

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



CENTER FOR MEDICAID AND CHIP SERVICES (CMCS)

Mr. Jerry Dubberly
Chief, Division of Medicaid
Georgia Department of Community Health
2 Peachtree Street, NW
Atlanta, Georgia 30303-3159

SEP -6 2012

Re: Georgia State Plan Amendment 12-003

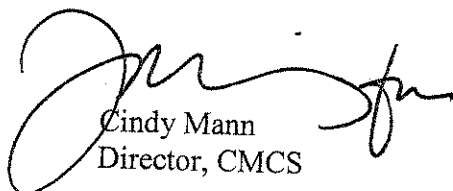
Dear Mr. Dubberly:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 12-003. Effective February 1, 2012 this amendment proposes to adjust the payment methodology for Long Term Care services. Specifically the amendment proposes to increase reimbursement rates resulting from a change to the 2009 cost report from the 2006 cost report as the basis for reimbursement rates. In addition, the amendment proposes to convert from the Minimum Data Set 2.0 to 3.0 resulting in new case mix index scores used in the calculation of nursing facility rates. The State estimates that the Federal budget impact of this SPA will be an increase of \$30,999,930 and \$41,232,839 for Fiscal Years 2012 and 2013 respectively.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of February 1, 2012. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Anna Dubois at (850) 878-0916.

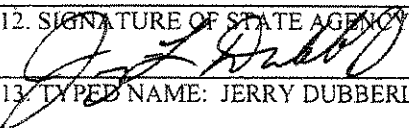

Sincerely


Cindy Mann
Director, CMCS

RECEIVED

SEP 10 2012

Chief's Office

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 12-003	2. STATE GEORGIA
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE February 1, 2012	
5. TYPE OF PLAN MATERIAL (Check One):			
<input type="checkbox"/> NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION:		7. FEDERAL BUDGET IMPACT: FFY 2012 \$ 30,999,930 FFY 2013 \$ 41,232,839	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <i>ATTACHMENT 4.19D pgs 1-9 Suppl 1 to ATTACHMT 4.19D pgs 1 Suppl 2 to ATTACHMT 4.19D pgs 1-26 Suppl 3 to ATTACHMT 4.19D pgs 1-12 Suppl 4 to ATTACHMT 4.19D pgs 1-5</i>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Section 4.19-D pp. 6, 8, 9, 11, 27, 35, 44, 48, 49, and 50	
10. SUBJECT OF AMENDMENT: Nursing Home Reimbursement			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input checked="" type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Department of Community Health Division of Medicaid 2 Peachtree Street, NW, 36 th Floor Atlanta, Georgia 30303-3159	
13. TYPED NAME: JERRY DUBBERLY			
14. TITLE: CHIEF, DIVISION OF MEDICAID			
15. DATE SUBMITTED:			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: SEP - 6 2012	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: FEB - 1 2012		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <i>Julia Hinckley</i>		22. TITLE: <i>Sr. Policy Advisor</i>	
23. REMARKS: <i>Per ink changes made to box # 8</i>			

**PART II, POLICIES AND PROCEDURES FOR
NURSING FACILITY SERVICES**

CHAPTER 1000

BASIS FOR REIMBURSEMENT

Rev. 01/01/2006

1001 General

This chapter provides an explanation of the Division's reimbursement methodology.

1002 Reimbursement Methodology

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 Part I, Chapter 400 of the Manual and Supplement 4 to Attachment 4.19-D.

1002.1 Definitions

- a. Patient Income is that dollar amount shown on the Summary Notification letter issued by the Department 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 in Sections 1002.2 and 1002.3.

Rev 01/01/06

- c. A nursing facility is an institution licensed and regulated to provide nursing care services or intermediate care services for the mentally retarded in accordance with the provisions of this Manual. 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 classification of a nursing facility may change as described in this chapter. The types are described below:

- 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 the Mentally Retarded (ICF-MR) -
These facilities provide care to patients that are mentally retarded.
- d. Cost Center refers to one of 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 (Lines 17 and 77), Dietary (Line 89), Laundry and Housekeeping and Operation and Maintenance of Plant (Lines 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 the mentally retarded.
- 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 the following conditions are met:
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. 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

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Section B

- a) accounting
- b) admissions
- c) collections
- d) data processing
- e) maintenance of personnel

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 Sections 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.

Rev. 01/09

Rev 01/2011

In making the determination that a long-term care facility is hospital-based, collocation 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 qualify 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 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 Division of Health Planning of the relevant proposal.
 4. The effective date of licensing by the Georgia Department of Community Health Standards and Licensure Unit.
 5. The effective date of the Statement of Participation in the Georgia Medical Assistance Program.
 6. The date on which physical construction is certified complete by whichever agency(s) is/are responsible for this determination.
 7. The date of the approval of a Certificate of Need by the Division of Health Planning.

Rev. 07/01/2010

- 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.

Rev. 07/01/2010

- j. Age is defined in Section 1002.5(5).

SEP - 6 2012

TN No.: 12-003
Supersedes
TN No.: 06-021

Approval Date: _____

Effective Date: 02-01-2012

- 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 Centers for Medicare and Medicaid Services Provider Reimbursement Manual (CMS-15-1). In addition to those non-allowable costs discussed in CMS-15-1, the costs listed below are non-allowable.**

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

Memberships in civic organizations;

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;

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. ambulances);

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.

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

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

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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.

Funds expended for personal purchases.

Rev. 07/01/06

1002.2 Total Allowed Per Diem Billing Rate for Facilities for Which a Cost Report is Used To Set a Billing Rate

Rev. 07/2010

For dates of service beginning February 1, 2012, the 2009 Cost Report is the basis for reimbursement.

Rev. 04/09

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 quarter for which information is available) for each of the four Non-Property Cost Centers plus the Net Per Diem for the Property and Related Cost Center. The Property and Related Cost Center reimbursement for those facilities whose cost reimbursement is limited to the standard (90th percentile) per diem in this cost center will be based upon the standard per diem calculated from the cost reports for the year ending June 30, 1981.

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.

Rev. 07/01/2010

Growth Allowance =

Rev. 01/01/2008

Summation of 0% of the Allowed Per Diem for each of the four Non-Property and Related cost centers (Routine and Special Services; Dietary;

Landry and Housekeeping and Operations and Maintenance of Plant; and Administrative and General).

Further explanation of these terms is included below:

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

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

See Section 1002.5 for additional description 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 to a \$100,000 maximum salary for CEO, COO, CFO and other Home Office 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 designated maximums.

Routine and Special Services Net Per Diem =

Nursing Facilities Net Per Diem =

Rev. 07/01/2010

(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 in Section 1002.2. 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 of this Attachment.

ICF-MR Net Per Diem =

(Historical ICF-MR Routine and Special Services (Schedule B, Lines 6 plus 7, Column 4) divided by (Total ICF-MR Patient Days, Schedule A, Line 13, Column 8).

