RELATIONS WITH STANDARD-SETTING AND SURVEY AGENCIES

Designated Agency

The Georgia Department of Human Resources establishes and maintains standards for health, and standards other than those relating to health, for institutions that provide services to Medicaid recipients. This Department is responsible for licensing health institutions in the State and determines for Medicaid if institutions meet requirements for participation in the Medicaid Program.

Standards

Categories of health and other standards which institutions must meet are described below.

Long Term Care Facilities

Facilities must meet Medicare conditions of participation at 42 CFR 405 Subpart K and requirements at 42 CFR 442 Subparts A through G, as appropriate to the facility type.

SNF Nursing Service: Nursing service must be under the direction of an appropriately licensed full-time nurse. There must be supervised nursing and sufficient nursing staff on duty at all times to provide care for each patient according to needs. All nursing care and related services must be carried out in accordance with the facility's patient care policies.

ICF Personal Care Service: An appropriately licensed nurse must be employed full-time as supervisor of care. Sufficient staff must be on duty at all times to insure proper care of each resident. All resident care and related services must be carried out according to written policies.

SNF Professional Service: Each facility must have an organized professional staff with a physician designated as chief of staff. Patients are admitted only on referral of a physician and are under the continuing care of a physician. Patients' plans of care are reviewed by the attending physician as directed by Federal and State requirements.

ICF Professional Service: Residents are admitted only through medical/psychological evaluation and referral. The health care of each resident is under continuing supervision of a physician who sees the resident as needed and in no case less often than directed by Federal and State agency requirements.

Long term care facilities must

Have a governing body which is responsible for the overall conduct of the facility and for compliance with pertinent laws and regulations.

Be under the supervision of an appropriately licensed administrator.

Fully disclose ownership and make known to the State corporate officers and others owning ten percent or more of the ownership.

Satisfy fire, safety, sanitation and health requirements.

Have a written transfer agreement in effect with one or more hospitals or nursing homes, as appropriate, to assure prompt transfer of care when needed.

Be operated according to policies established by the State agency.

Maintain a separate personnel folder for each employee containing all personal information; application and qualifications for employment; physical examination and job title assigned.

Provide dietary service under supervision of qualified personnel. Nutritionally adequate meals are required in sufficient numbers with between-meal and bedtime snacks. Modified diets are provided on written orders of a physician or dentist.

Provide social services by on-staff caseworkers or through arrangements with an appropriate outside agency.

Comply with State and Federal laws and regulations in providing pharmacy services and in handling patient medication.

Provide care to each patient/resident according to need and the individual plan of care.

Have an effective microbial and infection control program.

Use restraint and/or forcible seclusion only on a signed physician order except in emergency and then only until a physician can be consulted.

Maintain medical and health records for each patient/resident according to accepted professional standards and practices.

Provide patient activities according to the needs and interests of patients/residents.

Be constructed, equipped and maintained to protect the health and safety of patients, personnel and the public and be accessible to and functional for the physically handicapped.

Have a written, acceptable disaster plan.

TRANSMITTAL 85-8
APPROVED 3-29-85
EFFECTIVE 1-1-85

Hospitals must

Meet conditions of participation in the Medicare Program as provided at 42 CFR 405 Subpart J.

Have a governing body which is responsible for compliance with all pertinent laws and regulations.

Have a professional staff organized under bylaws which is responsible for quality of medical care provided and for ethical professional practices of its members.

Have an administrator who is responsible for the management and operation of the hospital.

Fully disclose ownership and make known to the State corporate officers and others owning ten percent or more of ownership.

Comply with all laws, codes, ordinances and regulations which apply to its location, construction, maintenance and operation. The condition of the physical plant and overall hospital environment must be developed and maintained to insure health and safety of patients and staff.

Provide nursing service under the supervision of a registered nurse and have available professional nursing service for all patients at all times.

Provide qualified personnel to operate services included in its program such as administration and business, dietary, emergency room, housekeeping, laboratory, laundry, maintenance, medical records, pharmacy, therapy and x-ray.

Maintain a separate personnel folder for each employee containing all personal information; application; qualifications for employment; physical examination and job description.

Maintain medical records for each patient containing sufficient information to validate the diagnosis and establish the basis for treatment.

Provide pharmaceutical services under the direction of a registered pharmacist in accordance with Federal and State laws.

Have a clinical laboratory equipped and staffed to perform services commensurate with needs.

Make available anatomical pathology and blood bank services in the facility or by arrangement.

Provide radiological services within the facility or which are readily available by arrangement.

Have a written, acceptable disaster plan.

The Department keeps these standards on file and makes them available to HHS on request.

Written Agreement

The Department has a written agreement with the Department of Human Resources covering activities of the Office of Regulatory Services in carrying out its responsibilities. The agreement specifies that Federal standards and designated forms, methods and procedures will be used to determine institutional certification and enrollment eligibility.

Inspectors surveying the institution will complete inspection reports, note whether each requirement is satisfied and document deficiencies in reports.

The survey agency keeps on file all information/reports used to determine that participating facilities meet Federal requirements and will make them readily accessible to HHS and Medicaid as necessary for meeting other Plan requirements and effective administration of the Medicaid Program.

Responsibilities of Survey Agency

In certifying skilled and intermediate care facilities, the survey agency reviews and evaluates medical and independent professional review team reports and statements from facility payroll records showing the average number and types of personnel, in full-time equivalents, on each tour of duty during at least one week of each quarter.

The survey agency takes necessary action to achieve compliance or withdraws certification and has qualified personnel perform on-site inspections at least once during each certification period or more frequently if there is a compliance question. For ICFs with deficiencies described in 42 CFR 442.112-113, on-site inspections are performed within six months after initial correction plan approval and every six months thereafter as required.

Certification of Need for Care

Prior to a patient being admitted to a facility or transferred between facilities, the patient' s attending physician will evaluate the need for Nursing Facility placement by assessing social and medical information. This also includes the physician completing and signing the DMA-6. The DMA-6 verifies certification by the physician that the applicant is determined eligible for Nursing Facility Level of Care. When certification of Level of Care is assigned it is valid for sixty (60) days. Certifications and attestations for the Level of Care are performed according to Federal timeliness requirements.

Review Medical Evaluation and Admission

Before admission to an institution for the mentally retarded or related conditions, Intermediate Care Facility for the Mentally Retarded (ICFMR), an interdisciplinary team of health professionals makes a comprehensive medical and social evaluation and a psychological evaluation of each applicant's/ recipient's need for care in the ICFMR.

Evaluations made before admission include:

- Diagnoses.
- Current medical, social and developmental findings.
- Mental/ physical functional capacity.
- Prognoses.
- Services needed.
- Recommendation of admission to or continued ICFMR care.

Plan of Care

A physician must legalize a written plan of care, the active treatment services, by personally signing the plan for each applicant or recipient before admission to an ICFMR. Medical and social information is required to be submitted on the Plan of Care which contains the following elements:

- Identification of the recipient.
- Name of the recipient' s physician.
- Date of admission.
- Dates of application for and authorization of Medicaid benefits if application is made after admission.
- Diagnoses, symptoms, complaints, and complications indicating the need for admission.
- Description of the functional level of the individual.

Plan of Care: Nursing Facilities (Continued)

- Objectives.
- Orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures designed to meet the objectives of the plan of care.
- Plans for continuing care, including review and modification of the plan of care.
- Plans for discharge.

The team must review and follow through each plan as required by 42CFR483.440.

Explanation of Alternative Services

Before admission to a ICFMR, if the physician recommends services for an applicant or recipient whose needs could be met by alternative services that are currently unavailable, the facility must enter this fact in the recipient's record and begin to look for alternative services.

RELATIONS WITH STATE HEALTH AND VOCATIONAL REHABILITATION AGENCIES AND TITLE V GRANTEES

The Department has an agreement with the Georgia Department of Human Resources to establish cooperative administration and supervision for certain services. Mutual objectives for the arrangement are to produce a statewide system for informing and referral and to enhance the administrative capability to provide maximum utilization of services.

DHR agrees to provide the various support services described in this contract, and DMA agrees to pay DHR the appropriate federal share of the cost of these services on a quarterly basis, with the exception of the Community Care Services program for which DHR agrees to pay DMA the appropriate non-federal share of the cost of the Community Care Services program on a quarterly basis. DHR agrees to bear the non-Federal share of such costs from state or other funds eligible for use in matching such non-Federal share for all other services. DMA and DHR mutually agree that the level and extent of services provided in this contract are contingent upon the availability of both State and Federal funds. In the event either party determines that a service or activity provided for in this contract cannot be performed, a formal written notice will be provided to the Commissioner of the other party no less than thirty (30) days prior to deletion of the service or activity.

Pursuant to the requirements of 42 CFR 431.615, DHR and DMA have established a coordinating committee consisting of the Commissioner or his designee from DMA, the Commissioner or his designee from DHR, and a representative of each appropriate program division of DHR and DM. Said committee shall meet no less than once per quarter to review and evaluate the services provided for in this contract, to explore other avenues of interaction between the parties, and to otherwise meet the requirement os 42 CFR 431.615. The committee, at its discretion, may set up subcommittees to research and/or develop recommendations for solutions to pertinent issues.

Non-Emergency Transportation (NET)

Medicaid Related NET

The provision of Medicaid related NET services (with the exception of EPSDT related NET and NET services provided by direct provider) is the responsibility of the appropriate county Department of Family and Children Services. The local office will arrange and coordinate or provide non-emergency transportation services to DMA eligible clients in accordance with DMA's Policies and Procedures Manual for Non-Emergency Transportation.

TRANSMITTAL 94-012
APPROVED 5-19-9
EFFECTIVE 4-01-9
SUPERSEDES 86-2

RELATIONS WITH STATE HEALTH AND VOCATIONAL REHABILITATION AGENCIES AND TITLE V GRANTEES

EPSDT Related NET

During Fiscal Year 1986, the responsibility for arranging and coordinating or providing non-emergency transportation services for EPSDT Services will be transferred on a phased-in basis from DFCS to DPH with local health department case managers assuming full responsibility. This will include the locating and negotiation of NET services with the providers of this services to establish contractual arrangements for this purpose. DHR will encourage local health departments to negotiate with local DFCS for assistance in developing or sharing lists of these providers, or the actual provision of the NET services in counties where appropriate and feasible. DMA, Division of Program Management, agrees to provide recipients with notice of availability of non-emergency transportation services. Program Management agrees to provide to DHR NET Manuals, manual revisions, and copies of the Medicaid Provider list.

DHR and DMA Program Management agree to work jointly in the development of policies and procedures for non-emergency transportation services.

Family Planning Services

DFCS agrees that the county offices will inform and explain the availability of family planning services and provide literature to recipients in need of such services.

DHR, Division of Public Health (DPH), agrees to administer a statewide program of family planning clinic services which shall include the provision of pregnancy testing and family planning services to eligible recipients, development of contractual relations with non-profit clinics which provide family planning services, documentation of services rendered and the establishment of policy and procedures in conformity with DMA's policy.

DPH agrees to monitor and evaluate the scope, quality, and utilization of family planning services and to provide clinic utilization reports to DMA. These reports must be sent to the Division Director, Program Management.

DPH agrees to submit a monthly computer tape to the DMA, Systems Management Division, which shall contain at a minimum the name and Medicaid number of clients receiving pregnancy test or other family planning services.

DMA agrees to provide reimbursement to the DPH for Medicaid covered services rendered to eligible recipients.

DPH, DFCS and DMA agree to work jointly in the development of policies and procedures for Family Planning services.

TRANSMITTAL 86-22
APPROVED 10-10-86
EFFECTIVE 7-1-86

RELATIONS WITH STATE HEALTH AND VOCATIONAL REHABILITATION AGENCIES AND TITLE V GRANTEES

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Division of Family and Children Services (DFCS)

DFCS agrees that county DFCS offices will notify, verbally and in writing, all eligible clients under 21 years (at the point of application and each reapplication) of the availability and advantage of the EPSDT Program using the EPSDT pamphlet or other resources provided by DMA.

DFCS agrees that county DFCS offices will offer newly eligible clients screening and support services and will document acceptance or declination of the program. Dates of informing, acceptance or declination of the program will be documented by DFCS on Form 256. DFCS agrees to send the Case Summary Form and final case summary to DPH.

DFCS agrees to appoint a state eligibility representative who will serve on an EPSDT Interdivisional Committee, accompany Program Management staff on the quarterly EPSDT program overviews and make arrangements for Program Management staff to visit county DFCS offices.

Division of Public Health (DPH)

DPH agrees that case managers will contact all individuals listed on the DMA EPSDT newly eligible report, including SSI recipients, and all newly eligible EPSDT individuals on the first page of the final case summary form PARIS (DFCS Computer System).

DPH agrees that county DPH offices will assist eligible clients in locating participating Medicaid screening, diagnostic and treatment providers and offer support services assistance with scheduling appointments and transportation when requested for screening, diagnosis and treatment.

DPH agrees to develop and use in all counties a DMA-approved referral protocol.

DPH agrees that each county office will recall all eligible children including SSI children due rescreening using as their primary tool the EPSDT Due List provided monthly by DMA. DPH agrees to document the dates of recall and recall responses.

DPH agrees that case managers will contact recipients overdue for rescreenin as listed on the overdue list.

DPH agrees that each county office will provide local Medicaid screening providers with information on the current screening status of children.

TRANSMITTAL 86-22
APPROVED 10-10-86
EFFECTIVE 7-1-86

RELATIONS WITH STATE HEALTH AND VOCATIONAL REHABILITATION AGENCIES AND TITLE V GRANTEES

DPH agrees that each county office will document and provide to Program Management information on the local provision of EPSDT informing, tracking, and follow-up on all eligible children.

DPH agrees to provide follow-up for screening, diagnosis and treatment within 120 days of receiving notification of eligible clients and acceptance of EPSDT services by client.

DPH agrees to assign full-time nurses to perform program reviews and evaluate the provision of EPSDT screening services in county health departments and provide reports to DMA. The reports will describe problems identified at the time of the program review visit and will outline a plan of corrective action and follow-up on the appropriateness of the corrective action, subject to DMA review and approval.

DPH agrees to provide training for DPH nurses who perform EPSDT screenings.

DPH agrees to appoint a state representative(s) who will serve on a EPSDT Interdivisional Committee, accompany Program Management staff to perform quarterly county EPSDT program overviews, or make arrangements for Program Management staff to visit county health departments.

DPH State Office agrees to set minimal standards and protocols for each component of the EPSDT examination or screening services, and to maintain written evidence of such standards.

DPH agrees that county case managers will inform EPSDT eligibles who are eligible for Title V services of the services available to them and will refer them to Title V grantees, if desired.

DMA will provide state DPH office with reports generated from data on the DMA-267.

DMA will provide state and county DPH offices with the following:

- EPSDT manuals and revisions
- EPSDT pamphlets
- EPSDT screen/claim forms
- Lists of new EPSDT individuals
- Quarterly lists of Medicaid and screening providers
- Lists of recipients due for screening
- Monthly lists of recipients 120 days late for rescreening

DMA agrees to reimburse DPH for screening services on a claim-for-claim basis at the reimbursement rate in effect on the date of screening.

RELATIONS WITH STATE HEALTH AND VOCATIONAL REHABILITATION AGENCIES AND TITLE V GRANTEES

DMA agrees to provide the state DPH with the following materials related to the provision of EPSDT services by the health departments:

A quarterly screening report giving the number of individuals by age sequence receiving services, (subject to availability).

A quarterly report of child health status giving the numbers of children screened by age sequence and county and the type of abnormality referred, (subject to availability).

Statewide list of the numbers of Medicaid enrolled recipients by county twice a year.

A monthly claims processing activity report giving the number and reasons for claims being rejected, in-process or pending.

Provider ranking list twice a year.

Subject to Federal Regulation, DMA agrees to provide matching federal funds at 75% Federal for nursing positions to perform program reviews.

DFCS, DPH and DMA agree to hold interdivisional meetings at least quarterly.

DPH and DMA agree to conduct EPSDT program reviews in counties and to do so jointly with state representatives identified by the respective Division.

DFCS, DPH and DMA agree to work jointly to develop policies and procedures for the EPSDT Program.

Community Care Services Program (CCSP)

DFCS agrees to determine eligibility for potential Medical Assistance Only (MAO) clients appropriate for CCSP, to determine the amount of MAO client cost share liability, and to transmit this information to the CCSP case manager.

In conjunction with DMA, Division of Program management, Office of Aging and DFCS will develop and coordinate an appropriate vendor authorization payment system.

DFCS agrees to provide training for MAO Specialists.

DPH agrees to provide assessment teams comprised of a registered nurse and social worker. The attending Physician on the assessment team shall provide input verbally or through the provision of written medical data.

RELATIONS WITH STATE HEALTH AND VOCATIONAL REHABILITATION AGENCIES AND TITLE V GRANTEES

DPH agrees to reassess clients as determined through standards and procedures established in conjunction with the Office of Aging and DMA, Division of Program Management, to determine the appropriateness of community care and the level of services needed if the client remains in the community.

DPH agrees to maintain and distribute the Program Policies and Procedures Manual for assessment teams. Any revision to these manuals must be submitted to OA and DMA, Division of Program Management, for review and approval.

The Office of Aging (OA) agrees to visit each service provider facility, where necessary, to assess physical conditions and compliance with established standards.

The OA agrees to provide technical assistance, training seminars and training packages for providers as determined necessary.

The OA agrees to arrange for the limits of services and containment of costs through the case management function. The case management function will be carried out through contracts with lead agencies.

The OA agrees to develop and update the Program Policies and Procedures Manuals for home and community-based waiver services provided under the Community Care Services Program. DMA will distribute these manuals.

The OA, in conjunction with DMA, agrees to coordinate a prior approval and prepayment review system to authorize services above the monthly limit but not to exceed the annual limit. This includes form changes, policies, procedures, system edits, etc.

The OA, in cooperation with DPH, agrees to provide to Program Management information needed to complete federal reports for 2176 waivered services, i.e., HCFA 371 & 372.

The OA agrees to assist Program Management with the provision of information for all federal and state program assessments.

The OA agrees to submit to Program Management a monthly report reflecting program statistics regarding service utilization.

The OA agrees to provide Program Management with copies of the Client Assessment Instrument (CAI) and the Provider Notification Form (PNF) when either form changes.

The OA, in conjunction with DMA, agrees to establish standards and requirements for provider participation.

RELATIONS WITH STATE HEALTH AND VOCATIONAL REHABILITATION AGENCIES AND TITLE V GRANTEES

DMA Program Management agrees to maintain, through DMA's Fiscal Agent, an automated case management client file.

DMA Administration agrees to prepare and submit to the OA a quarterly statement of expenditures by recipient, service provider and major service type.

Program Management agrees to provide to OA a monthly list of enrolled home and community-based service providers.

Program Management agrees to conduct utilization reviews for Community Care Services Program recipients and to provide written reports on UR findings.

DMA agrees to establish reasonable reimbursement rates for the provision of Community Care Services and to provide OA with up-to-date reimbursement rates for all enrolled and approved CSP providers.

Program Management agrees to work jointly with the OA on the development of policies and procedures for the Community Care Services Program. OA will involve DPH as appropriate.

Program Management agrees to notify OA in writing of any changes in related policy and regulation requirements needing incorporation into policy manuals. OA will notify DPH of changes as appropriate.

Community Mental Health and Mental Retardation Area Programs

Division of Mental Health and Mental Retardation (DMH/MR) agrees to conduct certification and re-certification reviews for mental health/mental retardation and substance abuse (MH/MR/SA) services rendered by Area Programs. Upon completion of each on-site review, DMH/MR will provide DMA with a summary of Area Program compliance with Federal regulations and DHR/DMA policy. The summary shall identify areas of non-compliance. A subsequent summary shall be forwarded to DMA on a quarterly basis which documents action taken to correct previously identified areas of non-compliance, and the certification status of the Area Programs review.

DMH/MR agrees to continue a utilization review program. Reports and analyses of these data shall be forwarded to DMA.

DMH/MR agrees to provide initial and on-going training for the staff who conduct the certification reviews for outpatient MH/MR/SA services and for staff who monitor and supervise the utilization review program.

RELATIONS WITH STATE HEALTH AND VOCATIONAL REHABILITATION AGENCIES AND TITLE V GRANTEES

DMH/MR agrees to coordinate and supervise the implementation of provisions contained in DMA's Policies and Procedures for Outpatient MH/MR/SA Services and the DMH/MR's Policy Memorandum 40-01 and Quality Assurance Standards Manual Document, and DMH/MR's minimum requirements for area MH/MR Programs.

DMH/MR agrees to provide sufficient professional staff in the Office of Quality Assurance.

DMH/MR agrees to assure that all providers participating in the Community MH/MR/SA services program will prepare cost reports annually.

MH/MR agrees to appoint state office representatives to serve on an interdivisional committee.

DMH/MR agrees to work jointly with DMA in the development of policies and procedures for community MH/MR/SA services.

DMA agrees to reimburse area programs at rates approved by the Board of Medical Assistance.

Program Management agrees to provide area programs with manuals and manual revisions in a timely fashion.

Program Management agrees to work jointly with DMH/MR in the development of policies and procedures for community MH/MR/SA services.

Program Management agrees to hold interdivisional committee meetings with state office representatives of MH/MR.

Long-Term Care Services

DMH/MR agrees to be responsible for developing long-term care plan for ICF-MR residential services; monitoring the facilities for federal and state standards compliance; developing and providing in-service training and staff development for current ICF-MR facilities and facilities that wish to join the program; coordinating DMH/MR activities with the Office of Regulatory Services; and for obtaining statistics from the Georgia Medical Care Foundation regarding MH/MR recipients in long-term care facilities.

DMA, Division of Program Management, agrees to reimburse long-term care facilities for services provided MH/MR recipients according to rates approved by the Board of Medical Assistance.

RELATIONS WITH STATE HEALTH AND VOCATIONAL REHABILITATION AGENCIES AND TITLE V GRANTEES

Rehabilitation Services

DHR, Division of Rehabilitation Services (DRS) agrees to provide Vocational Rehabilitation applicants eligible for Medical Assistance with notification of services provided under the Medical Assistance Program, and to refer Vocational Rehabilitation applicants under twenty-one (21) years of age to the EPSDT Program.

DMA, Program Management, agrees to provide DRS with literature which explains the EPSDT Program and the advantages of participation in it for distribution to vocational rehabilitation applicants under 21 years of age.

DRS and DMA agrees to furnish, on request, information concerning prevailing rates of payment for services.

Reimbursement

DHR and DMA agree that this is a cost reimbursement contract. DHR agrees to provide the state portion of matching funds necessary to receive Federal Financial Participation (FFP). DHR agrees that reimbursable costs will be determined in accordance with applicable provisions of 45 CFR Part 74, "Administration of Grants" and the approved DHR Cost Allocation Plan filed pursuant to such regulations. The reimbursable cost is for administrative and support services required under this Contract.

DHR agrees that the applicable provisions of 45 CFR Part 74 shall govern the administration of funds under this Contract and that DHR will observe and adhere to such requirements as detailed in Part 74, Subparts A, B. C, D, F, G. H, O, P and Q.

DHR agrees to submit financial statements detailing the costs incurred by DHR in carrying out the administrative provisions of this Contract. Such financial statements shall be submitted within sixty (60) days after the end of each calendar quarter and shall indicate the particular service by the type and applicable FFP rate. DHR will ensure that charges for Skilled Professional Medical Personnel (SPMP) included in financial statements will be in accordance with federal regulations regarding FFP for SPMP activities.

RELATIONS WITH STATE HEALTH AND VOCATIONAL REHABILITATION AGENCIES AND TITLE V GRANTEES

DMA agrees to pay DHR the applicable FFP percentage of each service, with the exception of services provided under the Community Care Services Program, covered by this Contract as provided in the State Medicaid Plan and as detailed on the financial statement described in the previous paragraph.

DMA agrees to submit financial statements to DHR detailing the payments made to providers for services rendered under the Community Care Services Program. Such financial statements shall be submitted within sixty (60) days after the end of each calendar quarter and shall be in a mutually agreed upon format.

DHR agrees to pay DMA the non-federal share of costs as detailed on the financial statement described in the previous paragraph. DHR agrees to notify DMA of any payments included on this financial statement for which services are not authorized. Unauthorized payments will be credited to DHR promptly upon notification. DMA may recoup unauthorized payments from providers.

Any disallowance of FFP by the Health Care Finance Administration is the ultimate responsibility of DMA; however, DHR is responsible for all disallowances resulting from failure to comply with rules, regulations, policies and procedures, etc., relative to the terms of this administrative agreement. DMA will notify DHR promptly of any audits, financial reviews, etc., relative to DHR responsibilities under this agreement. DMA will provide draft findings and recommendations to DHR with adequate time for input before DMA's response, to assure both agencies' concerns and comments are addressed. DHR will respond promptly when notified by DMA. Financial responsibility for any repayments, sanctions, etc., will be determined on a case by case basis, depending on the circumstances and state bedgetary requirements and restrictions.

Disallowance by the Health Care Finance Administration relative to areas where DHR is functioning as a service provider will be handled by DMA in the same manner as that of any other Medicaid service provider.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **GEORGIA**

LIENS AND ADJUSTMENTS OR RECOVERIES

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1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

   The State may place a lien on the member's home when there is not a reasonable expectation that the member will return home and when none of the following persons are living in the home:

   (a) The member's spouse;

   (b) A child under twenty-one (21) years of age;

   (c) A disabled child of any age; or

   (d) A sibling with an equity interest in the home who has lived in the home for at least one (1) year before the member entered the nursing home.

   The Department shall notify the member and the personal representative, if applicable, of its determination that the member is permanently institutionalized and not reasonably expected to return home and its intent to file a lien on member's real property. Notice must include an explanation of liens and their effect on an individual's ownership of real property. The notice must also state that imposing a lien does not mean the individual will lose their home. A lien may not be filed less than thirty-one (31) days from the date of the notice to the member and before any hearing process has been completed, if a hearing is requested.

