Following the physician's written order for discharge on the chart.
- When a utilization review denial letter is given prior to the physician's written order for discharge.

The allowable covered number of administrative days is three days or 72 hours for either situation outlined above. Any administrative days greater than three days that a recipient remains in the acute care setting awaiting placement in a nursing facility are non-covered days.