Rev. 07/01/2010

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:

Total Routine Services Costs, (Medicaid Cost Report)

Schedule B, Line 6, Column 4	\$5,000,000	
Patient Days		
Total Medicaid ICF_MR 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-MR (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.

Administrative and General Net Per Diem =

Historical Administrative and General, Schedule B, Line 11, Column 4, Divided By Total Patient Days.

Property and Related Net Per Diem =

Rev. 07/01/2010

Historical Property and Related costs (Schedule B (Medicaid Cost Report), Line 12, Column 4) are divided By Total patient Days. The resulting net per diem will be adjusted to the greater of the facilities Dodge Rate, or the approved property reimbursement per diem in effect as of July 1, 2009, or the Fair Rental Value System per diem rate. Property reimbursement under FRVS will replace use of the Dodge index over a three year period beginning July 1, 2009. FRV reimbursement beginning July 1, 2009, shall not increase by more than 150% of the amount that would have been paid using the Dodge index alone or the approved property reimbursement per diem in effect on June 30, 2009. After three years FRV will replace the property component determined by the Dodge index and any otherwise previously approved property reimbursement per diem.

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

Rev. 07/2010

Rev 07/2004

b. Standard Per Diem for each of the five cost centers (Routine and Special Services; Dietary; Laundry and Housekeeping and Operation and Maintenance of Plant; Administrative and General; and Property and Related) 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 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 the 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 Mentally Retarded group. If the Maximum Percentile does not correspond to a specific value in the array of net per diem amounts, the maximum percentile is determined by interpolation (i.e., finding the mid-point between whole integers).

Rev. 07/06

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 .. Standards effective February 1,2012, will not be recalculated based upon changes in rates due to subsequent determination of additional allowable cost, disallowance of previously allowable cost or any change in the Net Per Diem in any cost center. The following examples show groupings by Net Per Diem:

Rev. 07/2010

Rev. 07/06

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 \text{ net per diems}) \times (90^{\text{th}} \text{ percentile}) = 9^{\text{th}} \text{ 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

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Median Net Per Diem is the per diem amount that falls in the middle of the group or \$120
 $\$120 \times 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

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 \times 105\% = \124

Rev. 07/2010

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

Rev. 07/2010

Rev. 07/2006

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 mentally retarded) 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 any 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:

Nursing Facility

Intermediate Care Facility for the Mentally Retarded

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 Mentally Retarded

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

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

Nursing Facility

Intermediate Care Facility for the Mentally Retarded

Administrative and General Standard Per Diem

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

Nursing Facility

Intermediate Care Facility for the Mentally Retarded

Property and Related Standard Per Diem

Rev 07/01/2010

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.

Rev. 07/01/2010

- 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 Per 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:

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

1002.3 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 will be resolved as described in the provisions discussed below for unauditible 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.

Rev. 07/01/2010

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 under Section 1002.5(a) through (g)

Rev 07/05

- 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 unauditible cost reports. If the Division determines that a cost report which was to be used to set a reimbursement rate is unauditible (i.e., the Division's auditors cannot render an opinion using commonly accepted auditing practices on the filed cost report, either on the desk review or on-site audit), 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 unauditible cost report;
 - The Total Allowed Per Diem Billing Rate calculated from the unauditible cost report; or
 - 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 becomes auditable and appropriate, the Total Allowed Per Diem Billing Rate will then be calculated using the audited cost report as a basis. The resulting reimbursement rate will then be applied to the appropriate period.

Effective April 1, 1982, the Property and Related cost center reimbursement for those facilities whose cost reimbursement is limited to the Standard (90th percentile) Per Diem in this cost center will be based upon the Standard Per Diem calculated from the cost reports for the year ending June 30, 1981.

- 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 limited so as to make the resulting average case mix score unreliable for rate calculations, the Department may elect to use the average score for all facilities.

Rev. 07/01/07

1002.4 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 in section 1003.1
- b. For the most recent calendar quarter for which MDS information is available, Cognitive Performance Scale (CPS) 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 CPS scores are moderately severe to very severe. The adjustment factors are as follows:

% of Medicaid Patients	Adjustment Factor
<20%	0%
20% - <30%	1%
30% - <45%	2.5%
45% - 100%	4.5%

Rev. 07/01/2010

- 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 Center 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.
- (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.

- (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.

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.

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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:

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

Rev. 07/01/2010

1002.5 Property and Related Reimbursement

1. Effective for dates of service on and after July 1, 2009, the Property and Related Net Per Diem shall be the higher of: (i) such Per Diem being paid as of June 30, 2009 (based on the Dodge index); or (ii) the amount computed using the fair rental value (FRV) reimbursement system described below. Property reimbursement under FRV will replace use of the Dodge index over a three year period beginning July 1, 2009. FRV reimbursement beginning July 1, 2009, shall not increase by more than 150% of the amount that would have been paid using the Dodge index alone., but will also be no less than the amount based on the Dodge index or the approved property reimbursement per diem in effect on June 30, 2009. After three years FRV will replace the property component determined by the Dodge index and previously approved property reimbursement per diems. Under a FRV system, a facility 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 initially established under the FRV System shall be calculated as follows:
 - (a) Effective for dates of service on and after July 1, 2009, the value per square foot shall be based on the \$141.10 construction cost for nursing facilities, as derived from the 2009 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 initially set at 1.000. 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 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).
- (c) 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.
- (d) A Depreciated 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 all of Section 1002.5(5), by a 2% Facility Depreciation Rate. The Initial Adjusted Facility Age will be the lesser of the calculated facility age or 25 years.
- (e) The Land Value of a facility is calculated by multiplying the Facility Replacement Value by 15% to approximate the cost of the land.
- (f) 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.
- (g) The Annual Rental Amount is divided by the greater of the facility's actual cumulative resident days during the 2006 cost reporting period or 85% of the licensed bed capacity of the facility multiplied by 365. The resulting figure constitutes 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
		XYZ Nursing	
A	Facility Name	Home	Department Data
B	Medicaid Provider ID	12345678A	Department Data
C	Rate Setting Year	2009	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	30,312	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 RSMean Cost per Square Foot	\$141.10	RSMean lookup based on Rate Year
M	RSMean Location Factor	0.9	RSMean lookup based on Zip Code (G)
N	Construction Cost Index	1	Department Criteria
O	Adjusted Cost per Square Foot	\$126.99	L x M x N
P	Facility Replacement Value	8,744,150	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	\$9,572,150.00	P + S
U	Bed Additions and Facility Renovations	0	Separate calculations affecting the Nursing Facility (see D and V)
V	Nursing Facility Age	20	C - D (D is based on initial age adjusted by additions/renovations per U)
W	Maximum Years for FRV Age	25	Department Criteria