   A member or his or her designee may, within thirty (30) days after receipt of notice request an administrative hearing under this rule. A member is deemed to have received notice within five (5) days from the date of the notice. Administrative hearings and appeals by Medicaid members are governed by the procedure and time limits set in Georgia Administrative Comprehensive Chapter §290-1-1-.01. Only one (1) appeal shall be afforded on behalf of a member, for each notice received. The member or his/her representative bears the burden of proof in proving that the member is not permanently institutionalized. The administrative law judge shall make the determination that an individual can or cannot reasonably be expected to be discharged from the institution.

   The Department or its designee shall file a notice of lien with the recorder of the county in which the real property subject to the lien is located. The notice shall be filed prior to the member's death and shall include the following:

   (a) Name and place of residence of the real property subject to the lien; and

   (b) Legal description of the real property subject to the lien.

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The Department shall file one (1) copy of the notice of lien with the local DFCS office in the county in which the real property is located. The county in which the real property is located shall retain a copy of the notice with the county office's records. The Department or its designee shall provide one (1) copy of the notice of lien to the member or the member 's authorized representative, if applicable, whose real property is affected.

The lien continues from the date of filing until the lien is satisfied, released or expires. From the date on which the notice of lien is recorded in the office of the county recorder, the notice of lien:

(a) Constitutes due notice against the member or member's estate for any amount recoverable under this article; and

(b) Gives a specific lien in favor of the Department on the Medicaid member's interest in the real property.

The State may not place a lien on an individual's home if anyone of the following individuals are living in the home:

(a) The member's spouse ;

(b) The member's child under twenty-one (21) years of age;

(c) The member's blind or disabled child of any age as defined in §1614 of the Act;

(d) The member's brother or sister who has an equity interest in the home and who has been in the member's home for at least one year immediately before the member's admission to a nursing home.

The Department has the authority to release any lien placed upon the property of an individual deemed permanently institutionalized should that person be discharged and return to a non-institutional home environment. The Department shall release a lien obtained under this rule within thirty (30) days after the Department receives notice that the member is no longer institutionalized and is living in his or her home. If the real property subject to the lien is sold, the office shall release its lien at the closing and the lien shall attach to the net proceeds of the sale.

"Permanently institutionalized" means residing in a nursing facility or intermediate care facility for the mentally retarded and developmentally disabled for 6 consecutive months or more.

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR §433.36(f):

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **GEORGIA**

The son or daughter has resided in the home at least two (2) years immediately before the member's admission to the institution. The member's sibling has resided in the residence at least one (1) year prior to the member's entrance to a nursing home. The son, daughter or sibling must provide the State with acceptable documentation that is clear and convincing evidence to prove residency and equity interest such as receipts, mortgage statements, bills, mail forwarded to member's address, and no other known residence for that sibling, son or daughter during that time frame. The sibling, son, or daughter has the burden of proof in all administrative reviews and/or hearings.

3. The State defines the terms below as follows:

"Estate" means all real and personal property under the probate code. Estate also includes real property passing by reason of joint tenancy, right of survivorship, life estate, survivorship, trust, annuity, homestead or any other arrangement. The estate also includes a life estate interest and excess funds from a burial trust or contract, promissory notes, cash, and personal property.

"Individual's home" means true, fixed and permanent home and principal establishment to which whenever absent, the individual has the intention of returning to his domicile.

"Equity interest in the home" means value of the property that the individual holds legal interest in to beyond the amount owed on it in mortgages and liens.

"Residing in the home for at least one or two years" Means the principal place of residence.

"On a continuous basis" means that the qualifying relative lived with the member in the member's residence as his or her principal place of residence without any breaks in the time frame.

"Discharge from the medical institution and return home" means that in order to be a qualifying discharge the member must be dismissed from the nursing institution and/or facility for at least thirty (30) days. Also, the member's personal effects and bed must be released at the same time of his/her discharge.

"Lawfully residing" means permissive use by the owner/power of attorney and the law.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **GEORGIA**

4. The state defines undue hardship as follows:

"Undue hardship" means (1) The asset to be recovered is the sole income-producing asset of the Medicaid beneficiary's heirs; or (2) The recovery of the assets would result in the heirs becoming eligible for governmental public assistance based on need and/or medical assistance programs.

5. The following procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective:
Procedures-
   - The creditor's claim contains information on the right to apply for an undue hardship waiver.
   - The personal representative completes a request for Undue Hardship Waiver within 30 days of the creditor's claim being filed, enclosed supporting documentation and forwards it to the Department for an evaluation on whether to grant a waiver. If a waiver is granted, recovery may be terminated or the Department may compromise by delaying recovery until the death of the eligible heir. In determining whether an undue hardship exists, the following criteria will be used:
   - (a) The asset to be recovered is a income producing farm of one or more of the heirs and the annual gross income is limited to $25,000 or less; or
   - (b) The recovery of assets would result in the applicant becoming eligible for governmental public assistance based on need and/or medical assistance programs.
   - Heirs who disagree with the Department's denial may file for an administrative appeal within 30 days of the notice of denial.
   - The heirs have the burden of proof in all administrative reviews and/or hearings.

6. The State defines cost-effective as follows (include methodology/thresholds used to determine cost-effectiveness):

   - The State employs the following methodology in determining if recovery is cost effective. The regulations of estate recovery mandate that we must pay years support for the family, funeral expense up to five thousand dollars ($5000.00), necessary expenses of administration, and unpaid taxes prior to any claims for Medicaid. In addition, the State must pay the third party administrator of the estate recovery program's collection expenses and pay a special assistant attorney general to handle these claims in Probate Court. Estates valued at $25,000 or less are exempt from estate recovery because it is not cost effective for the state to pursue recovery.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **GEORGIA**

7. The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):

- At application and during re-determination the applicant or the member is notified of the estate recovery program.

- Potential recovery cases are identified by data matches, newspaper clipping services, and referrals received from, probate courts, nursing facilities and local county offices.

- After death of the member, a Notice of Intent to File a Claim Against the Decedent's Estate is forwarded to the member's representative or the representative's attorney. In addition, a questionnaire is forwarded requesting information about a surviving spouse, a child under the age of 21, a blind or disabled child, any real property, and the administration of the estate.

- If all the criteria to pursue estate recovery is met, upon the estate being opened, the Department files a Creditor's Claim for the total amount of medical assistance paid on the deceased member's behalf.

- If an estate is not opened, the State may recoup funds through the member's bank account. The administrator of the program may present an affidavit to a financial institution requesting that the financial institution release account proceeds to recover the cost of services correctly provided to a member. The affidavit shall include the following information:

  (a) The name of the decedent;

  (b) The name of any person who gave notice that the decedent was a Medicaid member and that person's relationship to the decedent;

  (c) The name of the financial institution;

  (d) The account number;

  (e) A description of the claim for estate recovery;

  (f) The amount of funds to be recovered.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **GEORGIA**

A financial institution shall release account proceeds to the administrator of the program if all of the following conditions apply:

(a) The decedent held an account at the financial institution that was in the decedent's name only;

(b) No estate has been, and it is reasonable to assume that no estate will be, opened for the decedent;

(c) The decedent has no outstanding debts known to the administrator of the program;

(d) The financial institution has received no objections or has determined that no valid objections to release proceeds have been received.

If proceeds have been released pursuant to this section and the Department receives notice of a valid claim to the proceeds that has a higher priority under O.C.G.A. §53-7-40 than the claim of this section, the Department may refund the proceeds to the financial institution or pay them to the person or government entity with the claim.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____

A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

Service and Basis for Determination	Type of Charge			
	Deduct.	Coins	Co-pay.	Amount
Outpatient non-emergency visits			X	$ 3.00

A co-payment study was conducted within Georgia and a comparison study with other states was completed. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

Service and Basis for Determination	Type of Charge			
	Deduct.	Coins	Co-pay.	Amount
Oral Maxillofacial Surgery Services			x	$2.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

Service and Basis for Determination	Type of Charge Deduct.	Coins	Co-pay.	Amount
Nurse practitioners evaluation and management office visits			x	2.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

Service and Basis for Determination	Type of Charge Deduct.	Coins	Co-pay.	Amount
Durable Medical Equipment			x	$3.00
Durable Medical Supplies and Rentals			x	1.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

Service and Basis for Determination	Type of Charge			
	Deduct.	Coins	Co-pay.	Amount
Orthotics and Prosthetic Services			x	$3.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

Service and Basis for Determination	Type of Charge Deduct.	Coins	Co-pay.	Amount
Home Health Services			x	$3.00

. A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

Service and Basis for Determination	Type of Charge			
	Deduct.	Coins	Co-pay.	Amount
Non-Emergency Transportation			x	$1.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

Service and Basis for Determination	Type of Charge Deduct.	Coins	Co-pay.	Amount
Physicians and Podiatrists Evaluation and Management office visits			x	$2.00
Ophthalmology Service visits			x	2.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

Service and Basis for Determination	Type of Charge			
	Deduct.	Coins	Co-pay.	Amount
Optometric evaluation and management office visits			x	$1.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

A. The following charges are imposed on the categorically needy for services other that those provided under Section 1905 (a) (1) through (5) and (7) of the Act.

The co-payment structure was established to administer the Preferred Drug List program. Copayments listed below are applicable to drug identified as "non-preferred" only. Preferred branded drug, as well as, preferred generic drug have a co-pay of $0.50.

Type of Charge

Service and Basis For Determination	Deduct.	Coins	Co-pay.	Amount
Pharmacy Services			X	

Cost to State	Co-Payment
$10.00 or less	$0.50 co-payment
$10.01 to $25.00	$1.00 co-payment
$25.01 to $50.00	$2.00 co-payment
$50.01 or more	$3.00 co-payment

Recipients under age twenty-one (21), pregnant women, institutionalized individuals, hospice care, QMB dual eligible, and Breast and Cervical Cancer Program participant recipients are not required to pay this co-payment. Emergency services, family planning services, are also exempt from this co-payment.

Copayments are based on the maximum allowable charges as described in CFR 447.54 (2) non-institutional services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

Service and Basis for Determination	Type of Charge Deduct.	Coins	Co-pay.	Amount
Ambulatory Surgical Centers			x	$3.00
Rural Health Centers			x	2.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

Service and Basis for Determination	Type of Charge			
	Deduct.	Coins	Co-pay.	Amount
Federally Qualified Health Centers [Communmity Health Center Services (CHC)]			x	$2.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

Service and Basis for Determination	Type of Charge			
	Deduct.	Coins	Co-pay.	Amount
Inpatient Hospital Services			x	$12.50

Recipients affected by the co-payment are limited to adult recipients of Supplemental Security Income (SSI) benefits, certain other adult disabled and aged recipients and parents of children receiving Aid to Families with Dependent Children (AFDC) benefits. Children under age twenty-one, pregnant women, nursing home residents, and hospice care recipients are not required to pay this co-payment. Emergency services and family planning services received by Medicaid recipients do not require a co-payment.

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

B. The method used to collect cost sharing charges for categorically needy individuals:

[X] Providers are responsible for collecting the cost sharing charges from individuals.

___ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Providers accept the recipients' word as to their ability to pay the co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

Exclusions are determined by edits and audits of the claims payment system.

E. Cumulative maximums on charges:

[X] State policy does not provide for cumulative maximums.

[ ] Cumulative maximums have been established as described below:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____

A. The following charges are imposed on the medically needy for services:

Service and Basis for Determination	Type of Charge			
	Deduct.	Coins	Co-pay.	Amount
Non-Emergency outpatient services (visits)			X	$ 3.00

A co-payment study was conducted within Georgia and a comparison study with other states was completed. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the medically needy for services:

Service and Basis for Determination	Type of Charge			
	Deduct.	Coins	Co-pay.	Amount
Oral Maxillofacial Surgery Services			x	$2.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the medically needy for services:

Service and Basis for Determination	Type of Charge Deduct.	Coins	Co-pay.	Amount
Nurse practitioners evaluation and management office visits			X	2.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the medically needy for services:

Service and Basis for Determination	Type of Charge Deduct.	Coins	Co-pay.	Amount
Durable Medical Equipment			x	$3.00
Durable Medical Supplies and Rentals			x	1.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the medically needy for services:

Service and Basis for Determination	Type of Charge Deduct.	Coins	Co-pay.	Amount
Orthotics and Prosthetics Services			X	$3.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the medically needy for services:

Service and Basis for Determination	Type of Charge Deduct.	Coins	Co-pay.	Amount
Home Health Services			x	$3.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the medically needy for services:

Service and Basis for Determination	Type of Charge			
	Deduct.	Coins	Co-pay.	Amount
Non-Emergency Transportation			x	$1.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORIGA

A. The following charges are imposed on the medically needy for services:

Service and Basis for Determination	Type of Charge Deduct.	Coins	Co-pay.	Amount
Physicians and Podiatrists Evaluation and Management office visits			X	$2.00
Ophthalmology Service visits			X	2.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the medically needy for services:

Service and Basis for Determination	Type of Charge Deduct.	Coins	Co-pay.	Amount
Optometric evaluation and management office visits			X	$ 1.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

A. The following charges are imposed on the medically needy for services:

The co-payment structure was established to administer the Preferred Drug List program. Copayments listed below are applicable to drug identified as "non-preferred" only. Preferred branded drug, as well as, preferred generic drug have a co-pay of $0.50.

Type of Charge

Service and Basis For Determination	Deduct.	Coins	Co-pay.	Amount
Pharmacy Services			X	

Cost to State	Co-Payment
$10.00 or less	$0.50 co-payment
$10.01 to $25.00	$1.00 co-payment
$25.01 to $50.00	$2.00 co-payment
$50.01 or more	$3.00 co-payment

Recipients under age twenty-one (21), pregnant women, institutionalized individuals, hospice care, QMB dual eligible, and Breast and Cervical Cancer Program participant recipients are not required to pay this co-payment. Emergency services, family planning services, are also exempt from this co-payment.

Copayments are based on the maximum allowable charges as described in CFR 447.54 (2) non-institutional services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the medically needy for services:

Service and Basis for Determination	Type of Charge Deduct.	Coins	Co-pay.	Amount
Ambulatory Surgical Centers			X	$3.00
Rural Health Centers			X	2.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the medically needy for services:

Service and Basis for Determination	Type of Charge Deduct.	Coins	Co-pay.	Amount
Federally Qualified Health Centers [Community Health Center Services (CHC)]			x	$2.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

A. The following charges are imposed on the medically needy for services:

Service and Basis for Determination	Type of Charge Deduct.	Coins	Co-pay.	Amount
Inpatient Hospital Services			x	$12.50

Recipients affected by the co-payment are limited to adult recipients of Supplemental Security Income (SSI) benefits, certain other adult disabled and aged recipients and parents of children receiving Aid to Families with Dependent Children (AFDC) benefits. Children under age twenty-one, pregnant women, nursing home residents, and hospice care recipients are not required to pay this co-payment. Emergency services and family planning services received by Medicaid recipients do not require a co-payment.

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

B. The method used to collect cost sharing charges for medically needy individuals:

[X] Providers are responsible for collecting the cost sharing charges from individuals.

[ ] The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Providers accept the recipients' word as to their ability to pay the co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

The exclusions are determined by edits and audits of the claims payment system.

E. Cumulative maximums on charges:

[X] State policy does not provide for cumulative maximums.

[ ] Cumulative maximums have been established as described below:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

NONE

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

NONE

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

C. State or local funds under other programs are used to pay for premiums:

☐ Yes ☒ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

NONE

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

NONE

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

NONE

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

C. State or local funds under other programs are used to pay for premiums:

☐ Yes ☒ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

None

*Description provided on attachment.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

I. Cost Finding and Cost Reporting

A. Cost Reporting

1. Each hospital participating in the Georgia Medicaid Hospital Program will submit a Uniform Cost Report, using the appropriate CMS Form 2552. The cost reporting period for the purpose of this plan shall be the same as that for the Title XVIII and Title V cost reporting, if applicable. A complete, legible copy of the cost report shall be submitted to the Medicare intermediary and to the Department as appropriate.

2. Allowable costs will not include costs that are in excess of charges. Allowable costs are documented costs that are ordinary and necessary in the delivery of a cost-effective service. Allowable costs shall be determined in accordance with the CMS Provider Reimbursement Manual 15, except as may be modified in this plan or as modified in the Department's "Policies and Procedures for Hospital Services" as published on January 1, 2008.

3. A hospital must furnish its cost report within five months after its fiscal year end. If the report has not been received after this five-month period and a request for extension has not been granted, a written warning will be issued. This warning will indicate that if, after an additional month (total six months), the cost report has not been received, a one hundred percent reduction will be imposed on all payments made during that period that the cost report is late. These payments will be withheld until an acceptable Medicaid cost report is received. After the cost report is received and is determined to be acceptable, the withheld funds will be released. If the cost report is not received after seven months from the hospital's fiscal year end, the hospital's agreement of participation will be subject to termination.

4. A hospital which voluntarily or involuntarily ceases to participate in the Georgia Medicaid program or experiences a change of ownership must file a final cost report within five (5) months of the date of termination or change of ownership. For the purpose of this plan, filing a final cost report is not required when: 1) the capital stock of a corporation is sold without change in title to assets or 2) a partnership interest is sold as long as one of the original limited partners becomes a general partner, or control remains unchanged. Any change of ownership must be reported to the Department within 45 days after such change of ownership.

5. All hospitals are required to maintain a Medicaid Log and financial and statistical records. For purposes of this plan, statistical records shall include beneficiaries' medical

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

request records. These records must be available upon to representatives, employees or contractors of the Department, State Auditors, the General Accounting Office (GAO) or the United States Department of Health and Services (HHS).

6. Records of related organizations must be available upon demand to representatives, employees or contractors of the Department, the Inspector General, GAO, or HHS.

7. The Department shall retain all uniform cost reports submitted for a period of at least three years following the date of submission of such reports and will maintain those reports pursuant to the record keeping requirements. Access to submitted cost reports will be in conformity with Georgia law. Unless enjoined by a court of competent jurisdiction, the cost report will be released to the requestor.

B. Reasonable Cost of Inpatient Hospital Services

1. Allowable costs will be determined using requirements of licensure and certification and the duration and scope of benefits provided under the Georgia Medicaid Program. Allowable costs shall be determined in accordance with the CMS Provider Reimbursement Manual 15, except as may be modified in this plan or as modified in the Department's "Policies and Procedures for Hospital Services" as published on January 1, 2008. Allowable costs will include:

a. Cost incurred by a hospital in meeting any requirements for licensing under the State law which are necessary for providing inpatient hospital services.

b. Medicaid reimbursement will be limited to an amount, if any, by which the hospital's per case rate exceeds the third party payment amount for each admission.

c. Under this plan, hospitals will be required to accept Medicaid reimbursement as payment in full for services provided. As a result, there will be no Medicaid bad debts generated by patients. Bad debts will not be considered as an allowable expense.

d. The Department does not use Medicare regulations regarding payment for malpractice insurance costs. The methodology that currently is used for Medicaid will continue to be applied in the determination of allowable costs.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

e. All procedures or drugs ordered by the patient's physician that result in costs being passed on by the hospital to the Georgia Medicaid Program through the cost report shall be subject to review by the Department. All procedures determined through the Department's or hospital's utilization review committee to be unnecessary or not related to the spell of illness will require appropriate adjustments to the Medicaid Log. Such adjustments for a patient may be rescinded upon a determination made by the hospital utilization review committee or the Department of Medical Assistance as being medically necessary.

f. Reimbursable costs will not include those reasonable costs that exceed customary charges.

4. The costs listed below are nonallowable. Reasonable costs used in the establishment of rates will reflect these costs as nonallowable (this list is not exhaustive).

a. 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;

b. Memberships in civic organizations;

c. Out-of-state travel paid by the provider for persons other than board members of those employed or contracted by the provider. Out-of-state travel for provider personnel must be related to patient care;

d. Vehicle depreciation or vehicle lease expenses in excess of the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles; provided, however, such limit shall not apply to specialized patient transport vehicles (e.g. , ambulances);

e. 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;

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

g. 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 reviews, issuance 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; and

h. 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.

i. Hospital Acquired Condition (HAC) Never Events (NE)/Present on Admission (POA)/ Other provider-preventable condition (OPPC)

For dates of service May 17,2012 and after, for all Medicaid patients, requests for Diagnosis Related Groups (DRGs) attributable to Medicare identified hospital acquired conditions and never events will not be approved by the Peer Review Organization (PRO) and are not reimbursable regardless of the setting (all inpatient hospital settings and in all health care settings). PRO review for present on admission is not required. This policy applies to all Medicaid reimbursement provisions, contained in Attachment 4.19-A, including Medicaid supplemental or enhanced payments and Medicaid disproportionate share hospital payments and complies with Medicare Billing Guidelines for Hospital Acquired Conditions, Provider Preventable Conditions, Never Events and Present on Admission.

C. Audits

1. Background - To assure that recognition of reasonable cost is being achieved, a comprehensive hospital audit program has been established. The hospital common audit program has been established to reduce the cost of auditing submitted reports under the above three programs and to avoid duplicate auditing effort. The purpose is to have one audit of a participating hospital which will serve the needs of all participating programs reimbursing the hospital for services rendered.

2. Common Audit Program
The Department has entered into a written agreement with the Georgia based Medicare intermediary for participation in a common audit program of Titles VI, XVIII and XIX. Under this agreement, the intermediary shall provide the result of Department the result desk review and field audits of those hospitals located in Georgia.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

3. Other Hospital Audits
For those hospitals not covered by the common audit agreement with the Medicare intermediary, the Department shall be responsible for the performance of desk reviews and field audits, the Department shall:

a. Determine the scope and format for on-site audits.
b. Contract annually for the performance of desk reviews and audits.
c. Ensure all audits are performed in accordance with generally accepted auditing standards of the AICPA.
d. Ensure that only those expense items that the plan has specified as allowable costs under Section I of this plan have been included by the hospital in the computation of the costs of the various services provided under Title XIX in Georgia;
e. Review to determine the Georgia Medicaid Log is properly maintained and current in those hospitals where its maintenance is required.

4. Retention of Cost Reports
All audited cost reports received from the Medicare intermediary or issued to the Department will be kept for at least 2 years.

5. Overpayments and Underpayments
The Department may adjust the reimbursement of any provider whose rate is established specifically for it on the basis of cost reporting, whenever the Department determines that such adjustment is appropriate. The provider shall be notified in writing of the Department's intention to adjust the rate, either prospectively, retroactively or both. The terms of payment will be in accordance with the Department's policy. All overpayments will be reported by the Department to CMS as required. Information intentionally misrepresented by a hospital in the cost report shall be grounds to suspend the hospital from participation in the Georgia Medicaid Program.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

II. Rate Setting

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

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

The calculation of prospective rates requires the use of claims data, cost data and supplemental expenditure data. The historical claims data is obtained from a chosen base year, with adjustments for inflation.

For admissions from July 1, 2002 through December 31, 2007:

The cost data is derived from a cost report year where the majority of hospitals have audited data. For rates effective on July 1, 2002, audited data was available for hospital fiscal years ending in 1999 for a majority of hospitals. Hospitals without audited data in the chosen year will have data derived from the hospital's most recently audited cost report; for rates effective July 1, 2002, if audited cost report data is not available for a period ending on or after July 31, 1996, a recent unaudited cost report will be used.

For admissions on and after January 1, 2008:

The cost data is derived from cost report periods ending in 2004. If available at the time that rate setting data were compiled, audited cost report information would be used; otherwise, unaudited cost report data would be used.

The supplemental data is obtained from state supplemental expenditure surveys. The rate components are used in the calculation of the prospective rates as described in Section II of this plan.

B. Payment Formulas

Non-Outlier DRG Payment Per Case =(Hospital-Specific Base Rate x DRG Relative Rate) +Capital Add-on +GME Add-on (if applicable)

Outlier DRG Payment Per Case =(Hospital-Specific Base Rate x DRG Relative Rate) + {[(Allowable Charges x Hospital-Specific Operating Cost to Charge Ratio)-(Hospital-Specific Base Rate x DRG Relative Rate)] x A Percentage} +Capital Add-on +GME Add-on (if applicable)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

C. Discussion of Payment Components

1. Base Rates

All hospitals are assigned to a peer group in order to develop a base rate that best matches payments to costs for hospitals that provide similar services. The peer group base rate is obtained by calculating the average operating cost standardized for case mix of Inlier DRG cases across all cases in a peer group, with an adjustment factor applied to maintain budget neutrality. If a hospital is assigned to the statewide or pediatric peer group, the peer group base rate becomes the hospital-specific base rate.

For admissions from July 1, 2002 through December 31, 2007:

If a hospital is assigned to the specialty peer group and has a sufficient claim volume, the hospital-specific base rate will be the greater of the peer group base rate or the individual hospital's base rate. 1f a hospital is assigned to the specialty peer group and does not have a sufficient claim volume, the peer group base rate becomes the hospital-specific base rate. For each case paid within the DRG methodology, the hospital specific base rate will be multiplied by the appropriate DRG relative weight to calculate a payment.

For admissions on and after January 1, 2008:
If a hospital is assigned to the specialty peer group and has a sufficient claim volume, the hospital-specific base rate will be the hospital's base rate. If a hospital is assigned to the specialty peer group and does not have a sufficient claim volume, the peer group base rate becomes the hospital-specific base rate. For each case paid within the DRG methodology, the hospital specific base rate will be multiplied by the appropriate DRG relative weight to calculate a payment.