Ref.	Data Element	Example	Source of Data
X	FRV Adjusted Facility Age	20	lesser of V or W
Y	Facility Depreciation Rate	2.00%	Department Criteria
Z	Depreciation Using FRV Adjusted Age	\$3,828,860.00	T x X x Y
AA	Depreciated Replacement Value	\$5,743,290.00	T - Z
AB	Land Percentage	15.00%	Department Criteria
AC	Land Value	\$1,311,623.00	P x AB
AD	Depreciated Replacement Value & Land	\$7,054,913.00	AA + AC
AE	Rental Rate	9.00%	Department Criteria
AF	Rental Amount	Supplement 2 to Attachment 4.19-D Page 22 State: GEORGIA	
AG	Minimum Occupancy Percentage		
AH	Bed Days at Minimum Occupancy		
AI	Total Allowed Patient Days	48,552	Higher of H or AH
AJ	Fair Rental Value per Diem	\$13.08	AF / AI
	06/30/09 Property and Related Net Per		Department Data (Dodge
AK	Diem	\$5.43	Index)
			Greater of AJ or AK, but not more than 150%
AL	Property and Related Net Per Diem	\$13.08	increase of AK

3. The Property and Related Net Per Diem initially established under Section 1002.5(2) shall 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 Section 1002.5(4a)) 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 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 initial age of each facility shall be determined as of July 1, 2009, comparing 2009 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, 2009.
 - (b) For periods subsequent to July 1, 2009, the FRV adjusted age determined in Section 1002.5(5a) of a facility will be reduced on a quarterly basis to reflect new Renovation Construction Projects or bed additions that were completed after July 1, 2009, and placed into service during the preceding quarter. The rate adjustment for Renovation Projects or bed additions will be effective the first day of the calendar quarter subsequent to such project being completed and placed into service.
 - (c) 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 will be recalculated each July 1 to make the facility one year older, up to the maximum age of 32.5 years and will be done in concert with the calculations of the Value per Square Foot as determined in

Section 1002.5(3a). Age adjustments and Rate adjustments are not synonymous.

- (d) 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:

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

Ref.	Data Element	Example Data	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
			Based on Initial Age adjusted by Prior Bed Additions and Facility Renovations
D	Base Year Prior to Additions	1970	Department Data
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	Adjusted 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)

- (e) If a facility performed a Renovation Construction Project as defined in Section 1002.5(4), 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.

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 Data	Source of Data
A	Facility Name	XYZ Nursing Home	Department Data
B	Medicaid Provider ID	12345678A	Department Data
C	Rate Setting Year	2009	Department Criteria
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 RSMeans Cost Index	132.00	RSMeans lookup based on Year Renovation Completed
K	Rate Year RSMeans 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	RSMeans 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	\$5,652,466.00	M x O
Q	RSMeans Location Factor	0.77	RSMeans 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)

1002.6 Overall Limitations on Total Allowed Per Diem Billing Rate

In no case shall the Total Allowed Per Diem Billing Rate, whether determined under either Section 1002.2 or Section 1002.3, Nursing Facility Manual, exceed the facility's customary charges to the general public for those services reimbursed by the Division.

1002.7 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.

1002.8 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.

1003 Additional Care Services

1003.1 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)

1003.2 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.

1004 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.

1005 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. A facility's status as government owned or operated will be based on its ability to make direct or indirect intergovernmental transfer payments to the State. 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.

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1006 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 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.

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1007 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.

**PART II, POLICIES AND PROCEDURES FOR
NURSING FACILITY SERVICES**

APPENDIX D

UNIFORM CHART OF ACCOUNTS, COST REPORTING,

REIMBURSEMENT PRINCIPLES AND OTHER REPORTING REQUIREMENTS

Revised 01/01/2006

General

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

1. Uniform Chart of Accounts

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

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

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

2. Cost Reporting

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

- a. Each nursing facility must annually file a cost report with the Division of Medical Assistance which covers a twelve-month period ending June 30th. Cost reports must be e-mailed to the Division on or before September 30th. (See Hospital-based facility exception in 2(d) below.)
- b. If such cost reports are not filed by September 30th, the Division shall have the option of either terminating the provider agreement upon thirty days written notice or imposing a penalty of \$50.00 per day for the first thirty days and a penalty of \$100.00 per day for each day thereafter until an acceptable cost report is received by the Division. The only condition in which a penalty will not be imposed is if written approval for an extension is obtained from the Program Manager of Nursing Home Reimbursement Services prior to September 30.
- c. If a cost report is received by the Division prior to September 30th but is unacceptable, it will be returned to the facility for proper completion. No penalty will be imposed if the properly completed report is filed by the September 30th deadline. However, the above described penalties may be imposed after the September 30th deadline until an acceptable cost report is received by the Division.
- d. Hospital-based facilities using Medicare fiscal year ending dates between July and April must submit cost reports to the Division on or before September 30. Facilities using fiscal year ending dates between May and June must submit cost reports on or before November 30. The financial information to be included on the Medicaid cost report must be taken in total from the provider's most recent Medicare cost report that precedes June 30. The rules regarding unacceptability and timeliness described above in sections b. and c. also apply to hospital-based facilities' cost reports.

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

- e. To be acceptable, a cost report must be complete and accurate, include all applicable schedules, and be correctly internally cross-referenced. Further, the amount per book

column for Schedules B and C must agree with the amounts recorded in the facility's general ledger; however, there may have to be certain groupings of the general ledger amounts to agree with the cost report line items. Estimated amounts used for a conversion to a June 30th year-end are not acceptable. Reported costs of interest paid to non-related parties must be reduced by non-related parties must be reduced by an amount equal to the lesser of: (1) interest paid to non-related parties; or (2) investment income other than the exceptions identified in CMS-15, Section 202.2. Reported costs of special services must be reduced, as indicated on Schedule B-1A, by an amount resulting from revenue received from sources other than the Division for these services.

Adjustments will be based on auditable records of charges to all patients as required by cost report instructions.

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- f. Any changes to the amount of or classification of reported costs and patient day information must be made within 30 days after the applicable September 30th, November 30th, or approved extended submission deadline. Amended cost reports submitted after these deadlines will not be accepted unless they have been requested by the Division. If the original cost report is used to set reimbursement rates, the provider has up to 30 days from the implementation of the original cost report to request changes to the amount of or classification of reported costs and patient day information in accordance with the appeal procedures outlined in Supplement 4 of Attachment 4.19-D (Billing rate and Disallowance of Cost from the Cost Report). Adjustments to amounts or changes in classification of reported costs in prior years will not be considered.
- g. Late cost report penalties will be invoiced through the Accounting Section of the Division for the total amount of the assessed penalty. The provider must submit payment to the Division. Penalties not properly paid will be deducted from the monthly reimbursement check. The assessments will not be refunded.
- h. New facilities, which have less than twelve but not less than six months of actual operating cost experience, will only submit cost data for their actual months of operation as of June 30. New facilities that have less than six months of actual operating cost experience are not required to submit a cost report. Facilities in which there has been a change of ownership must submit a separate report for each owner. The subsequent owner will be reimbursed based on the previous owner's cost report (with an adjustment in the property cost center only) until a new cost report is received from the new owner and determined reliable and appropriate. The Division will determine whether each submitted cost report is appropriate and reliable as a basis for computing the Allowed Per Diem billing rate and may calculate a facility's Allowed Per Diem billing rate in accordance with Supplement 2 of Attachment 4.19-D, Section 1002.3.