For admissions on or after July 1, 2010 through June 30, 2013:

Effective July 1, 2010, in order to recognize the Medicaid share of hospitals' cost of paying fees for under the Hospital Provider Payment Agreement Act of 2009 (GA HB 1055), an *adjustment to hospital inpatient base rates, capital add-on and GME add-on rates will be added to hospitals' inpatient rate. Critical Access Hospitals (CAHs), Psychiatric Hospitals and State-Owned / State-Operated Hospitals are exempt from the provider fee and the rate adjustment. Trauma hospitals will participate in the provider fee but at a lower percentage than other

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participating hospitals. The table below shows the provider fee and associated rate increase for different classes of hospitals.

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

In order to partially offset the 1.45% and 1.40% hospital fee rates levied by Georgia HB 1055, a new Base Rate Change will be created. This new base rate change will be a multiplier, which will be expressed as a constant percentage of the Allowed Charge. There will be two different values for this Base Rate Change. One will be used for Inpatient Medicare Crossover claims. The second will apply to non-Crossover Hospital claims. Two new system parameters will be created to store these percentages.

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

DRG Priced Claim Example

(DRG Weight-Based Payment +DC Cap Add-on) =Allowed Charge
Allowed Charge x .1188 (HT %) =HT Add-on (Base Rate Change)
(Allowed Charge - Co-Pay) =Reimbursement Amount

The 11.88% add-on increase will also be added to outlier per case payments.

2. Calculation of the Capital Add-on Amount

Hospitals receive a hospital-specific add-on based on capital costs from the cost report year, charges from the rate setting base year and supplemental data from the capital expenditure survey.

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

Only hospitals which have GME costs in the cost report year receive the GME add-on amount. The Medicaid portion of GME from the hospital's cost report year is adjusted for inflation, then divided by the number of cases in the base year to obtain the GME add-on.

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

The basis for the determination of capital add-on amounts and GME add-on amounts are described below. All hospital-specific information is based on data from three sources and may be updated periodically:

(a) the hospital's cost report (for capital and GME add-on amounts)
(b) the hospital's capital surveys, if utilized (for capital add-on amounts only)
(c) Georgia Medicaid and PeachCare paid claims data (for hospitals with a limited number of paid claims, add-on amounts may be determined based on average amounts for other hospitals.)

Part 1 - Calculation of the Capital Add-On Amount

(a) A Medicaid allocation ratio is used to apportion the Medicaid portion of the hospital's total capital. The allocation ratio is the hospital's Medicaid inpatient costs divided by total hospital costs.
(b) Sum the hospital's capital costs (total building and fixtures) and capital costs (total major movable) from the cost report.
(c) Determine the Medicaid allocation of capital costs from the cost report by multiplying the Medicaid allocation ratio (Item 1 (a)) by total capital costs from the cost report (Item 1 (b)).
(d) Determine the capital CCR by dividing the Medicaid allocation of capital costs (Item 1(c)) by the total allowed Medicaid charges for the cost report period.
(e) Calculate the base year capital costs by multiplying the capital CCR by the base year allowed charges.
(f) Calculate the preliminary capital costs per case by dividing the base year capital costs (Item 1(e)) by the base year number of cases.
(g) Sum the total amounts from the capital expenditure surveys, if utilized.
(h) Determine the Medicaid allocation of capital costs from surveys by multiplying the Medicaid allocation ratio (Item 1(a)) by total capital from surveys (Item 1(d)).
(i) Determine the survey rate of increase by dividing Item 1(h) by item 1(e).
(j) Calculate the Capital Add-On Amount by multiplying Item 1(f) by one plus Item 1(i).

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Part 2 - Calculation of the Direct Graduate Medical Education (GME) Add-On Amount
Only hospitals, which have GME costs in the base period cost report, receive the GME add-on amount.

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

D. Special Payment Provisions

1. New Facilities

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

2. Out-of-State Facilities

Out-of-state facilities under the DRG system will receive payments using the same payment formulas as stated in Sections A, B and C. However, the components of the formulas will be calculated on a statewide average. An out-of-state facility will receive a hospital specific base rate that is equal to the statewide average rate for the appropriate peer group in which the hospital is classified, a capital add-on payment equal to the statewide average add-on payment for the appropriate peer group, and a cost-to-charge ratio that is equal to the Georgia statewide average of the cost-to-charge ratios.

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3. New Medicaid Providers

Prospective payment rates for established facilities which did not submit a hospital-specific Medicare cost report because the facility did not participate in the Medicaid program will be determined in the same manner as a new facility stated in section D.1.

E. DRG Grouper

For admissions from July 1, 2002 through December 31, 2007, the grouper used to classify cases into DRG categories will be CHAMPUS Grouper version 16.0. For admissions on and after January 1, 2008, the grouper used to classify cases into DRG categories wil be TRICARE Grouper version 24.0. The grouper used to assign claims to DRG categories, as well as the corresponding DRG weights and threshold amounts, may be updated periodically.

F. Reviews and Appeals

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

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

Information concerning the base rate and prospective rate will be provided to each hospital prior to the effective date. A hospital will have 30 days from the date on the correspondence to submit a request for adjustment concerning the rate determination process. If no adjustment request is submitted within this time period, a hospital may not contest its rate of payment. There is no time limitation for the Department to reduce a hospital's rate when an error is discovered.

Written requests must be submitted to the Coordinator of the Hospital Reimbursement Unit. Requests for review must include evidence on which the request is being based. Hospitals which do not submit written request or inquiries within thirty days of the date of such information will be considered to have accepted their rates as received. Similarly, failure of the hospital to state the basis for review and to include relevant supporting

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evidence for the Department's consideration, when requesting an Administrative Review, will also result in a denial of further appeal rights on the rate of payment. The Coordinator of Hospital Reimbursement will have sixty (60) days from the date of receipt to render a decision concerning the written requests or inquiries submitted by a hospital if no additional information is required. The Coordinator may have more than sixty (60) days to render a decision if additional information is requested. If the Coordinator of Hospital Reimbursement requests additional information, the request must be issued within thirty (30) days of receipt, and the hospital must respond within thirty (30) days of receipt of such request. The Coordinator of Hospital Reimbursement will have thirty (30) days from the receipt of the additional information to render a decision in writing. The failure of the Coordinator of Hospital Reimbursement to render a decision within the above-stated time frame will result in a decision in favor of the hospital concerning the issue raised by the hospital on appeal.

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

G. Co-Payment

A co-payment of $12.50 will be imposed for certain inpatient hospital admissions. Recipients affected by the copayment are limited to adult recipient of Supplemental Security Income (SSI) benefits, certain other adult disabled and aged recipients and parents of children receiving Aid to Families with Dependent Children (AFDC) benefits. Children under age twenty-one, pregnant women, nursing home residents, or hospice care participants are not required to pay this copayment. Emergency services and Family Planning services received by Medicaid recipients do not require a copayment. Services cannot be denied based on the inability to pay these copayments.

H. Administrative Days

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

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

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

I. Hospital Crossover Claims

The maximum allowable payment to enrolled Georgia and non-Georgia hospitals for Medicare inpatient deductibles and coinsurance (crossover claims) will be the hospital-specific Medicaid per case rate. The maximum allowable payment to non-Georgia hospitals not enrolled the Georgia Medicaid program for Medicare inpatient crossover claims will be the average hospital-specific inpatient per case rate for enrolled non-Georgia hospitals.

J. Payment In Full

1. Participating in-state providers must accept the amount paid in accordance with the Georgia Title XIX Inpatient Hospital Reimbursement Plan as payment in full for covered services.

2. Settlement
For admissions occurring each calendar year, a comparison of a hospital's total Medicaid payments and its total charges will be made after completion of the calendar year. Except for hospitals receiving designation as a Critical Access Hospital in Georgia, a refund will be due from the hospital for any amount by which total Medicaid payments are in excess of a hospital's total charges for Medicaid patients. Total Medicaid payments included in the comparison shall not include payment adjustments made to Georgia or non-Georgia enrolled disproportionate share hospitals. Total payments will include the appropriate inpatient hospital copayments.

K. Expanded Newborn Screening Program

Effective for services provided on and after July 1, 2010, an additional payment of $50 per newborn admission will be made to fund costs associated with the expansion of the newborn screening program administered by the Georgia Department of Human Resources.

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Citation
42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions (PPC)

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions (HAC)

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19-A.

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients, for example.

Effective June 30, 2012, Medicaid will make zero payment to providers for services related to Provider Preventable Conditions (PPC) which includes Healthcare Acquired Conditions (HAC). Reimbursement for conditions described above is defined in Attachment 4.19A, Page 14a of this State Plan.

A. Dates of service beginning on or after May 17, 2012:
   1. The claims identified with a Present on Admission (POA) indicator through the claims payment system will be reviewed.
   2. When the review of claims indicates a HAC, the amount for the provider-preventable condition will be excluded from the provider's payment.

B. Reductions in provider payment may be limited to the extent that the following apply:
   1. The identified provider-preventable conditions would otherwise result in an increase in payment.
   2. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for any condition related to HACs and any other provider-preventable conditions.
   3. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

C. Non-payment of HACs or NEs shall not prevent access to services for Medicaid beneficiaries.

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Citation
42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions (PPC)

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19(A)

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

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Payment for Hospital Acquired Conditions:

Effective June 30, 2012 and in accordance with Title XIX of the Social Security Act – Sections 1902, 1903 and 42 CFRs 434, 438, and 447, Medicaid will make no payment to providers for services related to Provider Preventable Conditions (PPC) which includes Healthcare Acquired Condition (HCAC) and Never Events (NE).

In accordance with GA State Plan, Attachment 3.1-A, Page 1, Hospital Services payments are allowed except for the following conditions outlined below.

The above effective date and after, for all Medicaid patients, requests for Diagnosis Related Groups (DRGs) attributable to Present on Admission (POA) conditions will be reimbursed for allowable charges. Peer Review Organization (PRO) review for Present on Admission (POA) is not required.

Provider Preventable Conditions (PPC), which includes Healthcare Acquired Condition (HCAC), with diagnose codes with Y or W, or as defined by CMS, will be considered in the DRG calculation. Conversely, any diagnoses codes with N or U, or as defined by CMS, will not be considered in the DRG calculation. Provider Preventable Conditions (PPC) will not be approved by the Peer Review Organization (PRO). Providers must identify and report PPC occurrences.

Never Events (NE) are defined by the National Coverage Determination (NCD) manual for Inpatient Hospitals and practitioners, and these providers will be required to report NEs. Never Events (NE) for Inpatient Hospital claims will bill separate claims using by Bill Type 110 or as designated by the National Uniform Bill Committee for a non-payment/zero claim. The non-covered Bill Type 110 must have one of the ICD-9 diagnosis codes.

- E876.5 – Performance of wrong operation (procedure) on correct patient
- E876.6 – Performance of operation (procedure) on patient not scheduled for surgery
- E876.7 – Performance of correct operation (procedure) on wrong side/body part

The provider may file a separate claim for the same Medicaid recipient with the same dates of service to include the allowable charges for reimbursement. Providers must identify and report NE occurrences.

Prohibition on payments for PPCs, HCACs and NEs shall not result in a loss of access to care or services for Medicaid beneficiaries. This policy applies to all Medicaid reimbursement provisions, contained in 4.19A, including Medicaid supplemental or enhanced payments and Medicaid disproportionate share hospital payments.

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III. Disproportionate Share Hospitals (DSH)

A. Eligibility

Effective for DSH payment adjustments made on or after December 1, 2007, hospitals that are eligible to receive DSH payment adjustments under federal DSH criteria per Social Security Act Section 1923(d) will be eligible to receive an allocation of available DSH funds.

Federal Criteria:

1. The hospital has a Medicaid inpatient utilization rate of at least 1%; AND

2. The hospital has at least two (2) obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid recipients. This requirement does not apply to a hospital of which the inpatients are predominately individuals under 18 years of age or to hospitals which did not offer non-emergency obstetric services to the general population as of December 22, 1987. In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. For rural hospitals subject to a federal requirement to provide obstetric services, as an alternative to determining whether deliveries are provided at the hospital, the Department will consider the following factors:
   a. The hospital must have two or more physicians with staff privileges that are:
      i. Enrolled in the Medicaid program;
      ii. Credentialed to provide OB services at the hospital in family practice, general practice, or obstetrics; and
      iii. Located within 25 miles of the hospital or in an office in the hospital network or must attest to attendance at the hospital on some routine basis; and
   b. The hospital must be able to provide at least one obstetric service that is currently covered by Medicaid and appropriate to be provided in a hospital-based setting.

   For federal DSH criteria, a hospital will be considered a rural hospital if a hospital's county is not in a Metropolitan Statistical Area, as defined by the United States Office of Management and Budget, OR is a county having a population of less than 35,000 according to the United States decennial census; provided, however, that for counties which contain a military base or installation, the military personnel and their dependents living in such county shall be excluded from the total population of that county.

B. Allocation Methodology

Effective for DSH payment adjustments made on or after December 1, 2007, the following methodology will be used for determining payment amounts:

1. For each federal fiscal year, the amount of funds available for DSH payments will be determined based on the state's federal allotment and required state matching contribution.

2. Hospitals that meet federal DSH eligibility criteria will be eligible to receive an allocation of available DSH allotment funds.

3. The maximum amount of DSH payments (i.e., DSH Limit) for each hospital will be the hospital's loss incurred for services provided to Medicaid and uninsured patients based on federal definitions. Medicaid costs will be determined by applying Medicare per diem costs to Medicaid inpatient days and Medicare ratios of cost to charges to Medicaid inpatient and outpatient charges grouped by cost center. The patient day and charge amounts will be determined by Medicaid

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HS&R reports of paid claims, while per diem costs and ratios of cost to charges will be determined by available 2552 cost reports. Medicaid payments will include interim claim payments, outpatient settlement estimates and non-DSH rate adjustments. Uninsured costs will be determined by applying Medicare inpatient and outpatient cost to charge ratios, from available 2552 cost reports, to charges for uninsured reported on DSH data surveys. The DSH data surveys will also be used to determine amounts received for services provided to uninsured patients. DSH data surveys are conducted annually and subject to desk reviews and onsite reviews of supporting documentation, as warranted.

4. The amount of funds available for DSH payments will be allocated among eligible hospitals. Total available DSH funds will be divided into two pools:
   - Pool 1 – For FY 2008 DSH payments, Pool 1 will be equivalent to $53,735,261 and used in the calculation of DSH allocations for small, rural hospitals. For DSH payments after FY 2008, Pool 1 would change relative to changes in the state's federal DSH allotment as compared to the FY 2008 state DSH allotment;
   - Pool 2 – For FY 2008 DSH payments, Pool 2 will be equivalent to $347,439,065 and used in the calculation of the DSH allocations for all other, eligible hospitals. For DSH payments after FY 2008, Pool 2 would change relative to changes in the state's federal DSH allotment as compared to the FY 2008 state DSH allotment.

5. Each hospital's DSH limit is subject to the following DSH limit adjustments for allocation purposes:
   a. For hospitals receiving Upper Payment Limit (UPL) rate adjustments, the allocation basis will be increased by the amount of any intergovernmental transfer or certified public expenditure provided on behalf of the hospital.
   b. For hospitals receiving rate adjustment payments related to medical education, neonatal services or services provided under contract with the Georgia Department of Human Resources, the allocation basis will be increased by the amount of such rate adjustments.

6. The department will utilize the following steps to determine the amount each hospital is eligible to receive in DSH payments.
   a. Step 1: Determine the adjusted DSH limit (as determined in section (III)(B)(5)) as a percentage of total cost for each hospital.
   b. Step 2: For each hospital, multiply the hospital-specific percentage determined in Step 1 by the hospital's adjusted DSH limit. For private hospitals, the outcome of this calculation will be multiplied by the rate of federal matching funds for Medicaid benefit payments.
   c. Step 3: For each hospital, divide the hospital-specific amount identified in Step 2 by the aggregate "step 2" amount derived from all hospitals in the applicable pool, as defined in section (III)(B)(4), which will result in a hospital-specific allocation factor.
   d. Step 4: Apply the hospital's allocation factor calculated in Step 3 to the total amount of DSH funds available in the applicable pool, as defined in section (III)(B)(4). This will result in the hospital's DSH payment. Should the DSH payment amount calculated for a hospital exceed the hospital's DSH limit, as determined in section (III)(B)(3), the excess amount will be redistributed to the remaining hospitals in the applicable allocation pool.

7. To mitigate significant increases and decreases in hospital-specific DSH payments as compared to state fiscal year 2007, the following adjustments will be applied for the allocation of DSH funds:

   - Maximum DSH allocations for all hospitals are set at 75% of their specific adjusted DSH limits; however, for facilities ineligible for DSH payment adjustments prior to December 1, 2007 but newly eligible under the criteria specified in section A above or facilities who did

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7. To mitigate significant increases and decreases in hospital-specific DSH payments as compared to state fiscal year 2007, the following adjustments will be applied for the allocation of DSH funds:

   - Maximum DSH allocations for all hospitals are set at 75% of their specific adjusted DSH limits; however, for facilities ineligible for DSH payment adjustments prior to December 1, 2007 but newly eligible under the criteria specified in section A above or facilities who did not receive a DSH payment prior to December 1, 2007, their maximum DSH allocation factor, as calculated in Section (III)(B)(6), step 2, is limited to 25% of the calculated amount.
   - Final DSH payment amounts for small, rural hospitals reflects blending of 50% of state fiscal year 2007 net DSH payments and 50% of the allocation calculation based on the methodology specified in section (III)(B)(6);
   - Final DSH payment amounts for all other hospitals reflects blending of 25% of state fiscal year 2007 net DSH payments and 75% of the allocation calculation based on the methodology specified in section (III)(B)(6).

8. For private hospitals that meet the eligibility requirements of Section (III)(A) and meet Social Security Act Section 1923(b) criteria, allocations payments will be made at 100 % of calculated allocation amounts as determined by steps 1 through 7 of Section (III)(B). For private hospitals that meet the eligibility requirements of Section (III)(A) but do not meet Social Security Act Section 1923(b) criteria, allocation payments will be made at 100% of calculated allocation amounts as determined by steps 1 through 7 of Section (III)(B).

9. The state share of DSH payment amounts for state governmental and non-state governmental hospitals will come from intergovernmental transfers made on behalf of or by the hospital.

For allocation of 2010 DSH funds, provider eligibility and DSH limit calculations will be based on information available from hospital fiscal years ending in 2007; for hospitals not in operation during 2007, data for 2008 may be used. For allocation of DSH funds after 2008, eligibility and DSH limit calculations will be based on the most recent year for which comparable data would be available.

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IV. Other Rate Adjustments

Upper Payment Limit Rate Adjustments

For payments made for services provided on or after July 1, 2005, the following types of hospitals will be eligible for rate payment adjustments:

- State government-owned or operated facilities;
- Non-State government owned or operated facilities;
- Federally defined Critical Access hospitals;
- Hospitals designated by the Georgia Department of Human Resources as Regional Perinatal Centers;
- Hospitals providing the following program services for the Georgia Department of Human Resources: AIDS Clinic, Poison Control Center, Genetics/Sickle Cell Screening and Maternal and Infant Health Services; and
- Hospitals participating in selected residency grant programs administered by the Georgia Board for Physician Workforce.

The rate adjustment payments are intended to provide supplemental funding for Medicaid services to these facilities that need sufficient funds for their commitments to meet the healthcare needs of all members of their communities and to ensure that these facilities receive financial support for their participation in programs vital to the state's healthcare infrastructure.

The rate payment adjustments will be subject to federal upper payment limits. For the appropriate groupings of State government-owned or operated facilities, non-State government owned or operated facilities and all other facilities, aggregate rate adjustment payments available without exceeding upper payment limits will be determined by measuring the difference between:

- Amounts paid for services provided to Medicaid patients and
- Estimated payment amounts for such services if payments were based on Medicare payment principles. Either cost-based determined in accordance with 42 CFR 413s or based on Medicare Prospective payment methods determined in accordance with 42 CFR 412.

Comparisons of 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 determine facility-specific rate adjustment payments. If an individual facility cannot be paid a portion of its full rate adjustment payment due to a facility-specific charge limit, this rate adjustment amount can be

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allocated to other facilities that are eligible to receive additional rate adjustment payments without exceeding facility-specific charge limits. These rate payment adjustments will be made on a monthly, quarterly or annual basis and will be determined in a manner that will not duplicate compensation provided from payments for individual patient claims.

A sample of how a rate adjustment payment is calculated is presented on the following page.

Line	Field Descripiton	Comments	XYZ Hospital
1	base period report period beginning date		9/1/2003
2	base period report period ending date		8/31/2004
3	HS&R processing date for Medicaid data		9/6/2005
4	adjustment factor (if period not equal to 1 year)		1
5	Medicaid inpatient claims paid at amount > 0:		
6	covered charges	From HS&R	3,949,268
7	payments	From HS&R	1,828,506
8	annual covered charges	From HS&R	3,949,268
9	annual payments	From HS&R	1,828,506
10	Cost of Medicaid Services	Worksheets C, Part 1 and D-1, Part II	1,661,931
11	Covered Charges for Medicaid Services	Worksheets C, Part 1 and D-1, Part II	3,725,000
12	inpatient CCR	Line 14 / Line 9	0.446156

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13	annual cost of services	Line 4 X Line 6 X Line 12	1,761,990
15			
16	adjustment factors		
17	claim completion		1
18	inflation		1.073852
19	volume allowance		1.014000
20	combined adjustment factors	Line 17 X Line 18 X Line 19	1.088886
21	supplemental inpatient rate adjustments		0
22	adjusted annual charges	Line 4 X Line 6 X Line 20	4,300,302
23	adjusted Medicaid payments	Line 4 X Line 9 X Line 20	1,991,034
24	adjusted cost of services	Line 13 X Line 20	1,918,606
25	total Medicaid payments	Line 21 + Line 23	1,991,034

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26	DRG differential		1.176249
27	adjusted Medicare-based annual payments	Line 23 X Line 26	2,341,952
28	UPL estimate	Line 27 - Line 25	350,918

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V. Other Information

A. Payment Assurance

The State will pay each hospital for services provided in accordance with the requirements of the Georgia Title XIX State Plan and applicable State and Federal rules and regulations. The payment amount shall be determined for each hospital according to the standards and methods set forth in the Georgia Title XIX inpatient Hospital Reimbursement Plan.

Hospitals will continue to submit claims as they have in the past. All requirements for documented services and charges will remain in effect, and all screens for completeness will continue. Hospital claims will be subject to post-payment review. The Department will be requesting information from the hospitals to substantiate the necessity and appropriateness of services rendered. Any denials for lack of medical necessity, documentation, or other reasons will result in recoupment of monies paid to the provider. A reduced rate for less than acute care is not applicable nor required.

Unlike a per diem or percent or charges system, this reimbursement plan does not provide incentives for prolonging a patient's stay. If a patient remains in the hospital beyond the time of medical necessity, the effect is to reduce the daily reimbursement rate.

B. Provider Participation

This plan is designed to assure adequate participation of hospitals in the Medicaid Program, the availability of hospital services of high quality to recipients, and services within which are comparable to those available to the general public.

C. Swing-bed Services

1. Reimbursement Methodology

Swing-bed providers will be reimbursed a prospective rate per patient day which will be the statewide average Medicaid rate per diem paid to Level I nursing facilities for routine services furnished during the previous calendar year. The per diem rate covers the cost of certain routine services as described in Attachment 3.1A, page lc-3 of the Plan. Ancillary services such as laboratory, radiology, and certain prescription drugs must be billed and reimbursed separately under the appropriate Medicaid program. For example, radiology

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

services provided in the outpatient department of the hospital should be billed as outpatient hospital services. Providers must bill on a monthly basis.

Medicaid will reimburse the Medicare Part A coinsurance for skilled level care of swing-bed services provided to Medicaid/Medicare recipients.

Medicaid reimbursement will be reduced by the amount of the recipient's liability (patient income).Patient income is established by the county DFACS office and is the dollar amount shown on Form DMA-59, or the dollar amount shown on Form DMA-286 if the recipient has Medicaid/Medicare coverage. The patient's income is deducted in full from the Medicaid reimbursement rate until the income has been exhausted.

2. Cost Report and Cost Settlement

There will not be a year-end cost settlement process for the swing-bed services program. In addition, there is no swing-bed services cost report. Medicaid Swing-Bed program data should not be included in the Medicaid Hospital program cost report settlement data. The Medicaid routine swing-bed days should be excluded from the hospital's Medicaid routine days on Worksheet D-1, Part I of the cost report.

D. Public Process

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

E. Revisions

The plan will be revised as operating experience data are developed and need for changes is necessary in accordance with Federal and State regulations. If it is found that there are insufficient controls on utilization transfers or cost, or if the Department determines that a different reimbursement methodology is warranted, the Department maintains its right to discontinue this system upon appropriate public notice of the proposed change.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYES OF CARE OR SERVICE

W. Inpatient Psychiatric Facility Services (Psychiatric Residential Treatment Facility Services)

Effective July 1, 2008, Psychiatric Residential Treatment Facilities (PRTFs) will be reimbursed at provider specific prospective rates based on 2006, or more recently available cost reports, not to exceed the maximum amount of $370 per day (the cap). PRTFs will be reimbursed at a provider-specific, prospective per diem rate based on allowable costs as reported on the provider's Fiscal Year 2006, or more recent, cost reports filed with the Department of Community Health.

Annual reporting of audited allowable costs and utilization data adjusted to 90% of licensed capacity is used to find the program specific per-diem costs. DCH will apply the utilization standard of 90% of operational capacity for those PRTFs demonstrating appropriate staff to child ratios as described in Section 600.5.B. of the provider manual (Part II: Policies and Procedures for Psychiatric Residential Treatment Facilities). Reimbursement is set at the lesser of cost or approved rate cap. These rates will be trended for inflation to the mid-point of each rate year (State fiscal year), based on the CMS Hospital Market Basket (Global Insight's Health Care Cost Service, Fourth Quarter Forecast for each rate year)

Rates for PRTFs that do not have 2006, or more recent, cost reports reflective of the provision of PRTF services will be based on the median rate of other PRTF providers then in effect and shall not exceed the $370 per day. These initial rates will be subject to cost settlement and will be established as the lesser of the cost-settled rate or the cap. New PRTF providers may submit per diem rate proposals based on budgeted estimates so long as these estimates are no greater than the median of rates then in effect and shall not exceed the cap. Upon notice of the provider specific rate, providers will have 30 days to appeal their new rates based on the submission of an amended cost report.

PRTFs shall submit a cost report annually using a uniform cost report form prescribed by the Department of Community Health and supported by the facilities most recent certified financial audit. Cost reports are used as the basis for rate setting as well as establishing documentary support for federal reimbursement.

The definitions for allowable and unallowable costs and expenditures for federal claiming are based on federal criteria. These are identified in the Office of Management and Budget Circulars A-122, A-133 and A-87, "Cost Principles for Nonprofit Organizations", "Audit Principles for Non Profit Organizations" and "Cost Principles for State and Local

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The definitions for allowable and unallowable costs and expenditures for federal claiming are based on federal criteria. These are identified in the Office of Management and Budget Circulars A-122, A-133 and A-87, "Cost Principles for Nonprofit Organizations“, “Audit Principles for Non Profit Organizations” and “Cost Principles for State and Local Governments." Allocation of reasonable costs to the program shall be supported by approved methodology and documentation retained by the reporting agency.

Cost reports are subject to federal and state audit. An example of an Audit Reconciliation analysis for a fictitious Psychiatric Residential Treatment Facility is shown in the table below.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYES OF CARE OR SERVICE

Program Name:	XYZ - Residential Care Facility	
Program Vendor Number	XXXXXX	
Program Cost Totals		**Cost Report**
Personnel - Salaries (pg 2)		$7,909,494
Personnel - Fringe (pg 2)		$2,035,789
Personnel - Contract (pg 3)		$423,660
Indirect (pg 3)		$5,703,999
Consumables (pg 4)		$972,609
Occupancy (pg 5)		$716,116
Travel (pg 5)		$10,226
Equipment (pg 5)		$166,899
Total Program Cost per Cost Report		**$17,938,792**
Less revenue offsets		$17,761,462
Per diem Cost		$284
Program Cost per Audit -ENTER		$20,366,242
Variance		$2,427,449
Corp Unallowed (Alloc Depr Added)		$19,248
Education Costs		$2,207,540
Personal Client Needs/R&B Costs		$32,310
Bad Debt		$119,109
Public Relations		$23,693
Off Set Admin Income		$25,549
Total Expense Variance:		$2,427,449
Program Revenue Totals		**Cost Report**
USDA		$177,330
Other Federal		$0
DFCS		$14,302,150
DFCS OTHER		$0
DJJ		$2,671,657
Mental Health		$0
MAAC		$0
Other Public		$3,488,489
Private		$0
Total Program Revenue per Cost Report		**$20,639,626**
Program Revenues per Audit - ENTER		$20,665,175
Variance		$25,549
Admin Income Offset		$9,187
Admin. Income Offset		$16,362
Total Revenue Variance:		$25,549

PART II - CHAPTER 1000
BASIS FOR REIMBURSEMENT

1001. Reimbursement Methodology

Distinct methods of reimbursement have been established for inpatient services provided by Georgia hospitals, for outpatient services provided by Georgia hospitals, and for all services provided by non-Georgia hospitals. Descriptions of these reimbursement methods are presented in Subsections 1001.1 through 1001.4, and in Appendix C.

1001.1 Hybrid Diagnosis Related Group (DRG) Prospective Payment System

Inpatient services are reimbursed based on a hybrid-DRG prospective payment system. The majority of cases are reimbursed using a DRG per case rate based on the CHAMPUS DRG Grouper 15.0. Remaining cases are paid based on a hospital-specific cost-to-charge (CCR) system. Appendix C describes the hybrid-DRG system in greater detail.

1001.2 Reimbursement for New Hospitals

For the purposes of inpatient hospital reimbursement, a new hospital is defined as a hospital:

a) established by the initial issuance of a Certificate of Need, Medicare certification, and state license, and

b) for which historical base year paid claims data did not exist.

A hospital formed as a result of a merger, acquisition, other change of ownership, business combination, etc. is not a new hospital. Each hospital of this type will maintain the DRG-hybrid system reimbursement components it would otherwise be assigned. When rates are adjusted after the transaction, the appropriate base period information will be used in determining the hospital's rebased reimbursement components.

Reimbursement for inpatient services provided by new hospitals will vary based on when the hospital began operation.

1001.2A Hospitals Reimbursed Under the Hybrid-DRG System with Rate Components that are Not Hospital-Specific

a) A new hospital is subject to the Hybrid-DRG Prospective Payment System.

b) Within the DRG portion of the hybrid reimbursement system:

1. The DRG base rate will be the peer group base rate prior to any hospital-specific stop loss adjustment.

2. The per case capital add-on will be based on the peer group average per case capital add-on amount.

3. The per case graduate medical education add-on (if applicable) will be based on the peer group average per case graduate medical education add-on amount.

c) Within the CCR portion of the hybrid reimbursement system:

1. The CCR ratio will be based on the peer group average CCR ratio.

2. The per case capital add-on will be based on the peer group average per case capital add-on amount.

3. The per case graduate medical education add-on (if applicable) will be based on the peer group average per case graduate medical education add-on amount.

1001.3 Outpatient Services

a) Outpatient services by Georgia hospitals are reimbursed based on a determination of allowable

and reimbursable costs as determined from paid claims data.

b) The determination of allowable and reimbursable costs is made retrospectively and is based on a cost report submitted by the hospital in accordance with Section 1002 and data included in the Nonallowable Costs Questionnaire. Only costs incurred in providing patient care are eligible for reimbursement. Generally, the Provider Reimbursement Manual (HCFA-15), "Principles of Reimbursement for Provider Costs" and the pertinent policies contained in this manual serve as the basis for classifying a cost as allowable.

   Effective with dates of payment on and after July 1, 1997, the Department will reimburse for cost-based outpatient services at 90 percent of allowable operating costs plus 90 percent of allowable capital costs. The final determination of reimbursable costs will be made at the time outpatient settlements are made using audited cost reports.

c) The amount of interim payment is calculated as a particular percentage of covered charges submitted to the Department. This percentage of charges is specific to each hospital and is based on the actual experience of the hospital during the last period for which the Department has performed a cost report review. The percentage of charges represents an estimate of a payment rate which approximates the amount of subsequently determined allowable cost. An interim reimbursement rate cannot exceed ninety percent of covered charges. Interim payments are subject to a cash settlement determination as described in Section 1003.

d) All clinical diagnostic laboratory services performed for outpatients and nonpatients on and after October 1, 1984, are reimbursed at the lesser of the submitted charges or 60% of the prevailing Medicare charge level.

e) Effective with dates of payment of February 1, 1991, and after, the maximum allowable payment

for any outpatient hospital claim is the hospital-specific inpatient per case rate for participating (enrolled) hospitals. When the outpatient cost-based settlements are made, claims for outpatient services which were paid at the per case rate will be excluded from the settlement calculations.

f) Effective for dates of service April 1, 1991, and after, the Department reimburses enrolled hospitals which offer (either directly or through contract) birthing and parenting classes to Medicaid eligible pregnant women. Services may be billed once per year per recipient.

   Reimbursement is the lower of billed charges or $70. When the outpatient cost-based settlements are made, claims for outpatient services for birthing and parenting classes will be excluded from the settlement calculations.

g) Effective for dates of service July 1, 1993, and after, a $3 recipient co-payment is required on all non-emergency outpatient hospital visits. Pregnant women, recipients under twenty-one (21) years of age, nursing facility recipients, community care participants, hospice care participants and persons who have both Medicare and Medicaid coverage are not subject to the co-payment. When the outpatient cost-based settlements are made for hospital services, the co-payment plus Medicaid payment will be compared to the allowable cost to determine the amount of final settlement.

   Beginning with dates of service of January 1, 1995, co-payments will apply to the groups of recipients outlined below who were previously exempt from participation in co-payments.

   1. Dialysis recipients.
   2. Medicare/Medicaid dually eligible recipients.
   3. Recipients in waivered services programs.

   These groups are required to co-pay beginning with dates of service January 1, 1995, and after, for those services designated as co-pay services.

Maintenance dialysis services for end-stage renal disease are not designated as co-payment services and no co-payment is required for these services.

h) Effective for dates of service of July 1, 1993 and after, the professional services of certified registered nurse anesthetists (CRNAs), pediatric nurse practitioners, obstetrical nurse practitioners, family nurse practitioners, and physician's assistant anesthesiologist's assistant (PAAAs) will not be reimbursed through the Medicaid cost report. Effective July 1, 1993, CRNAs, specified nurse practitioners and PAAAs must enroll in the Medicaid program to receive payment for their services directly.

1001.4 Services Provided By Non-Georgia Hospitals

a) Participating (Enrolled) Non-Georgia Hospital

Enrolled non-Georgia hospitals will be paid based on a hybrid-DRG reimbursement system as described in b) and c) below (in greater detail in Appendix C).

Within the DRG portion of the hybrid reimbursement system:

1. The DRG base rate will be the peer group base rate prior to any hospital-specific stop loss adjustment.

2. The per case capital add-on will be based on the peer group average per case capital add-on amount.

Within the CCR portion of the hybrid reimbursement system:

1. The CCR ratio will be based on the peer group average CCR ratio.

2. The per case capital add-on will be based on the peer group average per case capital add-on amount.

Payments to non-Georgia hospitals will not be greater than the rate of payment that would be available from the Medicaid program in their home states. Outpatient services provided by enrolled non-Georgia hospitals are reimbursed at a rate of 65% of covered charges.

b) Nonparticipating (Nonenrolled) Non-Georgia Hospitals

Effective with dates of admission or service of July 1, 1989, and after, inpatient services provided by non-Georgia hospitals not enrolled in the Georgia Medicaid program are reimbursed according to rates established by the Medicaid program in the state in which the hospital is located for those procedures covered by that state. If the state in which the hospital is located reimburses DRG rates or per diem rates exceeding $999.99, reimbursement by Georgia Medicaid will be at a rate not to exceed 65% of covered charges. For procedures or services not covered by the state Medicaid program in the state in which the hospital is located, reimbursement will be at a rate of 65% of covered charges if the procedures or services are covered by Georgia Medicaid.

For certain specialized procedures for which services may not be available at the reimbursement rate as stated above, the Department may approve a percentage of charges rate in excess of 65%.

Outpatient services provided by non-Georgia hospitals not enrolled in the Georgia Medicaid program will be reimbursed at a rate of 65% of covered charges.

1001.5 Medicare Crossover Claims

Effective with dates of payment of October 1, 1990, and after, the maximum allowable payment to enrolled Georgia

and non-Georgia hospitals for Medicare inpatient and outpatient deductible and coinsurance (crossover claims) will be the applicable per case rate under the hybrid-DRG system. The maximum allowable payment to non-Georgia hospitals not enrolled in the Georgia Medicaid program for Medicare inpatient and outpatient crossover claims will be the weighted average inpatient per case rate of enrolled non-Georgia hospitals.

Effective with dates of admission on and after October 9, 1997, the Department will limit payment on outpatient Medicare crossover claims as follows: (a) multiply the allowable deductible and coinsurance amount by the hospital-specific percent of charges rate in effect on the date of payment; (b) compare the product from (a) to the applicable per case rate under the hybrid-DRG system; and (c) reimburse the lower of the two amounts in (b).

Effective with dates of payment on and after October 1, 1995, all outpatient Medicare crossover claims will be reimbursed at 100% of billed charges for Qualified Medicare Beneficiaries (QMBs) only.

1001.6 Third Party Claims

Hospital providers must attempt to pursue third party resources prior to filing a Medicaid claim. If a third party does not pay at or in excess of the applicable Medicaid reimbursement level, a hospital may submit a Medicaid claim and will be paid the applicable reimbursement less any reimbursement received from third party resources. If a third party pays at or in excess of the amount that Medicaid would pay, the hospital should not submit a claim to the Department for payment (see Part 1 Section 303, Third Party Payments). If a claim is submitted, it will be excluded from paid claims data used to establish per case rates and calculate outpatient settlements.

1001.7 Nonallowable Costs

Effective for the determination of reasonable costs used in the establishment of rates effective on and after July 1, 1991, the costs listed below are nonallowable:

1) 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;

2) Memberships in civic organizations;

3) Out-of-state travel paid by the provider for persons other than board members or those employed or contracted by the provider. Out-of-state travel for provider personnel must be related to patient care;

4) Vehicle depreciation or vehicle lease expense in excess of the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles; provided, however, such limit shall not apply to specialized patient transport vehicles (e.g., ambulances);

5) Air transport vehicles that are not used to transport patient care staff or patients. If these vehicles are sometimes used for patient care staff or patient transport, the portion of cost that is unrelated to patient care staff or patient transport is nonallowable;

6) Ten percent (10%) of membership dues for national, state, and local associations;

7) 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; and

8) 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.

Information regarding nonallowable costs for the appropriate fiscal period (as determined by the Department) will be requested from hospitals. The Nonallowable Cost Questionnaire will contain instructions for completion and the date by which the Department must receive the completed questionnaire. If the Questionnaire is not received by the due date, Medicaid payments will be withheld, as appropriate, until an acceptable Questionnaire is received.

Effective for the determination of reasonable costs used in the establishment of rates effective on and after November 1, 1991, fifty percent (50%) of membership dues for national, state and local associations are nonallowable.

Reimbursable costs will not include those reasonable costs that exceed customary charges except as outlined in HCFA Publication 15, Part 1, Chapter 26, Section 2614 (Carryover of Unreimbursed Cost).

1001.8 Reimbursement for Outlier Cases

All outlier cases under the hybrid-DRG system are determined based on cost. There are no length of stay thresholds. The determination of outliers is described further in Appendices C and M.

1001.8A Reimbursement for High Cost DRG Cases

High cost DRGs will be reimbursed a supplemental amount based on 90% of cost between the DRG base rate and the actual cost of the case.

1002. Cost Reporting Requirements

1002.1 Each participating (enrolled) hospital must submit a cost report using the appropriate Form HCFA-2552. The Department requires hospitals to list inpatient and outpatient costs and charges separately on Worksheet E-3 Part III or other revised form as appropriate.

1002.2 A hospital with a cost reporting period ending on or after June 27, 1995, must furnish its cost report within five months after its fiscal year end. If the report has not been received after this five-month period and a request for extension has not been granted, a written warning will be issued. This warning will indicate if, after an additional month (total six months), the cost report has not been received, a one hundred percent reduction will be imposed on all payments made during the period that the cost report is late.

These payments will be withheld until an acceptable Medicaid cost report is received. After the cost report is received and is determined to be acceptable, the withheld funds will be released. If the cost report is not received after a total of seven months from a hospital's fiscal year end, the hospital's agreement of participation will be subject to suspension or termination.

When a hospital undergoes a change of ownership or voluntarily or involuntarily terminates from the Medicare/Medicaid program, the hospital must notify the Department and file a terminating cost report within five (5) months of the date of termination. If a cost report is not received within this period, all Medicaid payments will be withheld until an acceptable cost report is received and accepted by the Department.

1002.3 The Department has entered into a "common audit" agreement with Blue Cross & Blue Shield of Georgia, Inc. If a hospital's Medicare fiscal intermediary is Blue Cross & Blue Shield of Georgia, Inc., the hospital's Medicaid cost report should be sent to the following address:

Provider Audit & Reimbursement Department
Blue Cross & Blue Shield of Georgia, Inc.
P.O. Box 7368
Columbus, Georgia 31908

If a hospital's Medicare fiscal intermediary is not as cited above, its Medicaid cost report should be sent to the Department at the following address:

Hospital Reimbursement Unit
Department of Medical Assistance
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159

1002.4 As part of the cost report review process, a hospital must make available to authorized representatives of the Department all medical and fiscal records, including Medicare cost reports and workpapers prepared by Medicare fiscal intermediary auditors.

1003. Cash Settlements

1003.1 As described in Subsection 1001.3(c), a determination will be made which may show that a hospital's interim payments were less than or more than a retrospectively determined settlement amount.

1003.2 Where the determination of reimbursable cost shows that additional payments due the hospital, the Department will provide payment upon receipt, review and acceptance of an audited Medicaid cost report from the intermediary. Tentative settlement will not be made based on an as-filed Medicaid cost report or an audited report which has not been reviewed and accepted by the Department.

1003.3 Where the determination of reimbursable cost shows that an overpayment has been made to a hospital, the hospital must refund the overpayment as outlined in Section 304. A hospital also must refund the Department the amount by which total Medicaid payments are in excess of total charges for Medicaid patients.

1004. Room Rate Reimbursement

1004.1 For those hospitals subject to Subsections 1001.1 and 1001.2, the Department does not reimburse for a private room under any circumstance. The difference in the cost of private and semi-private rooms should be identified and, if appropriate, excluded in the determination of allowable cost for services provided to Medicaid patients.

1004.2 For those hospitals subject to Subsections 1001.4, the Department does not reimburse for a private room under any circumstance. This provision will, if applicable, be taken into consideration for determining the appropriate payment for services provided to Medicaid patients.

1004.3 Semi-private room rate increases will be collected periodically by the Department through a survey process. The timeframe for collecting the data and incorporating new semi-private room rate changes into the claims processing system will be specified in the survey instrument.

1005. Hospital-Based Rural Health Clinics

Hospital-based rural health clinics enrolled in the Medicaid rural health clinic program are reimbursed based on a determination of allowable and reimbursable costs. The determination of such costs is made retrospectively and is based on the hospital's cost report submitted in accordance with Section 1002 and data included in the Nonallowable Costs Questionnaire. Rural health clinic services information should be included in the hospital's cost report as an outpatient services department. Hospital-based rural health clinics are reimbursed an interim rate based on the hospital's costs-to-charges ratio, and a final determination of reimbursable costs occurs at the time outpatient settlements for all hospital services are made. One hundred percent (100%) of reimbursable rural health clinic costs are included in the hospital outpatient settlements calculated as described in Section 1003. Please reference the Policies and Procedures for Rural Health Clinic Services manual for additional information.

1006. Uncompensated Costs

Subject to the availability of funds, make payment to the hospital with the highest number of inpatient Medicaid admissions in the previous fiscal year to reimburse for uncompensated inpatient Medicaid costs and medical education costs.

1007. Inpatient Co-payments

Effective for dates of admission of July 1, 1994, and after, a co-payment of $12.50 will be imposed on hospital inpatient services.

Recipients affected by the co-payment are limited to adult recipients of Supplemental Security Income (SSI) benefits, certain other adult disabled and aged recipients and parents of children receiving Aid to Families with Dependent Children (AFDC) benefits. Children under age twenty-one (21), pregnant women, nursing facility residents, home and community based waivered recipients, dialysis recipients of hospice care participants and recipients receiving family planning services are not required to pay this co-payment. In addition, persons who have both Medicare and Medicaid coverage are not required to pay the co-payment. Emergency services received by Medicaid recipients do not require a co-payment. Services cannot be denied based on the inability to pay these co-payments.

Beginning with dates of service of January 1, 1995, co-payments will apply to the groups of recipients outlined below who were previously exempt from participation in co-payments.

1. Dialysis recipients.
2. Medicare/Medicaid dually eligible recipients.
3. Recipients in waivered services programs.

These groups are required to co-pay beginning with dates of service January 1, 1995, and after, for those services designated as co-pay services.

Maintenance dialysis services for end-stage renal disease are not designated as co-pay services and no co-payment is required for these services.

APPENDIX C
DESCRIPTION OF HYBRID DIAGNOSIS RELATED GROUP (DRG) PROSPECTIVE PAYMENT SYSTEM

1. Hospitals Subject To Hybrid DRG Prospective Payment System

As described in Chapter 1000, Subsections 1001.1 and 1001.2, this reimbursement methodology is applicable to Georgia hospitals for admissions on or after October 9, 1997. It also applies to enrolled non-Georgia hospitals where noted.

2. Determination of Hybrid DRG Payment Rates

Effective with dates of admission on or after July 1, 1998, each hospital will be reimbursed for inpatient services based on a hybrid DRG prospective payment system. Within this system, an inpatient hospital claim may be reimbursed for operating cost using one of four payment calculations:

(a) Inlier Diagnosis Related Group (DRG)
(b) Outlier DRG
(c) Cost-to-Charge Ratio (CCR)

Exhibit C.1 is a list of each DRG and shows weights and cost thresholds used to evaluate claims for outlier status.

In addition to reimbursement for operating costs under one of the three methodologies above, hospitals will receive a hospital-specific per case add-on rate for capital costs (buildings and fixtures, and major movable equipment) and direct graduate medical education.

The basis for the determination of the payment rates under both the DRG and CCR methodologies is described below. All hospital-specific information is based on data from one of three sources:

(a) paid calendar year 1996 Georgia Medicaid paid claims data,

(b) for each DRG for which additional claims are needed, Georgia Medicaid paid claims data for state fiscal years 1995, 1996 and 1997 and

(b) the hospital's most recently audited Medicare cost report for hospital fiscal year 1995 or earlier as of January 30, 1998.

2.1 Calculation of the Inlier DRG Payment Hospital-Specific Base Rate (Operating Cost Reimbursement Only)

2.1.1 Calculation of the Peer Group Base Rate Before Stop Gain/Stop Loss

The peer group base rate is the average operating cost standardized for case mix of Inlier DRG cases across all cases in a peer group. For each case paid within the DRG methodology, the base rate will be multiplied by the appropriate DRG relative weight. This is the peer group base rate used in the calculation of the stop loss adjustment. If a hospital is not affected by the stop loss adjustment, the peer group base rate becomes the hospital-specific base rate.

(a) For each hospital's base year paid claims, the number of inlier cases that will be paid using the DRG methodology were identified.

(b) Inflation factors based the DRI hospital market basket minus 1 percent per year were calculated to inflate hospital claims from the claim's date of service to the midpoint of state fiscal year 1999.

(c) For each hospital's base year paid claims, the allowable charges for DRG inlier cases were identified.

(d) Allowable charges from Item 2.1.1(c) were inflated forward using the inflation factors from 2.1.1(b).

(e) For each hospital, the operating cost-to-charge ratio (CCR), which excludes capital and medical education, was obtained from the most recently audited Medicaid cost report. If the CCR was greater than 1, it was capped at 1 and then prorated between operating and capital.

(f) Total inlier DRG operating cost before adjustment for hospital case mix was obtained by multiplying Item 2.1.1(d) by Item 2.1.1(e).

(g) Per case inlier DRG operating cost before any adjustment for hospital case mix was calculated by dividing Item 2.1.1(f) by Item 2.1.1(a).

(h) Each hospital's case mix index was calculated based on base year inlier DRG claims.

(i) Total inlier DRG operating cost after adjustment for hospital case mix was then calculated by dividing Item 2.1.1(f) by Item 2.1.1(h).

(j) Per case inlier DRG operating cost after adjustment for hospital case mix was then calculated by dividing Item 2.1.1(i) by Item 2.1.1(a).

(k) Hospitals were assigned into one of three peer groups: statewide, specialty and pediatric.

(l) For all hospitals in the peer group, total inlier DRG cases from Item 2.1.1(a) above were summed across all hospitals in the peer group.

(m) For all hospitals in the peer group, the total inlier operating cost after any adjustment for hospital case mix (Item 2.1.1(i) above) have been summed across all hospitals in the peer group.

(n) Peer group inlier DRG operating cost per case were calculated by dividing 2.1.1(m) by Item 2.1.1(l). The result of this calculation was the peer group base rate before the hospital-specific stop loss adjustment.

2.1.2 Calculation of Hospital-Specific Stop Gain/Stop Loss Adjustment

A stop loss provision was implemented so that on a prospective basis the peer group base rates were adjusted to limit to 10% the amount that any hospital could lose on the DRG inlier operating cost component of the system.

(a) The estimated operating inlier DRG payment prior to add-on payment for capital and direct medical education was calculated as follows:

1. For each claim, the peer group base rate (Item 2.1.1(n)) was multiplied by the appropriate relative weight for that claim.

2. The result of 2.1.2(a)[1] summed across claims.

(b) The loss on the inlier DRG operating payment before the stop loss was calculated as the difference between the hospital-specific estimated operating payment for inlier DRG cases and total inlier DRG operating cost.

(c) For those hospitals not affected by the stop loss adjustment, the peer group base rate becomes the hospital-specific base rate amount. For those hospitals affected by the stop loss adjustment,

the hospital-specific base rate amount is the peer group base rate after the adjustment in (b) above.

(d) Operating payment for DRG inlier cases is equal to the hospital-specific base rate multiplied by the appropriate DRG relative weight.

2.2 Outlier DRG "Rates"

2.2.1 Criteria for Outlier DRG Calculation

(a) A case meets the outlier DRG criteria when it meets two (2) conditions:

1. It would normally be paid through the inlier DRG payment mechanism.

2. The operating cost of the case is more than the cost threshold stated in Exhibit C.1.

(b) In addition, a hospital must request that a claim be reviewed to assess manually if it meets the above two (2) conditions.

2.2.2 Calculation of Outlier DRG Claims and Payment

(a) In order to assess if a case meets outlier DRG criteria:

1. The total charge for a specific case will be multiplied by the hospital-specific operating CCR to calculate the cost per case.

2. The cost for the case will be compared to the outlier threshold amount for the DRG to which the case is assigned. (See Exhibit C.1 for DRG outlier thresholds)

(b) If a case qualifies as an outlier, it receives two payment components:

1. The claim will be paid the DRG base rate for the hospital multiplied by the appropriate DRG relative weight.

2 A supplemental amount equal to 90% of the difference between the dollar value of 2.2.2.(b)[1] above and the actual cost of the case.

2.3 CCR Reimbursement

2.3.1 Criteria for CCR Calculation

A case meets the CCR criteria if:

(a) The case is for a same day or one day stay (excluding delivery, false labor, death or a DRG identified for transfer cases), or

(b) the case is a transfer between hospitals for which claims are assigned to the same DRG.