For ownership changes effective with at least six months of patient day data on the applicable June 30 fiscal year cost report, the initially submitted cost report will be used to establish the new owner's rate when the comparable cost reports are used to

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

- i. Reported costs must conform to Divisional instructions, or in the absence of specific instructions, to the allowable costs discussed in the CMS-15-1. Reported costs are subject to audit verification by the Division, State or Federal auditors or their agents. Providers using computerized information systems for accounting or other purposes must make this information available in a suitable electronic format if requested by the Division or its agents. Where such audit verifications determine that the cost report was prepared based upon inadequate accounting records, the facility will be required to correct its records and submit a corrected cost report. A penalty will be imposed on the facility for the costs incurred by the Division for any additional audit work performed with the corrected cost report.
- j. For audit examinations described in (i) above, it is expected that a facility's accounting records will be available within the State. Should such records be maintained at a location outside the State, the facility will be required to pay for travel costs incurred for any examination conducted at the out-of-state location.
- k. Should a cost report submitted to the Nursing Home Unit for review need explanation or clarification, appropriate work papers or letters of explanation should be attached.

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1. All cost reports are to be emailed to nhcostreport@dch.ga.gov. Correspondence concerning the cost reports may be mailed to the following address:

Program Manager
Nursing Home Services Unit
39th Floor
Division of Financial Management
2 Peachtree Street, N.W.
Atlanta, GA 30303-3159

3. Reimbursement Principles

The objective of a system of reimbursement based on reasonable costs is to reimburse the institution for its necessary and proper expenses incurred related to patient care. As a matter

of general reimbursement principle, costs with respect to individuals covered by the Medicaid Program will not be borne by those not covered and costs with respect to individuals not covered by the Medicaid Program will not be borne by the Program. The principles of cost reimbursement require that institutions maintain sufficient financial records and statistical data for proper determination of costs payable under the Program. Such records and data must be maintained for a period of at least three years following the date of submission of the cost report

4. Case Mix Index Reports

- a. MDS Data for Quarterly Patient Listing - Using Minimum Data Set (MDS) information submitted by a facility, the Division will prepare a Case Mix Index Report, listing information for patients in a facility on the last day of a calendar quarter. A preliminary version of the report will be distributed to a nursing facility about the middle of the following quarter after each calendar quarter end. The preliminary version of the report will be distributed with instructions regarding corrections to patient payer source information that a nursing facility may submit for consideration before the final version of the report is prepared and distributed.
- b. RUG Classification - For each patient included in the quarterly Case Mix Index Report, the most recent MDS assessment will be used to determine a Resource Utilization Group (RUG) classification. Version 5.12, with 34 grouper and index maximizer, the RUG classification system will be used to determine a patient's RUG category.
- c. Payer Source - For each patient included in the quarterly Case Mix Index Report, a payer source will be identified. As described in section D.4.a, a facility will have the opportunity to submit updated payer source information for changes that may occur by the last day of the calendar quarter.
- d. Relative Weights and Case Mix Index Scores for All Patients - For each patient included in the quarterly Case Mix Index Report, a relative weight will be assigned by the Division. Exhibit D-1 identifies the relative weights for each RUG category. This data will be used to determine a case mix score for all patients in a facility.
- e. Relative Weights and Case Mix Index Scores for Medicaid Patients - For each Medicaid patient included in the quarterly Case Mix Index Report, a Medicaid relative weight will be assigned by the Division. Exhibit D-1 identifies the relative weights for each RUG category. This data will be used to determine a case mix score for Medicaid patients in a facility.
- f. CPS Scores - For each patient included in the quarterly Case Mix Index Report, the most recent MDS assessment will be used to determine a Cognitive Performance Scale (CPS) score.
- g. Corrections to MDS and Payer Source Information Corrections to MDS and payer source information used in payment rate calculations applicable to prior dates of service that result from appeals or audit adjustments may be processed as adjustments to rate calculations in a subsequent period. If the impact of the correction is significant, the Division may elect to process the correction by a retrospective adjustment to prior payments.

5. Nursing Hours and Patient Day Report

Rev. 09/11

Except for ICF-MR's, each nursing facility must submit a Nursing Hours and Patient Day Report for each calendar quarter, within one month after the end of the quarter. The required information will be submitted in accordance with a format and instructions as distributed by the Division. A facility's request to correct or amend a nursing home provider fee report will be limited to a 30 day period following the report's due date. Corrections to nursing hours and patient day data used in payment rate calculations applicable to prior dates of service that result from appeals or audit adjustments may be processed as adjustments to rate calculations in a subsequent period. If the impact of the correction is significant, the Division may elect to process the correction by a retrospective adjustment to prior payments.

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

Rev 07/01/2010

Rev 01/01/2011

6. Fair Rental Value System

A request for a fair rental value rate increase that is the result of a Renovation Construction Project, bed addition or replacement subsequent to July 1, 2009, must be submitted to the Department within thirty (30) days after completion of the project. The request must be completed on a standard form for rate requests and contain documented approval of the project from the Department's General Counsel Division.

Each facility must go through the following process before submitting for a fair rental value rate increase:

- a. If the Fair Rental Value Property rate increase being requested is due to a Renovation Construction Project, bed addition or replacement, the Georgia Certificate of Need Request for Determination form must be completed and submitted to the Division of Health Planning. Once approval for the Renovation Construction Project has been received from Health Planning, the provider may proceed with the project.
- b. Within thirty (30) days after completion of the project, complete the Initial Start Up And Fair Rental Value System Reimbursement (FRVS) Update Request Form, attach a copy of the letter received from the Division of Health Planning and documentation to support the Renovation Construction Project, bed addition or replacement. Mail a complete package to:

Program Manager
 Department of Community Health
 Nursing Home Reimbursement Services
 2 Peachtree Street, N.W.
 39th Floor

Atlanta, Ga. 30303

An electronic version of the Initial Start Up And Fair Rental Value System Reimbursement (FRVS) Update Request Form should also be emailed to FRVS@dch.ga.gov.

The Fair Rental Value Property rate increase will be effective the quarter following the completion of the approved Renovation Construction Project, bed addition or replacement and receipt of the completed Initial Start Up And Fair Rental Value System Reimbursement (FRVS) Update Request Form package.

EXHIBIT D-1

	Category	Classification	Code	Case Mix Index for All Patients	Case Mix Index for Medicaid Patients
1	Extensive	Extensive Special Care 3 / ADL > 6	SE3	2.839	2.896
2	Extensive	Extensive Special Care 2 / ADL > 6	SE2	2.316	2.362
3	Rehabilitation	Rehabilitation All Levels / ADL 17-18	RAD	2.284	2.330
4	Extensive	Extensive Special Care 1 / ADL > 6	SE1	1.943	1.982
5	Rehabilitation	Rehabilitation All Levels / ADL 14-16	RAC	1.936	1.975
6	Special Care	Special Care / ADL 17-18	SSC	1.877	1.915
7	Rehabilitation	Rehabilitation All Levels / ADL 9-13	RAB	1.772	1.807
8	Special Care	Special Care / ADL 15-16	SSB	1.736	1.771
9	Special Care	Special Care / ADL 4-14	SSA	1.709	1.743
10	Rehabilitation	Rehabilitation All Levels / ADL 4-8	RAA	1.472	1.501
11	Clinically Complex	Clinically Complex with Depression / ADL 17-18	CC2	1.425	1.454
12	Clinically Complex	Clinically Complex / ADL 17-18	CC1	1.311	1.337
13	Clinically Complex	Clinically Complex with Depression / ADL 12-16	CB2	1.247	1.272
14	Physical	Physical Function with Nursing Rehab / ADL 16-18	PE2	1.188	1.212
15	Clinically Complex	Clinically Complex / ADL 12-16	CB1	1.154	1.177
16	Physical	Physical Function with Nursing Rehab / ADL 11-15	PD2	1.095	1.117
17	Impaired Cognition	Cognitive Impairment with Nursing	IB2	1.061	1.082

	Category	Classification	Code	Case Mix Index for All Patients	Case Mix Index for Medicaid Patients
		Rehab / ADL 6-10			
18	Clinically Complex	Clinically Complex with Depression / ADL 4-11	CA2	1.043	1.064
19	Physical	Reduced Physical Function / ADL 16-18	PE1	1.077	1.077
20	Behavioral Problems	Behavior Problem with Nursing Rehab / ADL 6-10	BB2	1.021	1.041
21	Physical	Reduced Physical Function / ADL 11-15	PD1	0.990	0.990
22	Impaired Cognition	Cognitive Impairment / ADL 6-10	IB1	0.938	0.957
23	Physical	Physical Function with Nursing Rehab / ADL 9-10	PC2	0.937	0.956
24	Clinically Complex	Clinically Complex / ADL 4-11	CA1	0.934	0.953
25	Behavioral Problems	Behavior Problem / ADL 6-10	BB1	0.866	0.883
26	Physical	Physical Function with Nursing Rehab / ADL 6-8	PB2	0.824	0.841
27	Physical	Reduced Physical Function / ADL 9-10	PC1	0.865	0.865
28	Impaired Cognition	Cognitive Impairment with Nursing Rehab / ADL 4-5	IA2	0.777	0.777
29	Behavioral Problems	Behavior Problem with Nursing Rehab / ADL 4-5	BA2	0.750	0.750
30	Physical	Reduced Physical Function / ADL 6-8	PB1	0.749	0.749
31	Impaired Cognition	Cognitive Impairment / ADL 4-5	IA1	0.703	0.703
32	Physical	Physical Function with Nursing Rehab /	PA2	0.637	0.637

	Category	Classification	Code	Case Mix Index for All Patients	Case Mix Index for Medicaid Patients
		ADL 4-5			
33	Behavioral Problems	Behavior Problem / ADL 4-5	BA1	0.612	0.612
34	Physical	Reduced Physical Function / ADL 4-5	PA1	0.575	0.575

Exhibit D-2
Detailed Description of Data Presented in Case Mix Index Reports

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

AO310a – Reasons for assessment as reported in section AO310 of the MDS

Section a, primary reason for assessment

- 1 = admission assessment
- 2 = quarterly review assessment
- 3 = annual assessment
- 4 = significant change in status
- 5 = significant change to prior comprehensive assessment
- 6 = significant correction to prior quarterly assessment
- 99 = not OBRA required assessment

Section b, codes for assessments required for Medicare PPS or the State

- 1 = 5 day scheduled assessment
- 2 = 14 day scheduled assessment
- 3 = 30 day scheduled assessment
- 4 = 60 day scheduled assessment
- 5 = 90 day scheduled assessment
- 6 = readmission/return assessment
- 7 = unscheduled assessment used for PPS
- 99 = not PPS assessment

Resident Name – Self explanatory

SSN- Resident’s social security number

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

RUG Code – RUG classification code (see “Case Mix Index for All Patients” in Exhibit D-1) from application of 34 grouper with index maximizing

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

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

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

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

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

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

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Supersedes

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SEP - 6 2012

Approval Date: _____

Effective Date: 02-01-2012

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES NURSING FACILITY SERVICES

The following sections summarize the methods and procedures for determining nursing facility reimbursement rates in the format prescribed by the Department of Health and Human Services (DHHS).

Explanation of Commonly Used Terms

Dodge Index Factor: An index of activity in the construction industry in the United States, produced by McGraw Hill, an information services company.

Growth Allowance Factor: Inflation factor applied to the allowed per diem for each of the four non-property cost centers.

Net Per Diem: Net amount determined by dividing total audited cost by total audited patient days. This net per diem amount is calculated for each of the four non-property cost centers.

Quality Incentive Adjustment: A one or two percent increase to a provider's allowed Routine Services per diem amount as a result of achieving certain clinical and non-clinical criteria established by the Department.

Quarterly Medicaid Case Mix Score: The quarterly relative weight assigned to a Medicaid patient based on the patient's Resource Utilization Group (RUG) category.

Resource Utilization Group (RUG): Mutually exclusive categories that reflect levels of resource need in long-term care settings, primarily to facilitate Medicare and Medicaid payment.

Standard Per Diem: The maximum allowed per diem amount for each of the four non-property cost centers.