Additionally, the CCR calculation amount must be less than the inlier, and if applicable, the outlier DRG payment amount. To receive consideration for any outlier payment, a hospital must request that a claim be reviewed.

2.3.2 Calculation of Operating Payments for CCR Cases

(a) Allowed charges multiplied by the hospital-specific CCR.

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

The basis for the determination of capital add-on amounts and GME add-on amounts are described below. All hospital-specific information is based on data from two sources:

(a) the hospital's most recently audited cost report for hospital fiscal year 1995 or before as of January 30, 1998 (for capital and GME add-on amounts)

(b) the hospital's capital surveys from the base year to November 15, 1997 (for capital add-on amounts only)

3.1 Calculation of the Capital Add-On Amount

(a) A Medicaid allocation ratio is used to apportion the Medicaid portion of the hospital's total capital. The allocation ratio is the hospital's Medicaid inpatient costs divided by total hospital costs.

(b) Sum the hospital's capital costs (total buildings and fixtures) and capital costs (total major movable) from the cost report.

(c) Determine the Medicaid allocation of capital costs from the cost report by multiplying the Medicaid allocation ratio (Item 3.1(a)) by total capital costs from the cost report (Item 3.1(b)).

(d) Determine the capital CCR by dividing the Medicaid allocation of capital costs (Item 3.1(c)) by the total allowed Medicaid charges for the cost report period.

(e) Calculate the base year capital costs by multiplying the capital CCR by the base year allowed charges.

(f) Calculate the preliminary capital costs per case by dividing the base year capital costs (Item 3.1(e)) by the base year number of cases.

(g) Sum the total amounts from the capital expenditure surveys.

(h) Determine the Medicaid allocation of capital costs from surveys by multiplying the Medicaid allocation ratio (Item 3.1(a)) by total capital from surveys (Item 3.1(d)).

(i) Determine the survey rate of increase by diving Item 3.1(h) by item 3.1(c).

(j) Calculate the Capital Add-On Amount by multiplying item 3.1(f) by one plus item 3.1(i).

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

Only hospitals which have GME costs in the hospital's most recently audited Medicaid cost report receive the GME add-on amount.

(a) A Medicaid allocation ratio is used to apportion the Medicaid portion of the hospital's GME. The allocation ratio is the hospital's Medicaid inpatient costs divided by total hospital costs.

(b) Use the hospital's GME costs from the cost report.

(c) Determine the Medicaid allocation of GME costs from the cost report by multiplying the Medicaid allocation ratio (Item 3.1(a)) by total GME costs from the cost report (Item 3.1(b)).

(d) Determine the GME CCR by dividing the Medicaid allocation of GME costs (Item 3.1(c)) by the total allowed Medicaid charges for the cost report period.

(e) Calculate the base year GME costs by multiplying the capital CCR by the base year allowed charges.

(f) Multiply the Medicaid GME amount (Item 3.1(e)) by the DRI inflation factor. This will yield the inflated Medicaid GME amount.

(e) Divide the total Medicaid allocation of GME (Item 3.1(f)) by the Medicaid discharges from the base year. This will yield the Medicaid GME amount per discharge.

4. **Disproportionate Share Hospitals (DSH) Payment**

4.1 Federal regulations require that methods and standards used to determine payment rates must take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs. In the month of June each year, the Department designates enrolled Georgia hospitals as disproportionate share based upon the definition below, review of annual disproportionate share hospital surveys, review of hospital cost reports, and the requirements of Section 4112 of the Omnibus Reconciliation Act of 1987. On or around June 30 of each year, hospitals will be notified of their designation as disproportionate share and the effective date thereof. A provider will not be designated a disproportionate share hospital at any other time during the year. Should a hospital lose its disproportionate share designation, it must wait until the next disproportionate share hospital designation period (June) to again be considered for the designation. A hospital serving a disproportionate number of low-income patients with special needs is defined as:

(a) One whose Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments; or

(b) One which has a low-income inpatient utilization rate exceeding 25 percent of total revenue; or

(c) One with total covered Medicaid charges for paid claims, inpatient and outpatient, exceeding 15 percent of total revenue; or

(d) A non-State hospital with the largest number of Medicaid admissions in its Metropolitan Statistical Area; or

(e) A children's hospital; or

(f) A hospital that has been designated a Regional Perinatal Center by the Department of Human Resources; or

(g) A Georgia hospital that has been designated a Medicare rural referral center and a Medicare disproportionate share hospital provider by its fiscal intermediary or a Georgia hospital which is a Medicare rural referral center and which has 10% or more Medicaid patient days and 30% or more Medicaid deliveries; or

(h) A State-owned and operated hospital administered by the Board of Regents.

(i) Effective with payment adjustments made on and after May 15, 1997, a public hospital with less than 100 beds located in a non-metropolitan statistical area (non-MSA) with an inpatient Medicaid utilization rate of at least 1%. Inpatient Medicaid utilization rate is defined as the ratio of Medicaid inpatient days to total inpatient days.

No hospital may be designated a disproportionate share hospital provider unless the hospital has at least two (2) obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid recipients. This requirement does not apply to a hospital of which the inpatients are predominately individuals under 18 years of age or to a hospital which did not offer nonemergency obstetric services to the general population as of December 22, 1987. In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

No hospital can be deemed or defined as a disproportionate share hospital unless the hospital has a Medicaid inpatient utilization rate of at least 1% and meets at least one of the nine other established DSH criteria.

For public hospitals, the DSH payments may not exceed the costs incurred during the year of furnishing hospital services by the hospital to Medicaid patients and to patients who have no health insurance (or other source of third party coverage) for services provided during the year. Payments made by a state or unit of local government to a hospital for indigent patients shall not be considered a source of third party payment.

4.2 Enrolled Georgia disproportionate share hospitals which meet one of DSH criteria one through eight will receive a payment adjustment in the form of an intensity allowance of 1 percent per year (other than base year) added to the trend factor. Hospitals which have a Medicaid inpatient utilization rate at least one standard deviation above the mean statewide rate will have an additional payment adjustment calculated which is proportional to their rates in excess of the standard deviation.

4.3 Effective with admissions on and after July 1, 1990, disproportionate share hospital (DSH) providers which directly received grant funds in 1989 from the Department of Human Resources' (DHR) Regionalized Infant Intensive Care Program will have their rates revised to include an additional DSH payment adjustment. These hospitals provide intensive care services to a disproportionate number of high risk neonates and incur significant unreimbursed costs associated with the provision of such services. The payment adjustment will include reported unreimbursed costs for neonatal intensive care and related transportation services as determined by DHR and reviewed and accepted by the Department. Effective with admissions on and after July 1, 1991, subject to the availability of funds, these hospitals wills receive monthly lump-sum DSH payment adjustments instead of adjustments to their per case rates.

4.4 Effective with dates of service of July 1, 1991, and after, subject to the availability of funds, the Department will make quarterly payment adjustments to disproportionate share teaching hospitals which participate in the Family Practice or Residency Grants Program administered by the Joint Board of Family Practice (JBFP). These hospitals operate post-graduate training programs for physicians preparing to enter family practice and other medical specialties and incur significant costs associated with the operation of such training programs. The payment will include reported graduate medical education costs for these programs as determined by the JBFP and reviewed and accepted by the Department.

4.5 Effective for dates of admission of January 1, 1991, and after, the Department will make an additional disproportionate share hospital (DSH) adjustment to recognize the significant medical education and other costs incurred by a state-owned and operated teaching hospital which are only partially reimbursed by the Department. The payment adjustment amount is calculated by increasing the hospital's per case reimbursement rate, exclusive of other DSH adjustments, up to the Medicare upper limit rate.

4.6 Effective with dates of service of July 1, 1991, and after, subject to the availability of funds, the Department will make a monthly disproportionate share payment adjustment to those DSH providers which contract with the Department of Human Resources for services provided in

the following programs: AIDS Clinic, Poison Control Center, Genetics/Sickle Cell Screening and Maternal and Infant Health Services. The DSH payments will begin on or after July 16, 1991, and will be made to reimburse for significant costs incurred in the provision of program services. The payments will be reasonably related to cost or volume of services provided by these DSH providers to Medicaid or other indigent patients.

4.7 Effective for dates of admission of July 1, 1994, and after, the DSH provider which was designated the sixth tertiary center to receive grant funds from the Department of Human Resources' Regionalized Infant Intensive Care Program, subject to the availability of funds, will receive monthly lump-sum payment adjustments. This hospital provides intensive care services to a disproportionate number of high risk neonates and incurs significant unreimbursed costs associated with the provision of such services. The payment adjustment will include reported unreimbursed costs for neonatal intensive care and related transportation services as determined by DHR and reviewed and accepted by the Department.

4.8 The Department will make a payment adjustment to disproportionate share hospitals which agree to comply with Departmental Rule 350-6-.03(3). The payment adjustment will be calculated as outlined below.

(a) Calculate a payment adjustment percentage for each DSH using the steps below:

- Add 50% for each DSH provider.
- Add 0-50% proportionally for DSH providers whose percentage of Medicaid days is greater than the statewide mean percentage of Medicaid days.
- Add 12.5% for each additional DSH criterion that a hospital meets.
- Add 0-50% proportionally based on the percentage of Medicaid births for each hospital.
- Add 25% if the hospital is the only Medicaid-enrolled hospital in its county.
- Add 0-100% proportionally for hospitals admissions greater than 1000.

- Add no more than 40% to the payment adjustment percentage for all public DSH providers prior to multiplication of that percentage by the inflated hospital-specific base year operating costs.

- Sum the percentages derived from the steps above to determine the payment adjustment package.

(b) Multiply the payment adjustment percentage by the inflated hospital-specific base year operating costs to obtain inflated operating costs for each DSH.

(c) Calculate bad debt and uncompensated services costs by multiplying these total hospital costs by the percentage of Medicaid patient days to total patient days for each DSH.

(d) Add inflated operating costs and costs of uncompensated services and bad debts and divide by the discharges to obtain the payment adjustment amount per case for each DSH.

(e) Reduce the payment adjustment all non-public hospitals by 50%.

(f) Multiply the payment adjustment amount per case by the estimated number of admissions for each DSH. The product is the estimated DSH payment adjustment. The payment adjustment amount per case is subject to adjustment by the Department.

Effective with payment adjustments made on or after May 15, 1997, and subject to the availability of funds, the Department will adjust payments to public hospitals with less than 100 beds located in a non-MSA with an inpatient Medicaid utilization rate of at least 1% which agree to comply with Department Rule 350-6-.03(3).

The payment adjustment will be calculated as outlines below.

(a) Calculate the Medicaid shortfall.

(b) Calculate the costs of rendering services to individuals with no insurance or other third-party payer.

(c) Determine Medicaid admissions for each hospital's base fiscal year.

(d) Calculate base year cost per admission by adding (a) and (b) and dividing by (c) above.

(e) Multiply base year cost per admission by estimated Medicaid admissions for the current federal fiscal year.

As a condition of receipt of the DSH payment adjustment, disproportionate share hospitals must agree to the requirements outlined in the Letter of Understanding, an example of which is included in this Appendix. The hospital must sign and return to the Department the Letter of Understanding in order to receive a DSH payment adjustment.

Public DSH providers are limited to a calculated disproportionate share payment cap for the 1995 state fiscal year. The DSH cap limits public providers to uncompensated medical care costs. Public hospitals can exceed the DSH payment cap by up to 200%, in the 1995 state fiscal year only, if the state certifies the monies above the cap are used for health services.

Effective with DSH payments made on and after July 1, 1995, all DSH providers are subject to a hospital-specific DSH limit. The limit is defined as outlined below.

(Costs of Medicaid services LESS Medicaid non-DSH payments) PLUS (Costs of services to individuals with no insurance or other third-party coverage LESS payments received from individuals with no insurance or other third-party coverage)

5. **Adjustments to Rate (Georgia Hospitals Only)**

5.1 The Department will issue survey forms for completion by hospitals to document any changes for any additional building and fixed equipment costs associated with a Certificate of Need approved capital improvement since the hospital's base year. Surveys received after the due date will not be used to increase a hospital's per case rate.

5.2 Effective with per case rates calculated for dates of admission on and after July 1, 1993, costs related to the professional services of certified registered nurse anesthetists (CRNAs), pediatric nurse practitioners, obstetrical nurse practitioners and family nurse practitioners will be excluded from base year costs prior to calculating the rates. Effective July 1, 1993, CRNAs and specified nurse practitioners must enroll in the Medicaid program to receive payment for their services directly.

5.3 The Department reviews a hospital's cost report to verify various rate components. The reimbursement methodology assumes that services in the base period will continue; therefore, audited cost reports are reviewed to determine that all services and facilities included in the base period will

continue in the reimbursement year. Additionally, all surveyed items are subject to verification. As appropriate, the Department's findings on such items may cause a hospital's rate of payment to be adjusted.

6. **Settlement**

For payments occurring during each calendar year, a comparison of a hospital's total Medicaid payments and its total charges will be made after completion of the calendar year. A refund will be due from the hospital for any amount by which total Medicaid payments are in excess of a hospital's total charges for Medicaid patients. For enrolled non-Georgia hospitals, the comparison will be made beginning with payments and charges for admissions occurring during calendar year 1990 and after. Total Medicaid payments included in the comparison shall not include payment adjustments made to disproportionate share hospitals, but will include inpatient co-payment amounts that the hospitals should collect from recipients. There will be no other cash settlements except as noted in Sections 1001.3, and 1006.

7. **Amended Cost Reports**

An amended, audited cost report will not be recognized for the purpose of adjusting reimbursable costs (outpatient) if the amended cost report is received more than three (3) years after the initial audit of the cost report is completed. (For definition purposes, this date is established as the date of initial notification of audit completion to the provider.) The Department's paid claims data used with the audited cost report will be used with the amended cost report to calculate the revised per case rate and outpatient settlement.

8. **Transfer Cases**

If a patient is transferred from one hospital for admission to a second hospital for medically appropriate cause and the claims for both hospitals fall into the same DRG, both hospitals will be eligible for payment. If the claims would otherwise be paid under the DRG rate methodology, each hospital's payment will be the lesser of the DRG rate or a rate calculated by the CCR methodology. If a patient is transferred from one hospital for admission to a second hospital for medically appropriate cause and the claims for both hospitals fall into different DRGs, each hospital's payment will the amount that a non-transfer claim would be paid.

EXHIBIT C.1
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
1 CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	$61,798.67	6.0437
2 CRANIOTOMY FOR TRAUMA AGE >17	$62,585.79	6.1050
3 CRANIOTOMY AGE 0-17	$77,862.51	4.4117
4 SPINAL PROCEDURES	$26,418.82	2.0091
5 EXTRACRANIAL VASCULAR PROCEDURES	$28,462.91	2.5409
6 CARPAL TUNNEL RELEASE	$26,418.82	2.0091
7 PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	$26,418.82	2.0091
8 PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	$26,418.82	2.0091
9 SPINAL DISORDERS & INJURIES	$83,636.65	7.8905
10 NERVOUS SYSTEM NEOPLASMS W CC	$32,511.50	1.6731
11 NERVOUS SYSTEM NEOPLASMS W/O CC	$26,418.82	2.0091
12 DEGENERATIVE NERVOUS SYSTEM DISORDERS	$36,432.93	2.1164
13 MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	$26,418.82	2.0091
14 SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	$35,333.37	2.4431
15 TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS	$20,184.06	1.0671
16 NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	$26,418.82	2.0091
17 NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	$26,418.82	2.0091
18 CRANIAL & PERIPHERAL NERVE DISORDERS W CC	$20,184.06	1.2496
19 CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	$20,184.06	0.8823
20 NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	$40,860.94	2.4677
21 VIRAL MENINGITIS	$20,184.06	0.7989
22 HYPERTENSIVE ENCEPHALOPATHY	$26,418.82	2.0091
23 NONTRAUMATIC STUPOR & COMA	$26,418.82	2.0091
24 SEIZURE & HEADACHE AGE >17 W CC	$20,184.06	1.2143
25 SEIZURE & HEADACHE AGE >17 W/O CC	$20,184.06	0.9447
26 SEIZURE & HEADACHE AGE 0-17	$20,184.06	0.7985
27 TRAUMATIC STUPOR & COMA, COMA >1 HR	$26,418.82	2.0091
28 TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	$26,418.82	2.0091
29 TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	$26,418.82	2.0091
30 TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	$24,477.14	1.1600
31 CONCUSSION AGE >17 W CC	$26,418.82	2.0091
32 CONCUSSION AGE >17 W/O CC	$26,418.82	2.0091
33 CONCUSSION AGE 0-17	$26,418.82	2.0091
34 OTHER DISORDERS OF NERVOUS SYSTEM W CC	$40,763.32	2.0865
35 OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	$26,418.82	2.0091
36 RETINAL PROCEDURES	$161,018.72	1.6637
37 ORBITAL PROCEDURES	$20,184.06	1.2509
38 PRIMARY IRIS PROCEDURES	$20,184.06	1.2509
39 LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	$20,184.06	1.2509
40 EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	$20,184.06	1.2509
41 EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	$20,184.06	1.2509
42 INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	$20,184.06	1.2509
43 HYPHEMA	$20,184.06	1.2509
44 ACUTE MAJOR EYE INFECTIONS	$20,184.06	0.5625
45 NEUROLOGICAL EYE DISORDERS	$20,184.06	1.2509

EXHIBIT C.1
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
46 OTHER DISORDERS OF THE EYE AGE >17 W CC	$20,184.06	1.2509
47 OTHER DISORDERS OF THE EYE AGE >17 W/O CC	$20,184.06	1.2509
48 OTHER DISORDERS OF THE EYE AGE 0-17	$20,184.06	1.2509
49 MAJOR HEAD & NECK PROCEDURES	$20,184.06	1.1831
50 SIALOADENECTOMY	$20,184.06	1.1831
51 SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	$20,184.06	1.1831
52 CLEFT LIP & PALATE REPAIR	$20,184.06	1.1831
53 SINUS & MASTOID PROCEDURES AGE >17	$20,184.06	1.1831
54 SINUS & MASTOID PROCEDURES AGE 0-17	$20,184.06	1.1831
55 MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	$20,184.06	1.1831
56 RHINOPLASTY	$20,184.06	1.1831
57 T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE	$20,184.06	1.1831
58 T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE	$20,184.06	1.1831
59 TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	$20,184.06	1.1831
60 TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	$20,184.06	1.1831
61 MYRINGOTOMY W TUBE INSERTION AGE >17	$20,184.06	1.1831
62 MYRINGOTOMY W TUBE INSERTION AGE 0-17	$20,184.06	1.0377
63 OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	$40,547.62	2.5659
64 EAR, NOSE, MOUTH & THROAT MALIGNANCY	$20,184.06	1.1831
65 DYSEQUILIBRIUM	$20,184.06	1.1831
66 EPISTAXIS	$20,184.06	1.1831
67 EPIGLOTTITIS	$20,184.06	1.1831
68 OTITIS MEDIA & URI AGE >17 W CC	$20,184.06	0.7417
69 OTITIS MEDIA & URI AGE >17 W/O CC	$20,184.06	0.6325
70 OTITIS MEDIA & URI AGE 0-17	$20,184.06	0.5118
71 LARYNGOTRACHEITIS	$20,184.06	0.5941
72 NASAL TRAUMA & DEFORMITY	$20,184.06	1.1831
73 OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	$20,184.06	1.1831
74 OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	$20,184.06	1.1831
75 MAJOR CHEST PROCEDURES	$60,166.66	4.9188
76 OTHER RESP SYSTEM O.R. PROCEDURES W CC	$55,402.40	3.6667
77 OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	$29,180.85	1.4834
78 PULMONARY EMBOLISM	$20,184.06	2.2006
79 RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	$31,971.46	2.2529
80 RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	$20,184.06	1.2499
81 RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	$39,596.15	1.8729
82 RESPIRATORY NEOPLASMS	$20,184.06	1.8003
83 MAJOR CHEST TRAUMA W CC	$29,180.85	1.4834
84 MAJOR CHEST TRAUMA W/O CC	$29,180.85	1.4834
85 PLEURAL EFFUSION W CC	$20,184.06	1.5472
86 PLEURAL EFFUSION W/O CC	$29,180.85	1.4834
87 PULMONARY EDEMA & RESPIRATORY FAILURE	$51,274.11	2.7129
88 CHRONIC OBSTRUCTIVE PULMONARY DISEASE	$20,184.06	1.3590
89 SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	$20,184.06	1.4810
90 SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	$20,184.06	1.0153

EXHIBIT C.1
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
91 SIMPLE PNEUMONIA & PLEURISY AGE 0-17	$20,184.06	0.7169
92 INTERSTITIAL LUNG DISEASE W CC	$20,184.06	1.3253
93 INTERSTITIAL LUNG DISEASE W/O CC	$29,180.85	1.4834
94 PNEUMOTHORAX W CC	$20,184.06	1.5038
95 PNEUMOTHORAX W/O CC	$20,184.06	0.8020
96 BRONCHITIS & ASTHMA AGE >17 W CC	$20,184.06	1.0341
97 BRONCHITIS & ASTHMA AGE >17 W/O CC	$20,184.06	0.8192
98 BRONCHITIS & ASTHMA AGE 0-17	$20,184.06	0.7255
99 RESPIRATORY SIGNS & SYMPTOMS W CC	$38,026.59	1.4193
100 RESPIRATORY SIGNS & SYMPTOMS W/O CC	$20,184.06	0.7076
101 OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	$22,288.55	1.4014
102 OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	$20,184.06	0.6364
103 HEART TRANSPLANT	$27,861.56	1.8842
104 CARDIAC VALVE PROCEDURES W CARDIAC CATH	$92,117.34	11.2066
105 CARDIAC VALVE PROCEDURES W/O CARDIAC CATH	$77,284.78	8.5732
106 CORONARY BYPASS W CARDIAC CATH	$39,027.30	6.4173
107 CORONARY BYPASS W/O CARDIAC CATH	$45,343.68	5.3786
108 OTHER CARDIOTHORACIC PROCEDURES	$115,008.44	8.1418
110 MAJOR CARDIOVASCULAR PROCEDURES W CC	$89,288.39	6.5028
111 MAJOR CARDIOVASCULAR PROCEDURES W/O CC	$24,611.96	3.3711
112 PERCUTANEOUS CARDIOVASCULAR PROCEDURES	$20,846.83	2.5982
113 AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	$59,626.01	4.1308
114 UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	$20,184.06	2.2415
115 PERM CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK	$27,861.56	1.8842
116 OTH PERM CARDIAC PACEMAKER IMPLANT OR AICD LEAD OR GENERATOR	$108,547.62	4.0352
117 CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	$27,861.56	1.8842
118 CARDIAC PACEMAKER DEVICE REPLACEMENT	$27,861.56	1.8842
119 VEIN LIGATION & STRIPPING	$27,861.56	1.8842
120 OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	$41,165.25	2.7375
121 CIRCULATORY DISORDERS W AMI & C.V. COMP DISCH ALIVE	$20,184.06	2.0019
122 CIRCULATORY DISORDERS W AMI W/O C.V. COMP DISCH ALIVE	$20,184.06	1.8347
123 CIRCULATORY DISORDERS W AMI, EXPIRED	$27,861.56	1.8842
124 CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	$24,495.16	1.7892
125 CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DI	$20,184.06	1.6272
126 ACUTE & SUBACUTE ENDOCARDITIS	$27,861.56	1.8842
127 HEART FAILURE & SHOCK	$20,184.06	1.2750
128 DEEP VEIN THROMBOPHLEBITIS	$20,184.06	1.1252
129 CARDIAC ARREST, UNEXPLAINED	$27,861.56	1.8842
130 PERIPHERAL VASCULAR DISORDERS W CC	$20,184.06	1.3445
131 PERIPHERAL VASCULAR DISORDERS W/O CC	$22,177.21	1.0046
132 ATHEROSCLEROSIS W CC	$20,184.06	1.1203
133 ATHEROSCLEROSIS W/O CC	$27,861.56	1.8842
134 HYPERTENSION	$20,184.06	0.8440
135 CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	$27,861.56	1.8842
136 CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	$27,861.56	1.8842

EXHIBIT C.1
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
137 CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	$27,861.56	1.8842
138 CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	$20,184.06	1.1653
139 CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	$20,184.06	0.7655
140 ANGINA PECTORIS	$20,184.06	0.9114
141 SYNCOPE & COLLAPSE W CC	$20,184.06	0.8962
142 SYNCOPE & COLLAPSE W/O CC	$20,184.06	0.7040
143 CHEST PAIN	$20,184.06	0.8921
144 OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	$51,420.26	1.9821
145 OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	$27,861.56	1.8842
146 RECTAL RESECTION W CC	$20,184.06	1.6640
147 RECTAL RESECTION W/O CC	$20,184.06	1.6640
148 MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	$74,674.48	5.4835
149 MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	$20,184.06	2.1626
150 PERITONEAL ADHESIOLYSIS W CC	$65,412.09	4.0322
151 PERITONEAL ADHESIOLYSIS W/O CC	$20,184.06	1.5674
152 MINOR SMALL & LARGE BOWEL PROCEDURES W CC	$20,184.06	1.6640
153 MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	$20,184.06	1.7735
154 STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	$75,654.77	5.5624
155 STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	$20,184.06	2.2487
156 STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	$47,377.59	2.0053
157 ANAL & STOMAL PROCEDURES W CC	$20,184.06	1.6640
158 ANAL & STOMAL PROCEDURES W/O CC	$20,184.06	1.1318
159 HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	$20,184.06	1.9993
160 HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	$20,184.06	1.4504
161 INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	$20,184.06	1.6640
162 INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	$20,184.06	1.6640
163 HERNIA PROCEDURES AGE 0-17	$20,184.06	1.6640
164 APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	$35,536.38	3.0764
165 APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	$20,184.06	1.6640
166 APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	$20,184.06	1.5733
167 APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	$20,184.06	1.1659
168 MOUTH PROCEDURES W CC	$20,184.06	1.1831
169 MOUTH PROCEDURES W/O CC	$20,184.06	1.1831
170 OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	$20,184.06	1.6640
171 OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	$20,184.06	1.6640
172 DIGESTIVE MALIGNANCY W CC	$29,325.15	1.9166
173 DIGESTIVE MALIGNANCY W/O CC	$20,184.06	1.6640
174 G.I. HEMORRHAGE W CC	$20,184.06	1.3616
175 G.I. HEMORRHAGE W/O CC	$20,184.06	0.8550
176 COMPLICATED PEPTIC ULCER	$31,921.87	1.4590
177 UNCOMPLICATED PEPTIC ULCER W CC	$20,184.06	1.0245
178 UNCOMPLICATED PEPTIC ULCER W/O CC	$20,184.06	0.8030
179 INFLAMMATORY BOWEL DISEASE	$29,339.19	1.6516
180 G.I. OBSTRUCTION W CC	$20,184.06	1.1615
181 G.I. OBSTRUCTION W/O CC	$20,184.06	0.6998