A. Cost Finding and Cost Reporting

1. All nursing facilities are required to report costs for the twelve months ending June 30th of each year. Cost report instructions are published by July 31st of each year for use during that State fiscal year. Release of the instructions may be delayed on occasion in order to implement significant policy changes.
2. All nursing facilities are required to detail their entire costs for the reporting year, or for the period of participation in the plan (if less than the full cost reporting year) for allowable costs under the Georgia Plan. These costs are reported by the facility using a Uniform Chart of Accounts prescribed by the State Agency and on the basis of generally accepted accounting principles and accrual methods of accounting.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
NURSING FACILITY SERVICES**

- a. All nursing facilities are required to report costs on a uniform cost report form provided by the State Agency. Hospital-Based facilities using Medicare fiscal year ending dates between May 31 and June 30 must submit cost reports on or before November 30. Those using Medicare fiscal year ending dates between July 31 and September must submit cost reports on or before December 31 using the most recent complete fiscal year cost data. All other facilities are required to submit cost reports on or before September 30 of the year in which the reporting period ends.
 - b. All nursing facilities are required to submit to the Department any changes in the amount of or classification of reported costs made on the original cost report within thirty days after the implementation of the original cost report used to set reimbursement rates. Adjustments to amounts or changes in classification of reported costs in prior years will not be considered.
3. All nursing facilities are required to maintain financial and statistical detail to substantiate the cost data reported for a period of at least three years following the date of submission of the cost report form to the State Agency. These records must be made available upon demand to representatives of the State Agency or the DHHS.
 4. The State Agency shall retain all uniform cost reports submitted in accordance with paragraph 2a above for a period of three years following the date of submission of such reports, and will properly maintain those reports.

B. Audits

1. The State Agency has, as needed, updated and revised resource materials developed in prior years through the accomplishment of the following tasks:
 - a. The development of standards of reasonableness for each major cost center of a nursing facility;
 - b. The development of a computerized desk review process for the submitted uniform cost reports; and
 - c. The development of a detailed on-site audit plan, using generally accepted auditing standards.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES NURSING FACILITY SERVICES

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

2. The State Agency will conduct analyses of the uniform cost reports for the reporting year ending the previous June 30th to verify that the facility has complied with paragraphs 2 and 3 above in Section A.
3. Where the analyses conducted, as specified in paragraph B 2 above, reveal that a facility has not complied with requirements, further auditing of the facility's financial and statistical records and other documents will be conducted as needed.
4. On-site audits of the financial and statistical records will be performed annually in at least 15 percent of participating facilities. Such on-site audits of financial and statistical records will be sufficiently comprehensive in scope to ascertain whether, in all material respects, the uniform cost report complies with Section B, Paragraph 1 above.
5. The on-site audits conducted in accordance with Section B, paragraph 4 above shall produce an audit report which shall meet generally accepted auditing standards. The report shall declare the auditor's opinion as to whether, in all material respects, the uniform cost report includes only expense items allowable under the Georgia Plan, as detailed under Section C of this attachment, and that the expense items included are accurately determined, and are reasonable. These audit reports shall be kept by the State Agency for at least three years following the date of submission of such reports, and will be properly maintained.
6. Any overpayments found in audits under this paragraph will be accounted for on Form HCFA-64 no later than 60 days from the date that the final rate notification is sent to the nursing facility.

C. Allowability of Costs

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

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
NURSING FACILITY SERVICES**

1. Allowable Costs Include the Following:

- a. The cost of meeting certification standards. These costs include all items of expense which providers must incur to meet the definition of nursing facilities under Title XIX statutory and regulatory requirements and as otherwise prescribed by the Secretary of HHS for nursing facilities; in order to comply with requirements of the State Agency responsible for establishing and maintaining health standards; and in order to comply with any other requirements for nursing facility licensing under the State law;
- b. All items of expense which providers incur in the provision of routine services. Routine services include the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities. Additional allowable costs include depreciation, interest, and rent expense as defined in the principles of reimbursement in CMS-15-1, except that actual malpractice insurance costs are reimbursed as reported in the facility's cost report, subject to audit verification; and
- c. Costs applicable to services, facilities, and supplies furnished to a provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. Providers are required to identify such related organization and costs on the State's uniform cost report.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
NURSING FACILITY SERVICES**

2. Non-Allowable Costs Include the Following:

- a. Bad debts of non-Title XIX program patients and charity and courtesy allowances shall not be included in allowable costs. The only bad debts allowable are those defined in 42 CFR 413.80. The value of operating rights and licenses and/or goodwill is not an – allowable cost and is not included in the computation of the return on equity;
- b. Effective for the determination of reasonable costs used in the establishment of reimbursement rates on and after April 1, 1991, the costs listed below are nonallowable.
 - i. Costs related to lobbying and government relations, including costs for employees with duties related to lobbying and government relations, honorariums and reimbursement of travel or other expenses of elected officials;
 - ii. Memberships in civic organizations;
 - iii. 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;
 - iv. 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. ambulances);
 - v. 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 nonallowable;
 - vi. Fifty percent (50%) of membership dues for national, state and local associations;
 - vii. Legal services for an administrative appeal or hearing, or court proceeding involving the provider and the Department or any other state agency when judgment or relief is not granted to the provider. Legal services associated with certificate of need issuance reviews, appeals, disputes or court proceedings are not allowable regardless of outcome. Legal services associated with a provider's initial certificate of need request shall be allowable;

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
NURSING FACILITY SERVICES**

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

D. Methods and Standards for Determining Reasonable Cost-Related Payments

The 2009 cost report, using the reporting format and underlying instructions established by the Department, will be used to determine a facility's allowable cost that will be the basis for computing a rate.

1. Prospective Rates

Payment rates to nursing facilities and ICF/MRs are determined prospectively using costs from a base period. For dates of service beginning February 1, 2012, the 2009 Cost Report is the basis for reimbursement.

2. Determination of Payment Classes

Classes are determined in accordance with Section 1002 of Supplement 2 to Attachment 4.19-D of the State Plan.

E. Payment Assurances

The State will pay each provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the provider under the Plan according to the methods and standards set forth in Section D, above.

In no case shall the payment rate for services provided under the plan exceed the facility's customary charges to the general public for such services.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
NURSING FACILITY SERVICES**

F. Provider Participation

Payments made in accordance with methods and standards described in this attachment are designed to enlist participation of a sufficient number of providers of services in the program; so that eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public.

G. Payment in Full

Participation in the program shall be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the State Plan.

H. Payment Limitation Applicable to Patients in Nursing Facilities with Medicare Part A Entitlement

Effective with dates of payment of February 1, 1991, and after, 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 services of the crossover claims. The crossover claims will not be subsequently adjusted due to subsequent per diem rate adjustments.

Daily cost-sharing charges for beneficiaries will commence on the 21st day of service through the 100th day of service. These patients must be eligible for Part A Medicare and be admitted to an approved Medicare facility under conditions payable by Medicare.

I. Nurse Aide Training

The Department adjusts per diem payment rates to reimburse the costs associated with replacement wages and overtime for nurse aide training and testing. This adjustment does not apply to ICF/MR facilities. Beginning with dates of service July 1, 1992, and after, the Department will not adjust reimbursement rates for the cost of replacement wages and overtime for nurse aide training and testing because these costs are included in the 1991 cost reports.

J. Public Process

The State has a place a public process which complies with the requirement of Section 1902(a)(13)(A) of the Social Security Act.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
NURSING FACILITY SERVICES**

K. Other Adjustments to Rates

1. Effective July 1, 2003, in order to recognize the Medicaid share to a facility's cost of paying fees for Georgia's Nursing Home Provider Fee Act, an adjustment equal to the fee payable for each Medicaid patient day will be added to the facility's rate. During the quarter beginning July 1, 2003, the adjustment amount will be estimated by the Division; any difference between the estimated and actual fee will be corrected by changes to rates for a subsequent quarter. For periods beginning October 1, 2003, the adjustment amount will be based on the fee applicable for the prior quarter.
2. For payments made for services provided on or after July 1, 2005, State governmental facilities and non-State governmental facilities will be eligible for rate payment adjustments. The rate adjustment payments are intended to provide supplemental funding for Medicaid services to facilities that based on their governmental status, need sufficient funds for their commitments to meet the healthcare needs of all members of their communities. The rate payment adjustments will be subject to federal upper payment limits. For the appropriate groupings of State governmental facilities, non-State governmental facilities and non-governmental facilities, aggregate rate adjustment payments available without exceeding upper payment limits will be determined by measuring the difference between:
 - a. All amounts paid for services provided to Medicaid patients; and,
 - b. Estimated payment amounts for such services if payments were based on Medicare payment principles.
3. Comparison of all amounts paid for services provided to Medicaid patients and estimated payment amounts for such services if payments were based on Medicare payment principles will also be made for each facility to determined facility specific rate adjustment payments. These rate payment adjustments will be made at the end of the quarter and will be determined in a manner which will not duplicate compensation provided from payments for individual patient claims.

An example of how a rate adjustment payment is calculated is presented on the following pages. This table is for illustrative purposes only and the values are meaningless.

Provider Name: XYZ Nursing Home
 Provider Number: xxxxxxxxxA

	Quarter Ending 09/30/11	Quarter Ending 12/31/11	Quarter Ending 03/31/12	Quarter Ending 06/30/12	
Medicare UPL Rate					
Line 1	PPS rate based on Medicaid patients for each quarter	189.00	213.09	213.09	213.09
Line 2	Adjustment for change in case mix	1.0158	1.0093	1.0093	1.0096
Line 3	Adjusted Medicare rate for UPL	191.99	215.07	215.07	215.14
Medicaid UPL Rate					
Line 4	Medicaid rate without provider fee	161.02	161.02	161.02	161.02
Line 5	Provider Fee adjustment	13.39	13.39	13.39	13.39
Line 6	Statewide average payment for other services	14.11	14.11	14.11	14.11
Line 7	Adjusted Medicaid rate for UPL	188.52	188.52	188.52	188.52
Medicare UPL rate minus Medicaid UPL rate					
Line 8		3.47	26.55	26.55	26.62
Medicaid Patient Days					
Line 9	Medicaid days reported from quarterly provider fee report	26,500	28,317	28,317	28,317
Line 10	Estimated change in patient days for SFY2011	(0.0109)	(0.0101)	(0.0101)	(0.0067)
Line 11	Portion of year for each quarter	25%	25%	25%	25%
Line 12	Adjusted Medicaid patient days for UPL	6,553	7,008	7,008	7,032
Facility-Specific UPL calculation					
Line 13		22,763	186,088	186,088	187,218
Facility-Specific UPL calculation for 07-01-11 to 06-30-12					
		22,763	186,088	186,088	187,218
Allocation of UPL aggregate limit					
		(1)	0	0	0
UPL calculation subject to aggregate limit					
		22,762	186,088	186,088	187,218
UPL calculation for 07-01-11 to 06-30-12					
					582,156

TN No. 12-003

Supersedes

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SEP - 6 2012
Approval Date:

Effective Date: 02-01-12

**NURSING FACILITY RATE DETERMINATION FOR VENTILATOR DEPENDENT
RESIDENTS**

- (1) The nursing facility per diem for a ventilator dependent resident will be \$463.87 effective for dates of service on and after November 13, 2009. Through June 30, 2012, the per diem will increase annually on January 1 by an annual inflation factor. The Department will use the Skilled Nursing Facility Total Market Basket (with capital) inflation factors from Global Insight and use the first quarter of the current year and compare it to the first quarter of the prior year to determine the annual inflation amount to be applied.
- (2) The per diem costs of providing services to the ventilator dependent residents shall be maintained separately (as a distinct part) of each facility's annual cost report beginning November 13, 2009.
- (3) Ventilator dependent per diem rates will cover all skilled nursing care Services and will be all-inclusive.
- (4) No additional amount above the current nursing facility daily rate shall be allowed until the service is prior authorized by the Department's Medical Management Contractor.
- (5) The resident's clinical condition shall be reviewed every 90 days to determine if the resident's medical condition continues to warrant services at the ventilator dependent nursing facility rate. Prior authorization through the Department's Medical Management Contractor spans a 90-day maximum time period. The nursing facility is required to resubmit requests for continued stay prior to expiration of the current PA. If a resident no longer requires the use of a ventilator, the provider shall not receive additional reimbursement beyond the Georgia Medicaid nursing home per diem rate determined for the facility.

**PART II, POLICIES AND PROCEDURES FOR
NURSING FACILITY SERVICES**

APPENDIX I

NURSING FACILITY ADMINISTRATIVE REVIEWS

Application

This section describes appeals procedures for certain nursing facility (including ICF/MR) situations.

Pre-Admission Approval

- a. Upon application for pre-admission approval, the nursing facility and the applicant/recipient or an authorized representative shall be given written notification of the Division's determination. Upon denial of pre-admission approval, the applicant/recipient or an authorized representative may obtain a reconsideration by the Division by so requesting in writing.

All requests for reconsideration must be received by the Department of Community Health Program Specialist no later than ten (10) days following receipt of the initial denial and must be accompanied by additional medical documentation to justify a reconsideration. All such requests are to be addressed to:

Attn: Program Specialist
Department of Community Health
Aging and Special Populations Floor 37
2 Peachtree Street, NW
Atlanta, Georgia 30303-3159

- a. A decision on the request for reconsideration will be accomplished within fifteen (15) working days of its receipt by the Specialist. The applicant/recipient and the nursing facility will be notified in writing of the reconsideration decision by the Division .
- b. If an applicant/recipient disagrees with the Division's decision, that person, or an authorized representative, may file a request for a hearing. All such requests must be received by the local county Department of Family and Children Services Office or the Fair Hearings Unit of the Department of Human Services no later than thirty (30) days after the date of the notice of decision.
- c. An initial decision on any matter with respect to which a hearing is requested shall be rendered in writing by a Hearing Officer of the Fair Hearings Unit. Should such a decision be adverse to the medical assistance applicant/recipient,

that person or representative may appeal the decision by filing an appeal with the Hearing Officer for Final Appeals in accordance with directions from the Fair Hearings Unit.