EXHIBIT C.1
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
182 ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	$20,184.06	0.9784
183 ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O C	$20,184.06	0.8620
184 ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	$20,184.06	0.4725
185 DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	$20,184.06	1.1831
186 DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-1	$20,184.06	1.1831
187 DENTAL EXTRACTIONS & RESTORATIONS	$20,184.06	1.1831
188 OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	$38,375.83	1.6346
189 OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	$20,184.06	1.6640
190 OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	$20,184.06	1.6640
191 PANCREAS, LIVER & SHUNT PROCEDURES W CC	$89,212.86	6.8823
192 PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	$20,184.06	2.1599
193 BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W C	$20,184.06	2.1599
194 BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O	$20,184.06	2.1599
195 CHOLECYSTECTOMY W C.D.E. W CC	$27,013.59	2.9647
196 CHOLECYSTECTOMY W C.D.E. W/O CC	$20,184.06	2.1599
197 CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	$41,763.60	3.1077
198 CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	$20,184.06	1.6949
199 HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	$20,184.06	2.1599
200 HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	$20,184.06	2.1599
201 OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	$20,184.06	2.1599
202 CIRRHOSIS & ALCOHOLIC HEPATITIS	$30,259.17	1.9225
203 MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	$20,798.37	1.6636
204 DISORDERS OF PANCREAS EXCEPT MALIGNANCY	$23,062.55	1.3223
205 DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	$29,013.98	1.6204
206 DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	$20,184.06	2.1599
207 DISORDERS OF THE BILIARY TRACT W CC	$20,184.06	1.2958
208 DISORDERS OF THE BILIARY TRACT W/O CC	$20,184.06	0.8116
209 MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMIT	$25,174.40	3.7027
210 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	$26,002.54	2.7308
211 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	$20,184.06	2.2398
212 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	$20,184.06	2.0071
213 AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDER	$20,184.06	1.4485
216 BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	$20,184.06	1.4485
217 WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS	$49,376.34	3.8545
218 LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC	$20,184.06	2.3265
219 LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O	$20,184.06	1.8071
220 LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17	$20,184.06	1.6391
223 MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W C	$20,184.06	1.5628
224 SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC	$20,184.06	1.3474
225 FOOT PROCEDURES	$20,184.06	1.5180
226 SOFT TISSUE PROCEDURES W CC	$20,184.06	1.4485
227 SOFT TISSUE PROCEDURES W/O CC	$20,184.06	1.4322
228 MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC	$20,184.06	1.4485
229 HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	$20,184.06	1.4485
230 LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	$20,184.06	1.4485

EXHIBIT C.1
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
231 LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEM	$27,444.19	2.0810
232 ARTHROSCOPY	$20,184.06	1.4485
233 OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	$20,184.06	1.4485
234 OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	$20,184.06	2.6611
235 FRACTURES OF FEMUR	$20,184.06	1.1647
236 FRACTURES OF HIP & PELVIS	$20,184.06	1.4485
237 SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	$20,184.06	1.4485
238 OSTEOMYELITIS	$29,864.75	1.8614
239 PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNA	$28,440.97	1.7804
240 CONNECTIVE TISSUE DISORDERS W CC	$44,293.09	1.8289
241 CONNECTIVE TISSUE DISORDERS W/O CC	$20,184.06	1.4485
242 SEPTIC ARTHRITIS	$20,184.06	1.4485
243 MEDICAL BACK PROBLEMS	$20,184.06	1.0289
244 BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	$20,184.06	1.4485
245 BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	$20,184.06	1.4485
246 NON-SPECIFIC ARTHROPATHIES	$20,184.06	1.4485
247 SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	$20,184.06	1.4485
248 TENDONITIS, MYOSITIS & BURSITIS	$20,184.06	1.4485
249 AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	$20,184.06	1.4485
250 FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	$20,184.06	1.4485
251 FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	$20,184.06	1.4485
252 FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	$20,184.06	1.4485
253 FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	$20,184.06	1.4485
254 FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	$20,184.06	1.4485
255 FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	$20,184.06	1.4485
256 OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	$20,184.06	1.4485
257 TOTAL MASTECTOMY FOR MALIGNANCY W CC	$20,184.06	1.5351
258 TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	$20,184.06	1.4023
259 SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	$20,184.06	1.1936
260 SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	$20,184.06	1.1936
261 BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISIO	$20,184.06	1.6911
262 BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	$20,184.06	1.1936
263 SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	$65,491.23	4.1509
264 SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	$20,184.06	1.1936
265 SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W	$20,184.06	1.1936
266 SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W	$20,184.06	1.6914
267 PERIANAL & PILONIDAL PROCEDURES	$20,184.06	1.1936
268 SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	$20,184.06	1.1936
269 OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	$39,081.73	2.5615
270 OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	$21,346.72	1.2069
271 SKIN ULCERS	$28,528.84	1.6467
272 MAJOR SKIN DISORDERS W CC	$20,184.06	1.1936
273 MAJOR SKIN DISORDERS W/O CC	$20,184.06	1.1936
274 MALIGNANT BREAST DISORDERS W CC	$20,184.06	1.1936
275 MALIGNANT BREAST DISORDERS W/O CC	$20,184.06	1.1936

EXHIBIT C.1
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
276 NON-MALIGANT BREAST DISORDERS	$20,184.06	0.7779
277 CELLULITIS AGE >17 W CC	$20,184.06	1.2077
278 CELLULITIS AGE >17 W/O CC	$20,184.06	0.8399
279 CELLULITIS AGE 0-17	$20,184.06	0.6267
280 TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	$20,184.06	1.1936
281 TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	$20,184.06	1.1936
282 TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	$20,184.06	1.1936
283 MINOR SKIN DISORDERS W CC	$20,184.06	1.1936
284 MINOR SKIN DISORDERS W/O CC	$20,184.06	1.1936
285 AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDE	$20,184.06	1.9338
286 ADRENAL & PITUITARY PROCEDURES	$20,184.06	1.9338
287 SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDE	$20,184.06	1.9338
288 O.R. PROCEDURES FOR OBESITY	$20,184.06	1.9338
289 PARATHYROID PROCEDURES	$20,184.06	1.9338
290 THYROID PROCEDURES	$20,184.06	1.4509
291 THYROGLOSSAL PROCEDURES	$20,184.06	1.9338
292 OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	$20,184.06	1.9338
293 OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	$20,184.06	1.9338
294 DIABETES AGE >35	$20,184.06	0.9921
295 DIABETES AGE 0-35	$20,184.06	0.7919
296 NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	$20,184.06	1.2206
297 NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	$20,184.06	0.7521
298 NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	$20,184.06	0.5487
299 INBORN ERRORS OF METABOLISM	$20,184.06	1.9338
300 ENDOCRINE DISORDERS W CC	$20,184.06	1.9338
301 ENDOCRINE DISORDERS W/O CC	$20,184.06	1.9338
302 KIDNEY TRANSPLANT	$20,184.06	1.2201
303 KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	$29,975.18	3.5893
304 KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	$48,262.60	2.9291
305 KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	$20,184.06	1.8184
306 PROSTATECTOMY W CC	$20,184.06	1.2201
307 PROSTATECTOMY W/O CC	$20,184.06	1.2201
308 MINOR BLADDER PROCEDURES W CC	$20,184.06	1.2201
309 MINOR BLADDER PROCEDURES W/O CC	$20,184.06	1.2201
310 TRANSURETHRAL PROCEDURES W CC	$20,184.06	1.8149
311 TRANSURETHRAL PROCEDURES W/O CC	$27,901.51	1.3809
312 URETHRAL PROCEDURES, AGE >17 W CC	$20,184.06	1.2201
313 URETHRAL PROCEDURES, AGE >17 W/O CC	$20,184.06	1.2201
314 URETHRAL PROCEDURES, AGE 0-17	$20,184.06	1.2201
315 OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	$52,455.61	2.7267
316 RENAL FAILURE	$24,112.77	1.5255
317 ADMIT FOR RENAL DIALYSIS	$20,184.06	1.2201
318 KIDNEY & URINARY TRACT NEOPLASMS W CC	$20,184.06	1.2201
319 KIDNEY & URINARY TRACT NEOPLASMS W/O CC	$20,184.06	1.2201
320 KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	$20,184.06	1.0176

EXHIBIT C.1
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
321 KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	$20,184.06	0.7323
322 KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	$20,184.06	0.6313
323 URINARY STONES W CC, &/OR ESW LITHOTRIPSY	$20,184.06	1.1927
324 URINARY STONES W/O CC	$20,184.06	0.7690
325 KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	$20,184.06	1.2201
326 KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	$25,714.73	1.2201
327 KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	$20,184.06	1.2201
328 URETHRAL STRICTURE AGE >17 W CC	$20,184.06	1.2201
329 URETHRAL STRICTURE AGE >17 W/O CC	$20,184.06	1.2201
330 URETHRAL STRICTURE AGE 0-17	$20,184.06	1.2201
331 OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	$20,184.06	1.3303
332 OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	$20,184.06	1.2201
333 OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	$20,184.06	1.2201
334 MAJOR MALE PELVIC PROCEDURES W CC	$20,184.06	1.3392
335 MAJOR MALE PELVIC PROCEDURES W/O CC	$20,184.06	1.3392
336 TRANSURETHRAL PROSTATECTOMY W CC	$20,184.06	1.3392
337 TRANSURETHRAL PROSTATECTOMY W/O CC	$20,184.06	1.3392
338 TESTES PROCEDURES, FOR MALIGNANCY	$20,184.06	1.3392
339 TESTES PROCEDURES, NON-MALIGNANCY AGE >17	$20,184.06	1.3392
340 TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	$20,184.06	1.3392
341 PENIS PROCEDURES	$20,184.06	1.3392
342 CIRCUMCISION AGE >17	$20,184.06	1.3392
343 CIRCUMCISION AGE 0-17	$20,184.06	1.3392
344 OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANC	$20,184.06	1.3392
345 OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNAN	$20,184.06	1.3392
346 MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	$20,184.06	1.3392
347 MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	$20,184.06	1.3392
348 BENIGN PROSTATIC HYPERTROPHY W CC	$20,184.06	1.3392
349 BENIGN PROSTATIC HYPERTROPHY W/O CC	$20,184.06	1.3392
350 INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	$20,184.06	1.3392
351 STERILIZATION, MALE	$20,184.06	1.3392
352 OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	$20,184.06	1.3392
353 PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTO	$20,184.06	1.5474
354 UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	$20,184.06	1.5474
355 UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	$20,184.06	1.3154
356 FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	$20,184.06	1.3010
357 UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	$20,184.06	1.5474
358 UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	$20,184.06	1.7649
359 UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	$20,184.06	1.3242
360 VAGINA, CERVIX & VULVA PROCEDURES	$20,184.06	1.4014
361 LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	$20,184.06	1.5957
362 ENDOSCOPIC TUBAL INTERRUPTION	$20,184.06	1.5474
363 D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	$20,184.06	1.5474
364 D&C, CONIZATION EXCEPT FOR MALIGNANCY	$20,184.06	1.5474
365 OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	$25,211.73	2.0063

EXHIBIT C.1
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
366 MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	$20,184.06	1.5474
367 MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	$20,184.06	1.5474
368 INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	$20,184.06	0.7523
369 MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	$20,184.06	0.7065
370 CESAREAN SECTION W CC	$20,184.06	1.1532
371 CESAREAN SECTION W/O CC	$20,184.06	0.9167
372 VAGINAL DELIVERY W COMPLICATING DIAGNOSES	$20,184.06	0.7216
373 VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	$20,184.06	0.4935
374 VAGINAL DELIVERY W STERILIZATION &/OR D&C	$20,184.06	0.7278
375 VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	$20,184.06	1.4350
376 POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	$20,184.06	0.7408
377 POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	$20,184.06	1.4350
378 ECTOPIC PREGNANCY	$20,184.06	1.3542
379 THREATENED ABORTION	$20,184.06	0.7743
380 ABORTION W/O D&C	$20,184.06	0.7584
381 ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	$20,184.06	1.0604
382 FALSE LABOR	$20,184.06	0.5475
383 OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	$20,184.06	0.6420
384 OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	$20,184.06	0.7382
391 NORMAL NEWBORN	$20,184.06	0.3113
392 SPLENECTOMY AGE >17	$20,184.06	2.0784
393 SPLENECTOMY AGE 0-17	$20,184.06	2.0784
394 OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	$20,184.06	2.0784
395 RED BLOOD CELL DISORDERS AGE >17	$22,451.37	1.2974
396 RED BLOOD CELL DISORDERS AGE 0-17	$26,481.29	0.8955
397 COAGULATION DISORDERS	$26,019.43	1.4898
398 RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	$20,184.06	1.4906
399 RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	$20,184.06	0.7090
400 LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	$28,935.87	2.6931
401 LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	$28,935.87	2.6931
402 LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	$28,935.87	2.6931
403 LYMPHOMA & NON-ACUTE LEUKEMIA W CC	$43,255.29	2.4971
404 LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	$28,935.87	2.6931
405 ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	$28,935.87	2.6931
406 MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	$28,935.87	2.6931
407 MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O C	$28,935.87	2.6931
408 MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	$28,935.87	2.6931
409 RADIOTHERAPY	$28,935.87	2.6931
410 CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	$20,184.06	1.6163
411 HISTORY OF MALIGNANCY W/O ENDOSCOPY	$28,935.87	2.6931
412 HISTORY OF MALIGNANCY W ENDOSCOPY	$28,935.87	2.6931
413 OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	$28,935.87	2.6931
414 OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	$28,935.87	2.6931
415 O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	$69,817.77	4.8915
416 SEPTICEMIA AGE >17	$29,426.16	2.1843

EXHIBIT C.1
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
417 SEPTICEMIA AGE 0-17	$20,184.06	0.8200
418 POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	$20,184.06	1.1284
419 FEVER OF UNKNOWN ORIGIN AGE >17 W CC	$20,184.06	1.2345
420 FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	$20,184.06	1.3211
421 VIRAL ILLNESS AGE >17	$20,184.06	0.9821
422 VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	$20,184.06	0.5818
423 OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	$20,184.06	1.3211
424 O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	$20,184.06	1.7737
425 ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTIO	$20,184.06	0.8558
426 DEPRESSIVE NEUROSES	$20,184.06	0.5772
427 NEUROSES EXCEPT DEPRESSIVE	$20,184.06	0.5856
428 DISORDERS OF PERSONALITY & IMPULSE CONTROL	$20,184.06	0.7563
429 ORGANIC DISTURBANCES & MENTAL RETARDATION	$20,758.55	1.0048
430 PSYCHOSES	$20,184.06	0.7590
431 CHILDHOOD MENTAL DISORDERS	$20,184.06	0.7855
432 OTHER MENTAL DISORDER DIAGNOSES	$20,184.06	1.7737
433 ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	$20,184.06	0.5653
434 ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W CC	$20,184.06	0.9478
436 ALC/DRUG DEPENDENCE W REHABILITATION THERAPY	$20,184.06	0.5653
437 ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY	$20,184.06	0.5653
439 SKIN GRAFTS FOR INJURIES	$20,184.06	1.4422
440 WOUND DEBRIDEMENTS FOR INJURIES	$20,184.06	1.4422
441 HAND PROCEDURES FOR INJURIES	$20,184.06	1.4422
442 OTHER O.R. PROCEDURES FOR INJURIES W CC	$20,184.06	1.4422
443 OTHER O.R. PROCEDURES FOR INJURIES W/O CC	$20,184.06	1.4422
444 TRAUMATIC INJURY AGE >17 W CC	$20,184.06	1.4422
445 TRAUMATIC INJURY AGE >17 W/O CC	$20,184.06	1.4422
446 TRAUMATIC INJURY AGE 0-17	$20,184.06	1.4422
447 ALLERGIC REACTIONS AGE >17	$20,184.06	1.4422
448 ALLERGIC REACTIONS AGE 0-17	$20,184.06	1.4422
449 POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	$20,184.06	1.2205
450 POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	$20,184.06	0.6900
451 POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	$20,184.06	0.6794
452 COMPLICATIONS OF TREATMENT W CC	$20,184.06	1.4422
453 COMPLICATIONS OF TREATMENT W/O CC	$20,184.06	1.4422
454 OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	$20,184.06	1.4422
455 OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	$20,184.06	1.4422
456 BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	$25,714.73	2.7891
457 EXTENSIVE BURNS W/O O.R. PROCEDURE	$25,714.73	2.7891
458 NON-EXTENSIVE BURNS W SKIN GRAFT	$25,714.73	2.7891
459 NON-EXTENSIVE BURNS W WOUND DEBRIDEMENT OR OTHER O.R. PROC	$25,714.73	2.7891
460 NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	$20,184.06	0.9266
461 O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	$20,184.06	1.0507
462 REHABILITATION	$20,184.06	1.0507
463 SIGNS & SYMPTOMS W CC	$20,184.06	1.1670

EXHIBIT C.1
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
464 SIGNS & SYMPTOMS W/O CC	$20,184.06	1.0507
465 AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	$20,184.06	1.0507
466 AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	$20,184.06	1.0507
467 OTHER FACTORS INFLUENCING HEALTH STATUS	$20,184.06	0.5626
468 EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	$80,629.31	4.6159
469 PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	$0.00	0.0000
470 UNGROUPABLE	$0.00	0.0000
471 BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	$20,184.06	1.4485
472 EXTENSIVE BURNS W O.R. PROCEDURE	$25,714.73	2.7891
473 ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	$28,935.87	2.6931
475 RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	$94,403.18	6.5415
476 PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	$122,705.06	17.6221
477 NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSI	$49,385.67	2.6508
478 OTHER VASCULAR PROCEDURES W CC	$39,172.80	3.5051
479 OTHER VASCULAR PROCEDURES W/O CC	$22,812.11	2.4340
480 LIVER TRANSPLANT	$122,705.06	17.6221
481 BONE MARROW TRANSPLANT	$122,705.06	17.6221
482 TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	$72,582.56	6.1506
483 TRACHEOSTOMY EXCEPT FOR FACE,MOUTH & NECK DIAGNOSES	$350,066.39	28.2892
484 CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	$54,816.16	7.8370
485 LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICA	$54,816.16	7.8370
486 OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	$105,421.92	8.0937
487 OTHER MULTIPLE SIGNIFICANT TRAUMA	$76,041.04	4.7193
488 HIV W EXTENSIVE O.R. PROCEDURE	$32,707.96	5.0614
489 HIV W MAJOR RELATED CONDITION	$30,733.50	1.9373
490 HIV W OR W/O OTHER RELATED CONDITION	$20,184.06	1.3451
491 MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMIT	$20,184.06	2.5348
492 CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	$20,184.06	1.3222
493 LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	$32,574.73	2.4226
494 LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	$20,184.06	1.8354
495 LUNG TRANSPLANT	$122,705.06	17.6221
496 COMBINED ANERIOR/POSTERIOR SPINAL FUSION	$20,184.06	1.4485
497 SPINAL FUSION W CC	$36,012.23	3.9098
498 SPINAL FUSION W/O CC	$26,957.14	2.7781
499 BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	$27,201.74	2.2196
500 BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	$20,184.06	1.5310
501 KNEE PROCEDURES W PDX OF INJECTION W CC	$20,184.06	1.4485
502 KNEE PROCEDURES W/O PDX OF INJECTION W CC	$20,184.06	1.4485
503 KNEE PROCEDURES W/O PDX OF INJECTION	$20,184.06	1.8229
600 NEONATE, DIED W/IN ONE DAY OF BIRTH	$45,842.85	2.7771
601 NEONATE, TRANSFERRED <5 DAYS OLD	$45,842.85	2.7771
602 NEONATE, BIRTHWT <750G, DISCHARGED ALIVE	$294,222.93	33.4792
603 NEONATE, BIRTHWT <750G, DIED	$45,842.85	2.7771
604 NEONATE, BIRTHWT 750-999G, DISCHARGED ALIVE	$227,166.35	23.2690
605 NEONATE, BIRTHWT 750-999G, DIED	$45,842.85	2.7771

EXHIBIT C.1
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
606 NEONATE, BIRTHWT 1000-1499G, W SIGNIF OR PROC, DISCHARGED AL	$45,842.85	2.7771
607 NEONATE, BIRTHWT 1000-1499G, W/O SIGNIF OR PROC, DISCHARGED	$83,622.83	9.1723
608 NEONATE, BIRTHWT 1000-1499G, DIED	$45,842.85	2.7771
609 NEONATE, BIRTHWT 1500-1999G, W SIGNIF OR PROC, W MULT MAJOR	$45,842.85	2.7771
610 NEONATE, BIRTHWT 1500-1999G, W SIGNIF OR PROC, W/O MULT MAJO	$45,842.85	2.7771
611 NEONATE, BIRTHWT 1500-1999G, W/O SIGNIF OR PROC, W MULT MAJO	$65,956.78	5.9042
612 NEONATE, BIRTHWT 1500-1999G, W/O SIGNIF OR PROC, W MAJOR PRO	$34,542.84	3.2809
613 NEONATE, BIRTHWT 1500-1999G, W/O SIGNIF OR PROC, W MINOR PRO	$36,176.70	3.0819
614 NEONATE, BIRTHWT 1500-1999G, W/O SIGNIF OR PROC, W OTHER PRO	$20,184.06	1.4459
615 NEONATE, BIRTHWT 2000-2499G, W SIGNIF OR PROC, W MULT MAJOR	$45,842.85	2.7771
616 NEONATE, BIRTHWT 2000-2499G, W SIGNIF OR PROC, W/O MULT MAJO	$45,842.85	2.7771
617 NEONATE, BIRTHWT 2000-2499G, W/O SIGNIF OR PROC, W MULT MAJO	$45,842.85	2.7771
618 NEONATE, BIRTHWT 2000-2499G, W/O SIGNIF OR PROC, W MAJOR PRO	$27,021.73	2.2471
619 NEONATE, BIRTHWT 2000-2499G, W/O SIGNIF OR PROC, W MINOR PRO	$21,309.04	1.6406
621 NEONATE, BIRTHWT 2000-2499G, W/O SIGNIF OR PROC, W OTHER PRO	$20,184.06	0.8152
622 NEONATE, BIRTHWT >2499G, W SIGNIF OR PROC, W MULT MAJOR PROB	$238,491.52	14.9230
623 NEONATE, BIRTHWT >2499G, W SIGNIF OR PROC, W/O MULT MAJOR PR	$45,842.85	2.7771
624 NEONATE, BIRTHWT >2499G, W MINOR ABDOM PROCEDURE	$45,842.85	2.7771
626 NEONATE, BIRTHWT >2499G, W/O SIGNIF OR PROC, W MULT MAJOR PR	$89,270.70	3.1168
627 NEONATE, BIRTHWT >2499G, W/O SIGNIF OR PROC, W MAJOR PROB	$21,726.34	1.3444
628 NEONATE, BIRTHWT >2499G, W/O SIGNIF OR PROC, W MINOR PROB	$20,184.06	0.8309
630 NEONATE, BIRTHWT >2499G, W/O SIGNIF OR PROC, W OTHER PROB	$20,184.06	0.6062
631 BPD AND OTH CHRONIC RESPIRATORY DISEASES ARISING IN PERINATA	$29,180.85	1.4834
632 OTHER RESPIRATORY PROBLEMS AFTER BIRTH	$29,180.85	1.4834
633 MULTIPLE, OTHER AND UNSPECIFIED CONGENITAL ANOMALIES, W CC	$20,184.06	1.0507
634 MULTIPLE, OTHER AND UNSPECIFIED CONGENITAL ANOMALIES, W/O CC	$20,184.06	1.0507
635 NEONATAL AFTERCARE FOR WEIGHT GAIN	$45,842.85	2.7771
636 NEONATAL DIAGNOSIS, AGE > 28 DAYS	$45,842.85	2.7771
900 ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT AGE <= 21	$20,184.06	0.6124
901 ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT AGE > 21	$20,184.06	0.6186

State: Georgia

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT PSYCHIATRIC FACILITY SERVICES
(PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES)

Y. Inpatient Psychiatric Facility Services (Psychiatric Residential Treatment Facility)

Effective January 1, 2007, Psychiatric Residential Treatment Facilities (PRTFs) will be reimbursed at provider specific prospective rate:

- PRTF per diem rates are based on allowable costs and patient days as reported on the provider's Fiscal Year 2005 cost reports filed with the Department of Community Health.
- PRTF per diem rates from the FY 2005 cost reports will be trended for inflation to January 1, 2007 based on the CMS Hospital Market Basket (Global Insight's Health Care Cost Service, Second Quarter 2006 Forecast, and Table 6.3).
- PRTF rates will be subject to a maximum capped amount of $299.80 based on the current rate paid to the Therapeutic Residential Intervention Services (TRIS) Level 6 providers for treatment and room and board.
- Rates for new PRTF providers are set at the median total allowable costs as determined from the FY 2005 cost reports and trended for inflation to January 1, 2007 based on the CMS Hospital Market Basket (Global Insight's Health Care Cost Service, Second Quarter 2006 Forecast, and Table 6.3).
- Upon notice of the provider-specific per diem rate, providers will have 30 days to appeal their new rates, based on the submission of an amended cost report for Fiscal Year 2005.