- d. If an aggrieved applicant/recipient of medical assistance exhausts all the administrative remedies provided, judicial review of the decision may be obtained in the same manner and under the same standards which are applicable to those contested cases which are reviewable pursuant to O.C.G.A., Section 50-13-19.

Rev. 07/06

Billing Rate and Disallowance of Cost from the Cost Report

Reimbursement rates (billing rates) for nursing facilities (NF and ICF/MR) are established pursuant to the provisions discussed in Supplement 2 to Attachment 4.19-D. A billing rate calculation notice will be sent to a provider each time a rate is initially calculated for a given cost report period or is subsequently adjusted as a result of audit or review by the Division or its agent. A billing rate calculation will also be sent to a provider on a quarterly basis for rate changes that are a result of the case-mix reimbursement methodology (i.e. CPS, CMI, and nursing hour changes). Nursing facilities rates and percentiles will be based on costs reported by the providers which are reviewed by the Division or its agent. Cost reports and adjustments determined appropriate by the Division will be used to establish rates. Those cost reports and adjustments determined appropriate prior to initial establishment of the annual percentile ceilings (as described in Supplement 2 to Attachment 4.19-D) shall be used in calculation of the percentiles. Those cost reports and adjustments determined appropriate subsequent to initial establishment of the annual percentile ceilings shall be used to adjust rates only; percentile ceilings will not be adjusted.

Rev. 07/06

Any provider wishing to appeal its rate as initially established, its subsequent rate change as a result of audit or review, or its quarterly rate change as a result of the case-mix reimbursement methodology must follow the process set out in subsections (a) - (c) below:

Rev. 07/06

- a. Should a provider wish to appeal a decision of the Division regarding a billing rate calculation, including related disallowances from the cost report, the provider must file a written request for reconsideration with the Division. All such requests must be received by the Division within thirty (30) days of the date of the billing rate calculation notice. Requests received after this deadline shall not be considered. If no request for reconsideration is received by the Division by the deadline, the provider shall be deemed to have waived its right to a hearing concerning the calculation of the billing rate and related disallowances from the cost report. Initially established rate calculated for a given cost report period and

their related disallowances can only be appealed within 30 days after the rates are initially established.

The written request must address all questioned disallowance(s) and other specific point(s) of dispute and must be accompanied by supporting documents or other evidence to justify reconsideration. Requests for reconsideration must be directed to:

Rev. 07/06 Program Manager
 Nursing Home Reimbursement, 39th Floor
 Division of Medical Assistance
 2 Peachtree Street, N.W.
 Atlanta, GA 30303-3159

Rev. 07/06

The Program Manager of the Nursing Home Reimbursement Unit will have one hundred twenty days (120) from the date of receipt of the reconsideration request to render a decision unless the Program Manager determines there are extenuating circumstances (e.g., multiple facilities are involved or the rate change is a result of a federal disallowance) or additional information is required. If the Program Manager (or any authorized staff of the Nursing Home Unit) requests additional information, the nursing facility must submit to this information to the Unit within thirty (30) days of the date of such request. The Program Manager will have ninety (90) days from the date of receipt of the additional information to render a decision concerning the written requests or inquiries submitted by a nursing facility. Failure of a nursing facility to provide information within the specified time frame requested by the Division will result in the denial of the nursing facility's appeal by the Program Manager. Failure of the Program Manager to respond within the time frames described herein will result in approval of the nursing facility's request.

- a. The provider must file a request for a reconciliation conference if it wishes to appeal the Division's reconsideration decision. All such requests must be in writing and must be received within thirty (30) days from the date of the notice of the reconsideration decision. Requests received after this deadline shall not be considered. If no request for a reconciliation conference is received by the Division by the deadline, the provider shall be deemed to have waived its right to a hearing concerning the calculation of the billing rate and related disallowances from the cost report. All such requests must be directed to the address noted in subsection a) above.

Conferences will be scheduled at the Division's office. The Division Director will have sixty (60) days from the date of the reconciliation conference to render a decision unless both parties to the conference agree to extend the time limitation.

If the provider appeals a rate adjustment which is the result of a cost report adjustment(s) determined appropriate subsequent to the establishment of

percentile ceilings, the change will not be effected until the date of the Division's reconciliation conference decision. To the extent that such a rate change decreases a rate granted prior to review, it shall be affected by retroactive rate adjustment rather than through a request for refund or by recoupment.

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If the provider disagrees with the reconciliation conference decision, the provider may obtain a hearing on the matter by filing a written request there for with the Legal Services Section of the Division in accordance with O.C.G.A. §49-4-153.

Sanctions

In addition to the termination and suspension as a Medicaid provider, the Division may impose the sanctions described below.

Nursing Facilities

- a. The Division may sanction a nursing facility for failure to submit the required cost report as outlined in Supplement 3 of Attachment 4.19-D.
- b. The Division may deny reimbursement for services to ICF/MR recipients admitted to a facility on or after the effective date specified on written notice to that facility that it is not in compliance with Subsection 106.8 of the Part I, Policies and Procedure for Medicaid/PeachCare for Kids manual.

If the Division or its agent has determined that conditions in the facility have neither damaged nor immediately endanger the health, safety, or welfare of a recipient, the effective date of the notice shall be no earlier than five days after the date of receipt by the facility, during which time the facility will have the opportunity to correct the cited conditions.

The Division's action shall be predicated on a report from the agent, under its contract with the Division to perform on-site reviews of nursing facilities, which takes into account the medical, safety, environmental, and physical needs of the facility's residents. The denial of reimbursement shall remain in effect until such time as the Division determines, after subsequent on-site review, that the facility is meeting the aforementioned needs of its residents and is no longer damaging or endangering the health, safety, or welfare of any recipient. This denial shall not apply to temporarily hospitalized recipients previously residing in a facility, placed on such notice, who return to the facility after the date of notice. Neither shall it apply to persons who resided in the facility prior to the date of notice, and subsequently become Medicaid eligible.

A facility which has received notice of the Division's denial of reimbursement for newly admitted patients may appeal such action in the manner described in O.C.G.A. §49-4-153. However, nothing in this provision shall impede the authority of the Division to deny payment for new admissions or suspend or terminate a facility's participation under Section 402, Part I, Policies and Procedures for Medicaid/PeachCare for Kids manual.

- c. The Division may deny reimbursement for services to recipients in nursing facilities, who are admitted after the facility's receipt of notice that its participation in the program will be terminated by the Department of Community Health, under its own volition or as a result of an action taken by the Healthcare Facility Regulation Division of the Department of Community Health, or by the Health Care Financing Administration of the U.S. Department of Health and Human Services.

The Division may impose any or all of the remedies when a nursing facility fails to meet a Program Requirement as defined therein.

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