Cost information will be submitted annually using a uniform cost report form prescribed by the Department and supported by the facility's most recent certified financial audit.

PO LICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

A. Ambulance Services

Payment for covered services shall not exceed the lower of:

(a) The provider's submitted charge; or

(b) The statewide maximum allowable rate in effect on the date of service.

The maximum allowable amount is derived from Medicare's maximum allowable reimbursement rates for non-hospital based ambulance services. The maximum rates are 90% of the CY2002 Medicare fee schedule for Locality 01 for Medicaid-covered procedure codes in the Emergency Ambulance Services (EAS) program. Fee schedule rates for public and private providers of ambulance services are the same and the state does not subdivide or sub classify its payment rates based on whether the provider is a public or private entity/provider. Annual or periodic adjustments will be made and such adjustments will be reflected in the fee schedule that is made available to the providers and public.

B. Emergency Air Ambulance

Emergency air ambulance covered services consist of fixed wing air ambulance and rotary wing air ambulance. The reimbursement rate for fixed wing is determined by obtaining three estimates from Air Ambulance providers who provide fixed wing transports. These estimates include the base rate plus loaded mileage which will equal the cost to provide the transport. The three estimates are compared to the transportation provider's submitted charge. Payment for covered services will be the lower of the three estimates or the provider's submitted charge.

The reimbursement rate for rotary wing is determined by obtaining three estimates from Air Ambulance providers who provide rotary wing transport. These estimates include the base rate plus loaded mileage plus $750 which equals the cost to provide the transport. (The $750 payment is included as the cost for all medical personnel when a critical care flight is approved). The three estimates are compared to the transportation provider's submitted charge. Payment for covered services will be the lower of the three estimates or the provider's submitted charge.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE FOR SERVICES

B. Clinic Services

a. Family Planning Services

Billing rates for family planning services are based on 84.645% of the 2000 Medicare fee schedule for the Atlanta area. Reimbursement is provided at fixed rates for initial, annual, and follow-up visits using the CPT codes in the following table. There is no cost settlement.

2009 Medicaid Category of Service (COS)	Medicaid Billing Codes	Modifier	2009 Family Planning Medicaid Reimbursement Rate
Fam.Pl.	99201	FP	$35.13
Fam.Pl.	99211	FP	$17.33
Fam.Pl.	99212	FP	$38.95
Fam.Pl.	99213	FP	$24.08
Fam.Pl.	99204	FP	$105.75
Fam.Pl.	99214	FP	$60.01
Fam. Pl.	99215	FP	$89.43
Fam.Pl.	J1055	FP	$22.37
Fam. Pl.	J7307	FP	$581.84
Fam.Pl.	11975	FP	$108.00
Fam.Pl.	11976	FP	$61.20
Fam.Pl.	58300	FP	$66.45
Fam.Pl.	A4267	FP	$2.88
Fam.Pl.	81025	FP	$7.96
Fam. Pl.	J1056	FP	$14.18
Fam. Pl.	J7300	FP	$439.66

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE FOR SERVICES

C. Community Behavioral Health Rehabilitation Services

Effective for services provided on or after July 1, 2009, providers of Community Behavioral Health Rehabilitation Services (CBHRS) will be reimbursed at fee for service rates based on:

- Practitioner type;
- Service costs (salaries, fringe benefits, allocable direct and appropriate indirect costs);
- Location of services (in-clinic and out-of-clinic) and productivity factors;

State-developed fee schedule rates are the same for both governmental and private providers of all community mental health services. The fee schedule and any annual/periodic adjustments to the fee schedule are published in state plan amendments, Georgia Medicaid policy manuals and provider correspondence.

Detail on each of the factors involved in the CBHRS is described below. The fee schedule for Community Behavioral Health Rehabilitation Services is also presented below and is grouped by service area to correspond with the section 3.1-A of the Georgia Medicaid Plan. In addition, provider qualifications are detailed in section 3.1-A.

Practitioner Type

Each practitioner type is grouped into levels consistent with specific credentials and range of salaries. Salary data was derived from the May 2007 Occupational Employment and Wage Estimates for Georgia from the United States Department of Labor's Bureau of Labor Statistics and are generally classified below:

Level 1:	Physician, Psychiatrist
Level 2:	Psychologist, Physician's Assistant, Nurse Practitioner, Clinical Nurse Specialist/PMH, Pharmacist
Level 3:	Registered Nurse, Licensed Dietician, Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT)
Level 4:	Licensed Practical Nurse (LPN); Licensed Associate Professional Counselor (LAPC); Licensed Master's Social Worker (LMSW); Licensed Associate Marriage and Family Therapist (LAMFT);

	Certified/Registered Addictions Counselors (e.g. CAC-I/II, CADC, CCADC, GCADC, MAC), Certified Peer Specialists, Trained Paraprofessionals and Certified Psychiatric Rehabilitation Professionals (CPRP) with Bachelor's degrees or higher in the social sciences/helping professions
Level 5:	Trained Paraprofessionals, Certified/Registered Addiction Counselors (CAC-I, RADT), Certified Peer Specialists, Certified Psychiatric Rehabilitation Professionals, and Qualified Medication Aides

Service Costs

Service costs include practitioner salaries, fringe benefits, allocable direct and appropriate indirect costs. Service costs do not include room, board, or watchful oversight. Service costs were calculated as follows:

Salaries and Fringe Benefits

Using the annual salaries of the practitioners that were included within a level (data source described above), a median salary was calculated for each band. Salaries are increased by 41.71% to account for employee fringe benefits.

Allocable Direct and Appropriate Indirect Costs

The Community Behavioral Health Rehabilitation Services (CBHRS) rates also take into account costs that are directly allocable to individual practitioners. Allocable direct costs include those costs which are critical to the practitioner in providing treatment services to the patient. These costs include:

- Program clinical supervisors and support staff
- Staff training costs
- Staff mileage and vehicle costs
- Telephone costs
- Office supplies
- Computer costs
- Office space allocated to staff providing MRO services
- Liability/malpractice insurance

Indirect costs include:

- Management personnel costs (CEO, Medical Director, CFO)
- Support staff personnel costs such as human resources, payroll, quality improvement/accreditation, procurement, billing, accounting, information system technicians
- Management information system costs such as billing and general ledger accounting systems

- Occupancy costs not directly allocated to programs
- Professional costs such as audits and legal fees.

Federal Financial Participation through CBHRS is not available for:

a. room and board services;
b. educational, vocational and job training services;
c. habilitation services;
d. services to inmates in public institutions as defined in 42 CFR §435.1010;
e. services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010;
f. recreational and social activities; and
g. Services that must be covered elsewhere in the state Medicaid plan.

Based on data received through surveys of a large sample of agencies currently providing Community Behavioral Health Rehabilitation Services in multiple states, average allocable direct and indirect cost factors were calculated as a percentage of direct personnel costs. These costs were then calculated for each service and for each applicable practitioner level. All of these cost components were summed to yield an annual cost for the service for the particular practitioner level. Due to the large difference between the median annual salaries in Level 1 (physicians/psychiatrists) and the other levels, it was necessary to adjust the support and administrative factors applied to the highest level versus the other levels so that the support and administrative costs associated with the highest levels were not over-inflated. This was accomplished by adjusting the direct and indirect cost factors according to the proportion of personnel costs in an average agency accounted for by the top level versus the other four practitioner levels. The overall direct services cost factor is 39% and indirect is 15%. Once the factors were adjusted to account for the disparity between physician salaries and the other levels the cost factors became 19% for direct costs and 7% for indirect costs for Level 1 and 45% for direct costs and 17% indirect costs for the remaining four levels.

Once the total cost of a service for a practitioner at a particular level was calculated, the cost was distributed to billable time for staff providing CBHRS in the following manner:

- Total hours were reduced by the average paid time off for vacation, holiday and sick time to yield available time per practitioner per year.
- Productivity factors were established based on the CBHRS requirements for the service: national and state experience with the amount of billable time that can be expected over the course of an average week or month: consideration of travel time required for a community-based service in a large, rural state; time associated with missed appointments; and staff time required for chart

documentation, record-keeping, supervision, training, meetings and other administrative activities.

Location of Services (In-Clinic and Out-of-Clinic) and Associated Productivity Factors
Except as noted below, for services provided in clinic locations the targeted productivity is 60-70% of available hours depending on the service and practitioner. Productivity factors were set at 70% for in-clinic services provided by physicians and for all medication administration services and 60% for most other in-clinic services. Except as noted otherwise below, for out-of-clinic services the productivity time was 45-55% of available hours, with physician and medication administration services calculated using the 55% factor and most other out-of-clinic service rates calculated using the 50% factor. In addition, the following adjustments were made: productivity factors were reduced by 5% for services provided in a group setting to account for additional documentation time; productivity for Level 3 professionals for most services was also reduced by 5% to account for the required supervisory responsibilities of these licensed staff (e.g. RNs, LPCs, LCSWs) that reduce the amount of time available for direct billable services; productivity for Intensive Family Intervention team members was set at 45% to account for additional time required for IFI team meetings and contacts in which two team members are providing services in conjunction but only one is billing. Available hours times the productivity factor yields billable hours for each service for each practitioner level/band, and the total program costs (salary, fringe, direct and indirect costs) are then divided by billable time to arrive at a unit rate.

KEY: Code Modifiers Used:

GT = Via interactive audio and video telecommunication systems
HA = Child/Adolescent Program
HK = High Risk Population
HQ = Group Setting
HR = Family/Couple with client present
HS = Family/Couple without client present
HT = Multidisciplinary team
TG = Complex Level of Care
TF = Intermediate Level of Care
TN = Rural Service Area
U1 = Practitioner Level 1 (see below for description of all practitioner levels)
U2 = Practitioner Level 2
U3 = Practitioner Level 3
U4 = Practitioner Level 4
U5 = Practitioner Level 5
U6 = In-Clinic
U7 = Out-of-Clinic
UK = Collateral Contact

Description	Procedure Code	Unit	Rate	Max Units per Day
Service Area = Behavioral Health Assessment				
Mental Health Assessment by a non-physician				
Practitioner Level 2, In-Clinic	H0031 U2 U6	15 minutes	$ 38.97	24
Practitioner Level 3, In-Clinic	H0031 U3 U6	15 minutes	$ 30.01	24
Practitioner Level 4, In-Clinic	H0031 U4 U6	15 minutes	$ 20.30	24
Practitioner Level 5, In-Clinic	H0031 U5 U6	15 minutes	$ 15.13	24
Practitioner Level 2, Out-of-Clinic	H0031 U2 U7	15 minutes	$ 46.76	24
Practitioner Level 3, Out-of-Clinic	H0031 U3 U7	15 minutes	$ 36.68	24
Practitioner Level 4, Out-of-Clinic	H0031 U4 U7	15 minutes	$ 24.36	24
Practitioner Level 5, Out-of-Clinic	H0031 U5 U7	15 minutes	$ 18.15	24
Service Area = Service Plan Development				
Mental Health Service Plan Development by a non-physician				
Practitioner Level 2, In-Clinic	H0032 U2 U6	15 minutes	$ 38.97	24
Practitioner Level 3, In-Clinic	H0032 U3 U6	15 minutes	$ 30.01	24
Practitioner Level 4, In-Clinic	H0032 U4 U6	15 minutes	$ 20.30	24
Practitioner Level 5, In-Clinic	H0032 U5 U6	15 minutes	$ 15.13	24
Practitioner Level 2, Out-of-Clinic	H0032 U2 U7	15 minutes	$ 46.76	24
Practitioner Level 3, Out-of-Clinic	H0032 U3 U7	15 minutes	$ 36.68	24
Practitioner Level 4, Out-of-Clinic	H0032 U4 U7	15 minutes	$ 24.36	24
Practitioner Level 5, Out-of-Clinic	H0032 U5 U7	15 minutes	$ 18.15	24
Service Area = Diagnostic Assessment				
Psychiatric Diagnostic Examination				
Practitioner Level 1, In-Clinic	90801 U1 U6	1 episode	$ 174.63	2
Practitioner Level 1, In-Clinic, Child Program	90801 HA U1 U6	1 episode	$ 174.63	2
Practitioner Level 1, Out-of-Clinic	90801 U1 U7	1 episode	$ 222.26	2
Practitioner Level 1, Out-of-Clinic, Child Program	90801 HA U1 U7	1 episode	$ 222.26	2
Practitioner Level 1, Via interactive audio and video telecommunication systems	90801 GT U1	1 episode	$ 174.63	2
Practitioner Level 1, Via interactive audio and video telecommunication systems, Child Program	90801 GT HA U1	1 episode	$ 174.63	2
Practitioner Level 2, In-Clinic	90801 U2 U6	1 episode	$ 116.90	2
Practitioner Level 2, In-Clinic, Child Program	90801 HA U2 U6	1 episode	$ 116.90	2
Practitioner Level 2, Out-of-Clinic	90801 U2 U7	1 episode	$ 140.28	2
Practitioner Level 2, Out-of-Clinic, Child Program	90801 HA U2 U7	1 episode	$ 140.28	2

Description	Procedure Code	Unit	Rate	Max Units per Day
Practitioner Level 2, Via interactive audio and video telecommunication systems	90801 GT U2	1 episode	$ 116.90	2
Practitioner Level 2, Via interactive audio and video telecommunication systems, Child Program	90801 GT HA U2	1 episode	$ 116.90	2
Practitioner Level 3, In-Clinic	90801 U3 U6	1 episode	$90.03	2
Practitioner Level 3, In-Clinic, Child Program	90801 HA U3 U6	1 episode	$90.03	2
Practitioner Level 3, Out-of-Clinic	90801 U3 U7	1 episode	$110.04	2
Practitioner Level 3, Out-of-Clinic, Child Program	90801 HA U3 U7	1 episode	$110.04	2
Practitioner Level 3, Via interactive audio and video telecommunication systems	90801 GT U3	1 episode	$ 90.03	2
Practitioner Level 3, Via interactive audio and video telecommunication systems, Child Program	90801 GT HA U3	1 episode	$ 90.03	2
Psychiatric Diagnostic Examination, Interactive				
Practitioner Level 1, In-Clinic	90802 U1 U6	1 episode	$ 174.63	2
Practitioner Level 1, In-Clinic, Child Program	90802 HA U1 U6	1 episode	$ 174.63	2
Practitioner Level 1, Out-of-Clinic	90802 U1 U7	1 episode	$ 222.26	2
Practitioner Level 1, Out-of-Clinic, Child Program	90802 HA U1 U7	1 episode	$ 222.26	2
Practitioner Level 1, Via interactive audio and video telecommunication systems	90802 GT U1	1 episode	$ 174.63	2
Practitioner Level 1, Via interactive audio and video telecommunication systems, Child Program	90802 GT HA U1	1 episode	$ 174.63	2
Practitioner Level 2, In-Clinic	90802 U2 U6	1 episode	$ 116.90	2
Practitioner Level 2, In-Clinic, Child Program	90802 HA U2 U6	1 episode	$ 116.90	2
Practitioner Level 2, Out-of-Clinic	90802 U2 U7	1 episode	$ 140.28	2
Practitioner Level 2, Out-of-Clinic, Child Program	90802 HA U2 U7	1 episode	$ 140.28	2
Practitioner Level 2, Via interactive audio and video telecommunication systems	90802 GT U2	1 episode	$ 116.90	2
Practitioner Level 2, Via interactive audio and video telecommunication systems, Child Program	90802 GT HA U2	1 episode	$ 116.90	2
Practitioner Level 3, In-Clinic	90802 U3 U6	1 episode	$90.03	2
Practitioner Level 3, In-Clinic, Child Program	90802 HA U3 U6	1 episode	$90.03	2
Practitioner Level 3, Out-of-Clinic	90802 U3 U7	1 episode	$110.04	2
Practitioner Level 3, Out-of-Clinic, Child Program	90802 HA U3 U7	1 episode	$110.04	2
Practitioner Level 3, Via interactive audio and video telecommunication systems	90802 GT U3	1 episode	$ 90.03	2

Description	Procedure Code	Unit	Rate	Max Units per Day
Practitioner Level 3, Via interactive audio and video telecommunication systems, Child Program	90802 GT HA U3	1 episode	$ 90.03	2
Psychological Testing – Psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology e.g. MMP, Rorschach, WAIS (per hour of psychologist's or physician's time, both face-to-face with the patient and time interpreting test results and preparing the report)				
Practitioner Level 2, In-Clinic	96101 U2 U6	1 hour	$ 155.87	5
Practitioner Level 2, Out-of-Clinic	96101 U2 U7	1 hour	$ 187.04	5
Psychological Testing – Psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology e.g. MMP, Rorschach, WAIS) with qualified healthcare professional interpretation and report, administered by technician, per hour of technician time, face-to-face				
Practitioner Level 3, In-Clinic	96102 U3 U6	1 hour	$ 120.04	5
Practitioner Level 3, Out-of-Clinic	96102 U3 U7	1 hour	$ 146.71	5
Practitioner Level 4, In-Clinic	96102 U4 U6	1 hour	$ 81.18	5
Practitioner Level 4, Out-of-Clinic	96102 U4 U7	1 hour	$ 97.42	5
Service Area = Crisis Intervention Services				
Crisis Intervention Services				
Practitioner Level 1, In-Clinic	H2011 U1 U6	15 minutes	$ 58.21	48
Practitioner Level 2, In-Clinic	H2011 U2 U6	15 minutes	$ 38.97	48
Practitioner Level 3, In-Clinic	H2011 U3 U6	15 minutes	$ 30.01	48
Practitioner Level 4, In-Clinic	H2011 U4 U6	15 minutes	$ 20.30	48
Practitioner Level 5, In-Clinic	H2011 U5 U6	15 minutes	$ 15.13	48
Practitioner Level 1, Out-of-Clinic	H2011 U1 U7	15 minutes	$ 74.09	48
Practitioner Level 2, Out-of-Clinic	H2011 U2 U7	15 minutes	$ 46.76	48
Practitioner Level 3, Out-of-Clinic	H2011 U3 U7	15 minutes	$ 36.68	48
Practitioner Level 4, Out-of-Clinic	H2011 U4 U7	15 minutes	$ 24.36	48
Practitioner Level 5, Out-of-Clinic	H2011 U5 U7	15 minutes	$ 18.15	48
Service Area = Psychiatric Treatment				
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately 20-30 minutes face-to-face with patient with medical evaluation and management services.				
Practitioner Level 1, In-Clinic	90805 U1 U6	20-30 minutes	$ 97.02	1
Practitioner Level 1, In-Clinic, Child Program	90805 HA U1 U6	20-30 minutes	$ 97.02	1
Practitioner Level 1, Out-of-Clinic	90805 U1 U7	20-30 minutes	$ 123.48	1
Practitioner Level 1, Out-of-Clinic, Child Program	90805 HA U1 U7	20-30 minutes	$ 123.48	1
Practitioner Level 2, In-Clinic	90805 U2 U6	20-30 minutes	$ 64.95	1
Practitioner Level 2, In-Clinic, Child Program	90805 HA U2 U6	20-30 minutes	$ 64.95	1
Practitioner Level 2, Out-of-Clinic	90805 U2 U7	20-30 minutes	$ 77.93	1

Description	Procedure Code	Unit	Rate	Max Units per Day
Practitioner Level 2, Out-of-Clinic, Child Program	90805 HA U2 U7	20-30 minutes	$ 77.93	1
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately 45-50 minutes face-to-face with patient with medical evaluation and management services.				
Practitioner Level 1, In-Clinic	90807 U1 U6	45-50 minutes	$ 174.63	1
Practitioner Level 1, In-Clinic, Child Program	90807 HA U1 U6	45-50 minutes	$ 174.63	1
Practitioner Level 1, Out-of-Clinic	90807 U1 U7	45-50 minutes	$ 222.26	1
Practitioner Level 1, Out-of-Clinic, Child Program	90807 HA U1 U7	45-50 minutes	$ 222.26	1
Practitioner Level 2, In-Clinic	90807 U2 U6	45-50 minutes	$ 116.90	1
Practitioner Level 2, In-Clinic, Child Program	90807 HA U2 U6	45-50 minutes	$ 116.90	1
Practitioner Level 2, Out-of-Clinic	90807 U2 U7	45-50 minutes	$ 140.28	1
Practitioner Level 2, Out-of-Clinic, Child Program	90807 HA U2 U7	45-50 minutes	$ 140.28	1
Pharmacological Management				
Practitioner Level 1, In-Clinic	90862 U1 U6	1 episode	$ 58.21	1
Practitioner Level 1, In-Clinic, Child Program	90862 HA U1 U6	1 episode	$ 58.21	1
Practitioner Level 1, Via interactive audio and video telecommunication systems	90862 GT U1	1 episode	$ 58.21	1
Practitioner Level 1, Via interactive audio and video telecommunication systems, Child Program	90862 GT HA U1	1 episode	$ 58.21	1
Practitioner Level 1, Out-of-Clinic	90862 U1 U7	1 episode	$ 74.09	1
Practitioner Level 1, Out-of-Clinic, Child Program	90862 HA U1 U7	1 episode	$ 74.09	1
Practitioner Level 2, In-Clinic	90862 U2 U6	1 episode	$ 38.97	1
Practitioner Level 2, In-Clinic, Child Program	90862 HA U2 U6	1 episode	$ 38.97	1
Practitioner Level 2, Via interactive audio and video telecommunication systems	90862 GT U2	1 episode	$ 38.97	1
Practitioner Level 2, Via interactive audio and video telecommunication systems, Child Program	90862 GT HA U2	1 episode	$ 38.97	1
Practitioner Level 2, Out-of-Clinic	90862 U2 U7	1 episode	$ 46.76	1
Practitioner Level 2, Out-of-Clinic, Child Program	90862 HA U2 U7	1 episode	$ 46.76	1
Service Area = Nursing Assessment and Care				
Nursing Assessment/ Evaluation				
Practitioner Level 2, In-Clinic	T1001 U2 U6	15 Minutes	$ 38.97	16
Practitioner Level 3, In-Clinic	T1001 U3 U6	15 Minutes	$ 30.01	16
Practitioner Level 4, In-Clinic	T1001 U4 U6	15 Minutes	$ 20.30	16
Practitioner Level 2, Out-of-Clinic	T1001 U2 U7	15 Minutes	$ 46.76	16

Description	Procedure Code	Unit	Rate	Max Units per Day
Practitioner Level 3, Out-of-Clinic	T1001 U3 U7	15 Minutes	$ 36.68	16
Practitioner Level 4, Out-of-Clinic	T1001 U4 U7	15 Minutes	$ 24.36	16
RN Services, up to 15 minutes				
Practitioner Level 2, In-Clinic	T1002 U2 U6	15 Minutes	$ 38.97	16
Practitioner Level 3, In-Clinic	T1002 U3 U6	15 Minutes	$ 30.01	16
Practitioner Level 2, Out-of-Clinic	T1002 U2 U7	15 Minutes	$ 46.76	16
Practitioner Level 3, Out-of-Clinic	T1002 U3 U7	15 Minutes	$ 36.68	16
LPN/LVN Services, up to 15 minutes				
Practitioner Level 4, In-Clinic	T1003 U4 U6	15 Minutes	$ 20.30	16
Practitioner Level 4, Out-of-Clinic	T1003 U4 U7	15 Minutes	$ 24.36	16
Health and Behavior Assessment, Face-to-Face with the Patient, Initial Assessment				
Practitioner Level 2, In-Clinic	96150 U2 U6	15 Minutes	$ 38.97	16
Practitioner Level 3, In-Clinic	96150 U3 U6	15 Minutes	$ 30.01	16
Practitioner Level 4, In-Clinic	96150 U4 U6	15 Minutes	$ 20.30	16
Practitioner Level 2, Out-of-Clinic	96150 U2 U7	15 Minutes	$ 46.76	16
Practitioner Level 3, Out-of-Clinic	96150 U3 U7	15 Minutes	$ 36.68	16
Practitioner Level 4, Out-of-Clinic	96150 U4 U7	15 Minutes	$ 24.36	16
Health and Behavior Assessment, Face-to-Face with the Patient, Reassessment				
Practitioner Level 2, In-Clinic	96151 U2 U6	15 Minutes	$ 38.97	16
Practitioner Level 3, In-Clinic	96151 U3 U6	15 Minutes	$ 30.01	16
Practitioner Level 4, In-Clinic	96151 U4 U6	15 Minutes	$ 20.30	16
Practitioner Level 2, Out-of-Clinic	96151 U2 U7	15 Minutes	$ 46.76	16
Practitioner Level 3, Out-of-Clinic	96151 U3 U7	15 Minutes	$ 36.68	16
Practitioner Level 4, Out-of-Clinic	96151 U4 U7	15 Minutes	$ 24.36	16
Health and Wellness Supports (Behavioral Health Prevention Education Service (Delivery Of Services With Target Population To Affect Knowledge, Attitude And/Or Behavior)				
Practitioner Level 2, In-Clinic	96151 U2 U6	15 Minutes	$ 38.97	16
Practitioner Level 3, In-Clinic	H0025 U3 U6	15 minutes	$ 30.01	6
Practitioner Level 4, In-Clinic	96151 U4 U6	15 Minutes	$ 20.30	16
Practitioner Level 2, Out-of-Clinic	96151 U2 U7	15 Minutes	$ 46.76	16
Practitioner Level 3, Out-of-Clinic	H0025 U3 U7	15 minutes	$ 36.68	6
Practitioner Level 4, Out-of-Clinic	96151 U4 U7	15 Minutes	$ 24.36	16
Service Area = Detoxification Services				
Alcohol and/or drug services, Ambulatory Detoxification				
Practitioner Level 2, In-Clinic	H0014 U2 U6	15 Minutes	$ 38.97	32
Practitioner Level 3, In-Clinic	H0014 U3 U6	15 Minutes	$ 30.01	32
Practitioner Level 4, In-Clinic	H0014 U4 U6	15 Minutes	$ 20.30	32
Alcohol and/or drug services; Sub-acute Detoxification (Residential Addiction Program Outpatient)				
Level I	H0012 TF	1 day	$31.34	1

Description	Procedure Code	Unit	Rate	Max Units per Day
Level II	H0012 TG	1 day	$38.58	1
Alcohol and/or drug services; Acute Detoxification (Residential Addiction Program Outpatient)				
Level III	H0013	1 day	$209.22	1
Service Area = Individual Outpatient Services				
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately 20-30 minutes face-to-face with patient				
Practitioner Level 2, In-Clinic	90804 U2 U6	20-30 minutes	$ 64.95	2
Practitioner Level 3, In-Clinic	90804 U3 U6	20-30 minutes	$ 50.02	2
Practitioner Level 4, In-Clinic	90804 U4 U6	20-30 minutes	$ 33.83	2
Practitioner Level 5, In-Clinic	90804 U5 U6	20-30 minutes	$ 25.21	2
Practitioner Level 2, Out-of-Clinic	90804 U2 U7	20-30 minutes	$ 77.93	2
Practitioner Level 3, Out-of-Clinic	90804 U3 U7	20-30 minutes	$ 61.13	2
Practitioner Level 4, Out-of-Clinic	90804 U4 U7	20-30 minutes	$ 40.59	2
Practitioner Level 5, Out-of-Clinic	90804 U5 U7	20-30 minutes	$ 30.25	2
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately 45-50 minutes face-to-face with patient				
Practitioner Level 2, In-Clinic	90806 U2 U6	45-50 minutes	$ 116.90	2
Practitioner Level 3, In-Clinic	90806 U3 U6	45-50 minutes	$ 90.03	2
Practitioner Level 4, In-Clinic	90806 U4 U6	45-50 minutes	$ 60.89	2
Practitioner Level 5, In-Clinic	90806 U5 U6	45-50 minutes	$ 45.38	2
Practitioner Level 2, Out-of-Clinic	90806 U2 U7	45-50 minutes	$ 140.28	2
Practitioner Level 3, Out-of-Clinic	90806 U3 U7	45-50 minutes	$ 110.04	2
Practitioner Level 4, Out-of-Clinic	90806 U4 U7	45-50 minutes	$ 73.07	2
Practitioner Level 5, Out-of-Clinic	90806 U5 U7	45-50 minutes	$ 54.46	2
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately 75-80 minutes face-to-face with patient				

Description	Procedure Code	Unit	Rate	Max Units per Day
Practitioner Level 2, In-Clinic	90808 U2 U6	75-80 minutes	$ 194.84	2
Practitioner Level 3, In-Clinic	90808 U3 U6	75-80 minutes	$ 150.05	2
Practitioner Level 4, In-Clinic	90808 U4 U6	75-80 minutes	$ 101.48	2
Practitioner Level 5, In-Clinic	90808 U5 U6	75-80 minutes	$ 75.64	2
Practitioner Level 2, Out-of-Clinic	90808 U2 U7	75-80 minutes	$ 233.80	2
Practitioner Level 3, Out-of-Clinic	90808 U3 U7	75-80 minutes	$ 183.39	2
Practitioner Level 4, Out-of-Clinic	90808 U4 U7	75-80 minutes	$ 121.78	2
Practitioner Level 5, Out-of-Clinic	90808 U5 U7	75-80 minutes	$ 90.76	2
Individual psychotherapy, interactive, using play equipment, physical devises, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20-30 minutes face-to-face with patient				
Practitioner Level 2, In-Clinic	90810 U2 U6	20-30 minutes	$ 64.95	2
Practitioner Level 3, In-Clinic	90810 U3 U6	20-30 minutes	$ 50.02	2
Practitioner Level 4, In-Clinic	90810 U4 U6	20-30 minutes	$ 33.83	2
Practitioner Level 5, In-Clinic	90810 U5 U6	20-30 minutes	$ 25.21	2
Practitioner Level 2, Out-of-Clinic	90810 U2 U7	20-30 minutes	$ 77.93	2
Practitioner Level 3, Out-of-Clinic	90810 U3 U7	20-30 minutes	$ 61.13	2
Practitioner Level 4, Out-of-Clinic	90810 U4 U7	20-30 minutes	$ 40.59	2
Practitioner Level 5, Out-of-Clinic	90810 U5 U7	20-30 minutes	$ 30.25	2
Individual psychotherapy, interactive, using play equipment, physical devises, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45-50 minutes face-to-face with patient				
Practitioner Level 2, In-Clinic	90812 U2 U6	45-50 minutes	$ 116.90	2
Practitioner Level 3, In-Clinic	90812 U3 U6	45-50 minutes	$ 90.03	2
Practitioner Level 4, In-Clinic	90812 U4 U6	45-50 minutes	$ 60.89	2
Practitioner Level 5, In-Clinic	90812 U5 U6	45-50 minutes	$ 45.38	2

Description	Procedure Code	Unit	Rate	Max Units per Day
Practitioner Level 2, Out-of-Clinic	90812 U2 U7	45-50 minutes	$ 140.28	2
Practitioner Level 3, Out-of-Clinic	90812 U3 U7	45-50 minutes	$ 110.04	2
Practitioner Level 4, Out-of-Clinic	90812 U4 U7	45-50 minutes	$ 73.07	2
Practitioner Level 5, Out-of-Clinic	90812 U5 U7	45-50 minutes	$ 54.46	2
Individual psychotherapy, interactive, using play equipment, physical devises, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75-80 minutes face-to-face with patient				
Practitioner Level 2, In-Clinic	90814 U2 U6	75-80 minutes	$ 194.84	2
Practitioner Level 3, In-Clinic	90814 U3 U6	75-80 minutes	$ 150.05	2
Practitioner Level 4, In-Clinic	90814 U4 U6	75-80 minutes	$ 101.48	2
Practitioner Level 5, In-Clinic	90814 U5 U6	75-80 minutes	$ 75.64	2
Practitioner Level 2, Out-of-Clinic	90814 U2 U7	75-80 minutes	$ 233.80	2
Practitioner Level 3, Out-of-Clinic	90814 U3 U7	75-80 minutes	$ 183.39	2
Practitioner Level 4, Out-of-Clinic	90814 U4 U7	75-80 minutes	$ 121.78	2
Practitioner Level 5, Out-of-Clinic	90814 U5 U7	75-80 minutes	$ 90.76	2
Service Area = Family Outpatient Services				
Family – Behavioral health counseling and therapy (without client present)				
Practitioner Level 2, In-Clinic	H0004 HS U2 U6	15 minutes	$ 38.97	16
Practitioner Level 3, In-Clinic	H0004 HS U3 U6	15 minutes	$ 30.01	16
Practitioner Level 4, In-Clinic	H0004 HS U4 U6	15 minutes	$ 20.30	16
Practitioner Level 5, In-Clinic	H0004 HS U5 U6	15 minutes	$ 15.13	16
Practitioner Level 2, Out-of-Clinic	H0004 HS U2 U7	15 minutes	$ 46.76	16
Practitioner Level 3, Out-of-Clinic	H0004 HS U3 U7	15 minutes	$ 36.68	16
Practitioner Level 4, Out-of-Clinic	H0004 HS U4 U7	15 minutes	$ 24.36	16
Practitioner Level 5, Out-of-Clinic	H0004 HS U5 U7	15 minutes	$ 18.15	16
Family -- Behavioral health counseling and therapy (with client present)				
Practitioner Level 2, In-Clinic	H0004 HR U2 U6	15 minutes	$ 38.97	16
Practitioner Level 3, In-Clinic	H0004 HR U3 U6	15 minutes	$ 30.01	16
Practitioner Level 4, In-Clinic	H0004 HR U4 U6	15 minutes	$ 20.30	16
Practitioner Level 5, In-Clinic	H0004 HR U5 U6	15 minutes	$ 15.13	16

Description	Procedure Code	Unit	Rate	Max Units per Day
Practitioner Level 2, Out-of-Clinic	H0004 HR U2 U7	15 minutes	$ 46.76	16
Practitioner Level 3, Out-of-Clinic	H0004 HR U3 U7	15 minutes	$ 36.68	16
Practitioner Level 4, Out-of-Clinic	H0004 HR U4 U7	15 minutes	$ 24.36	16
Practitioner Level 5, Out-of-Clinic	H0004 HR U5 U7	15 minutes	$ 18.15	16
Family Psychotherapy without the patient present (appropriate license required)				
Practitioner Level 2, In-Clinic	90846 U2 U6	15 minutes	$ 38.97	16
Practitioner Level 3, In-Clinic	90846 U3 U6	15 minutes	$ 30.01	16
Practitioner Level 4, In-Clinic	90846 U4 U6	15 minutes	$ 20.30	16
Practitioner Level 5, In-Clinic	90846 U5 U6	15 minutes	$ 15.13	16
Practitioner Level 2, Out-of-Clinic	90846 U2 U7	15 minutes	$ 46.76	16
Practitioner Level 3, Out-of-Clinic	90846 U3 U7	15 minutes	$ 36.68	16
Practitioner Level 4, Out-of-Clinic	90846 U4 U7	15 minutes	$ 24.36	16
Practitioner Level 5, Out-of-Clinic	90846 U5 U7	15 minutes	$ 18.15	16
Conjoint Family Psychotherapy with the patient present (appropriate license required)				
Practitioner Level 2, In-Clinic	90847 U2 U6	15 minutes	$ 38.97	16
Practitioner Level 3, In-Clinic	90847 U3 U6	15 minutes	$ 30.01	16
Practitioner Level 4, In-Clinic	90847 U4 U6	15 minutes	$ 20.30	16
Practitioner Level 5, In-Clinic	90847 U5 U6	15 minutes	$ 15.13	16
Practitioner Level 2, Out-of-Clinic	90847 U2 U7	15 minutes	$ 46.76	16
Practitioner Level 3, Out-of-Clinic	90847 U3 U7	15 minutes	$ 36.68	16
Practitioner Level 4, Out-of-Clinic	90847 U4 U7	15 minutes	$ 24.36	16
Practitioner Level 5, Out-of-Clinic	90847 U5 U7	15 minutes	$ 18.15	16
Family - Skills training and development				
Practitioner Level 4, In-Clinic, without client present	H2014 HS U4 U6	15 minutes	$ 20.30	16
Practitioner Level 5, In-Clinic, without client present	H2014 HS U5 U6	15 minutes	$ 15.13	16
Practitioner Level 4, Out-of-Clinic, without client present	H2014 HS U4 U7	15 minutes	$ 24.36	16
Practitioner Level 5, Out-of-Clinic, without client present	H2014 HS U5 U7	15 minutes	$ 18.15	16
Practitioner Level 4, In-Clinic, with client present	H2014 HR U4 U6	15 minutes	$ 20.30	16
Practitioner Level 5, In-Clinic, with client present	H2014 HR U5 U6	15 minutes	$ 15.13	16
Practitioner Level 4, Out-of-Clinic, with client present	H2014 HR U4 U7	15 minutes	$ 24.36	16
Practitioner Level 5, Out-of-Clinic, with client present	H2014 HR U5 U7	15 minutes	$ 18.15	16
Service Area = Group Outpatient Services				
Group – Behavioral health counseling and therapy				

Description	Procedure Code	Unit	Rate	Max Units per Day
Practitioner Level 2, In-Clinic	H0004 HQ U2 U6	15 minutes	$ 8.50	20
Practitioner Level 3, In-Clinic	H0004 HQ U3 U6	15 minutes	$ 6.60	20
Practitioner Level 4, In-Clinic	H0004 HQ U4 U6	15 minutes	$ 4.43	20
Practitioner Level 5, In-Clinic	H0004 HQ U5 U6	15 minutes	$ 3.30	20
Practitioner Level 2, Out-of-Clinic	H0004 HQ U2 U7	15 minutes	$ 10.39	20
Practitioner Level 3, Out-of-Clinic	H0004 HQ U3 U7	15 minutes	$ 8.25	20
Practitioner Level 4, Out-of-Clinic	H0004 HQ U4 U7	15 minutes	$ 5.41	20
Practitioner Level 5, Out-of-Clinic	H0004 HQ U5 U7	15 minutes	$ 4.03	20
Practitioner Level 2, In-Clinic, Multi-family group, with client present	H0004 HQ HR U2 U6	15 minutes	$ 8.50	20
Practitioner Level 3, In-Clinic, Multi-family group, with client present	H0004 HQ HR U3 U6	15 minutes	$ 6.60	20
Practitioner Level 4, In-Clinic, Multi-family group, with client present	H0004 HQ HR U4 U6	15 minutes	$ 4.43	20
Practitioner Level 5, In-Clinic, Multi-family group, with client present	H0004 HQ HR U5 U6	15 minutes	$ 3.30	20
Practitioner Level 2, Out-of-Clinic, Multi-family group, with client present	H0004 HQ HR U2 U7	15 minutes	$ 10.39	20
Practitioner Level 3, Out-of-Clinic, Multi-family group, with client present	H0004 HQ HR U3 U7	15 minutes	$ 8.25	20
Practitioner Level 4, Out-of-Clinic, Multi-family group, with client present	H0004 HQ HR U4 U7	15 minutes	$ 5.41	20
Practitioner Level 5, Out-of-Clinic, Multi-family group, with client present	H0004 HQ HR U5 U7	15 minutes	$ 4.03	20
Practitioner Level 2, In-Clinic, Multi-family group, without client present	H0004 HQ HS U2 U6	15 minutes	$ 8.50	20
Practitioner Level 3, In-Clinic, Multi-family group, without client present	H0004 HQ HS U3 U6	15 minutes	$ 6.60	20
Practitioner Level 4, In-Clinic, Multi-family group, without client present	H0004 HQ HS U4 U6	15 minutes	$ 4.43	20
Practitioner Level 5, In-Clinic, Multi-family group, without client present	H0004 HQ HS U5 U6	15 minutes	$ 3.30	20
Practitioner Level 2, Out-of-Clinic, Multi-family group, without client present	H0004 HQ HS U2 U7	15 minutes	$ 10.39	20
Practitioner Level 3, Out-of-Clinic, Multi-family group, without client present	H0004 HQ HS U3 U7	15 minutes	$ 8.25	20
Practitioner Level 4, Out-of-Clinic, Multi-family group, without client present	H0004 HQ HS U4 U7	15 minutes	$ 5.41	20
Practitioner Level 5, Out-of-Clinic, Multi-family group, without client present	H0004 HQ HS U5 U7	15 minutes	$ 4.03	20
Group Psychotherapy other than of a multiple family group (appropriate license required)				
Practitioner Level 2, In-Clinic	90853 U2 U6	15 minutes	$ 8.50	20
Practitioner Level 3, In-Clinic	90853 U3 U6	15 minutes	$ 6.60	20
Practitioner Level 4, In-Clinic	90853 U4 U6	15 minutes	$ 4.43	20

Description	Procedure Code	Unit	Rate	Max Units per Day
Practitioner Level 5, In-Clinic	90853 U5 U6	15 minutes	$ 3.30	20
Practitioner Level 2, Out-of-Clinic	90853 U2 U7	15 minutes	$ 10.39	20
Practitioner Level 3, Out-of-Clinic	90853 U3 U7	15 minutes	$ 8.25	20
Practitioner Level 4, Out-of-Clinic	90853 U4 U7	15 minutes	$ 5.41	20
Practitioner Level 5, Out-of-Clinic	90853 U5 U7	15 minutes	$ 4.03	20
Group – Skills training and development				
Practitioner Level 4, In-Clinic	H2014 HQ U4 U6	15 minutes	$ 4.43	20
Practitioner Level 5, In-Clinic	H2014 HQ U5 U6	15 minutes	$ 3.30	20
Practitioner Level 4, Out-of-Clinic	H2014 HQ U4 U7	15 minutes	$ 5.41	20
Practitioner Level 5, Out-of-Clinic	H2014 HQ U5 U7	15 minutes	$ 4.03	20
Practitioner Level 4, In-Clinic, with client present	H2014 HQ HR U4 U6	15 minutes	$ 4.43	20
Practitioner Level 5, In-Clinic, with client present	H2014 HQ HR U5 U6	15 minutes	$ 3.30	20
Practitioner Level 4, Out-of-Clinic, with client present	H2014 HQ HR U4 U7	15 minutes	$ 5.41	20
Practitioner Level 5, Out-of-Clinic, with client present	H2014 HQ HR U5 U7	15 minutes	$ 4.03	20
Practitioner Level 4, In-Clinic, without client present	H2014 HQ HS U4 U6	15 minutes	$ 4.43	20
Practitioner Level 5, In-Clinic, without client present	H2014 HQ HS U5 U6	15 minutes	$ 3.30	20
Practitioner Level 4, Out-of-Clinic, without client present	H2014 HQ HS U4 U7	15 minutes	$ 5.41	20
Practitioner Level 5, Out-of-Clinic, without client present	H2014 HQ HS U5 U7	15 minutes	$ 4.03	20
Service Area = Intensive Family Intervention				
Intensive Family Intervention				
Practitioner Level 3, In-Clinic	H0036 U3 U6	15 minutes	$ 30.01	48
Practitioner Level 4, In-Clinic	H0036 U4 U6	15 minutes	$ 22.14	48
Practitioner Level 5, In-Clinic	H0036 U5 U6	15 minutes	$ 16.50	48
Practitioner Level 3, Out-of-Clinic	H0036 U3 U7	15 minutes	$ 41.26	48
Practitioner Level 4, Out-of-Clinic	H0036 U4 U7	15 minutes	$ 27.06	48
Practitioner Level 5, Out-of-Clinic	H0036 U5 U7	15 minutes	$ 20.17	48
Service Area = Medication Administration				
Comprehensive Medication Services				
Practitioner Level 2, In-Clinic	H2010 U2 U6	Per contact	$ 33.40	1
Practitioner Level 3, In-Clinic	H2010 U3 U6	Per contact	$ 25.39	1
Practitioner Level 4, In-Clinic	H2010 U4 U6	Per contact	$ 17.40	1
Practitioner Level 5, In-Clinic	H2010 U5 U6	Per contact	$ 12.97	1

Description	Procedure Code	Unit	Rate	Max Units per Day
Practitioner Level 2, Out-of-Clinic	H2010 U2 U7	Per contact	$ 42.51	1
Practitioner Level 3, Out-of-Clinic	H2010 U3 U7	Per contact	$ 33.01	1
Practitioner Level 4, Out-of-Clinic	H2010 U4 U7	Per contact	$ 22.14	1
Therapeutic, prophylactic or diagnostic injection				
Practitioner Level 2, In-Clinic	96372 U2 U6	Per contact	$ 33.40	1
Practitioner Level 3, In-Clinic	96372 U3 U6	Per contact	$ 25.39	1
Practitioner Level 4, In-Clinic	96372 U4 U6	Per contact	$ 17.40	1
Practitioner Level 2, Out-of-Clinic	96372 U2 U7	Per contact	$ 42.51	1
Practitioner Level 3, Out-of-Clinic	96372 U3 U7	Per contact	$ 33.01	1
Practitioner Level 4, Out-of-Clinic	96372 U4 U7	Per contact	$ 22.14	1
Alcohol, and/or drug services, methadone administration and/or service (provision of the drug by a licensed program)				
Practitioner Level 2, In-Clinic	H0020 U2 U6	Per contact	$ 33.40	1
Practitioner Level 3, In-Clinic	H0020 U3 U6	Per contact	$ 25.39	1
Practitioner Level 4, In-Clinic	H0020 U4 U6	Per contact	$ 17.40	1
Service Area = Psychosocial Rehabilitation				
Psychosocial Rehabilitation				
Practitioner Level 4, Group, In-Clinic	H2017 HQ U4 U6	1 hour	$ 17.72	5
Practitioner Level 5, Group, In-Clinic	H2017 HQ U5 U6	1 hour	$ 13.20	5
Practitioner Level 4, Group, Out-of-Clinic	H2017 HQ U4 U7	1 hour	$ 21.64	5
Practitioner Level 5, Group, Out-of-Clinic	H2017 HQ U5 U7	1 hour	$ 16.12	5
Practitioner Level 4, In-Clinic	H2017 U4 U6	15 minutes	$ 20.30	48
Practitioner Level 5, In-Clinic	H2017 U5 U6	15 minutes	$ 15.13	48
Practitioner Level 4, Out-of-Clinic	H2017 U4 U7	15 minutes	$ 24.36	48
Practitioner Level 5, Out-of-Clinic	H2017 U5 U7	15 minutes	$ 18.15	48
Service Area = Community Support Services				
Community Support Services				
Practitioner Level 4, In-Clinic	H2015 U4 U6	15 minutes	$ 20.30	48
Practitioner Level 5, In-Clinic	H2015 U5 U6	15 minutes	$ 15.13	48
Practitioner Level 4, Out-of-Clinic	H2015 U4 U7	15 minutes	$ 24.36	48
Practitioner Level 5, Out-of-Clinic	H2015 U5 U7	15 minutes	$ 18.15	48
Practitioner Level 4, In-Clinic, Collateral Contact	H2015 UK U4 U6	15 minutes	$ 20.30	48
Practitioner Level 5, In-Clinic, Collateral Contact	H2015 UK U5 U6	15 minutes	$ 15.13	48
Practitioner Level 4, Out-of-Clinic, Collateral Contact	H2015 UK U4 U7	15 minutes	$ 24.36	48
Practitioner Level 5, Out-of-Clinic, Collateral Contact	H2015 UK U5 U7	15 minutes	$ 18.15	48

Description	Procedure Code	Unit	Rate	Max Units per Day
Service Area = Addictive Disease Support Services				
Community Support Services				
Practitioner Level 4, In-Clinic	H2015 HF U4 U6	15 minutes	$ 20.30	48
Practitioner Level 5, In-Clinic	H2015 HF U5 U6	15 minutes	$ 15.13	48
Practitioner Level 4, Out-of-Clinic	H2015 HF U4 U7	15 minutes	$ 24.36	48
Practitioner Level 5, Out-of-Clinic	H2015 HF U5 U7	15 minutes	$ 18.15	48
Practitioner Level 4, In-Clinic, Collateral Contact	H2015 HF UK U4 U6	15 minutes	$ 20.30	48
Practitioner Level 5, In-Clinic, Collateral Contact	H2015 HF UK U5 U6	15 minutes	$ 15.13	48
Practitioner Level 4, Out-of-Clinic, Collateral Contact	H2015 HF UK U4 U7	15 minutes	$ 24.36	48
Practitioner Level 5, Out-of-Clinic, Collateral Contact	H2015 HF UK U5 U7	15 minutes	$ 18.15	48
Service Area = Case Management Support Services				
Case Management				
Practitioner Level 4, In-Clinic	T1016 U4 U6	15 minutes	$ 20.30	24
Practitioner Level 5, In-Clinic	T1016 U5 U6	15 minutes	$ 15.13	24
Practitioner Level 4, Out-of-Clinic	T1016 U4 U7	15 minutes	$ 24.36	24
Practitioner Level 5, Out-of-Clinic	T1016 U5 U7	15 minutes	$ 18.15	24
Practitioner Level 4, In-Clinic, Collateral Contact	T1016 UK U4 U6	15 minutes	$ 20.30	24
Practitioner Level 5, In-Clinic, Collateral Contact	T1016 UK U5 U6	15 minutes	$ 15.13	24
Practitioner Level 4, Out-of-Clinic, Collateral Contact	T1016 UK U4 U7	15 minutes	$ 24.36	24
Practitioner Level 5, Out-of-Clinic, Collateral Contact	T1016 UK U5 U7	15 minutes	$ 18.15	24
Practitioner Level 4, In-Clinic	T1016 HK U4 U6	15 minutes	$ 20.30	24
Practitioner Level 5, In-Clinic	T1016 HK U5 U6	15 minutes	$ 15.13	24
Practitioner Level 4, Out-of-Clinic	T1016 HK U4 U7	15 minutes	$ 24.36	24
Practitioner Level 5, Out-of-Clinic	T1016 HK U5 U7	15 minutes	$ 18.15	24
Practitioner Level 4, In-Clinic, Collateral Contact	T1016 HK UK U4 U6	15 minutes	$ 20.30	24
Practitioner Level 5, In-Clinic, Collateral	T1016 HK UK U5 U6	15	$ 15.13	24

Description	Procedure Code	Unit	Rate	Max Units per Day
Contact		minutes		
Practitioner Level 4, Out-of-Clinic, Collateral Contact	T1016 HK UK U4 U7	15 minutes	$ 24.36	24
Practitioner Level 5, Out-of-Clinic, Collateral Contact	T1016 HK UK U5 U7	15 minutes	$ 18.15	24
Service Area = Peer Supports				
Self Help/Peer Services				
Practitioner Level 4, Group, In-Clinic	H0038 HQ U4 U6	1 hour	$ 17.72	5
Practitioner Level 5, Group, In-Clinic	H0038 HQ U5 U6	1 hour	$ 13.20	5
Practitioner Level 4, Group, Out-of-Clinic	H0038 HQ U4 U7	1 hour	$ 21.64	5
Practitioner Level 5, Group, Out-of-Clinic	H0038 HQ U5 U7	1 hour	$ 16.12	5
Practitioner Level 4, In-Clinic	H0038 U4 U6	15 minutes	$ 20.30	48
Practitioner Level 5, In-Clinic	H0038 U5 U6	15 minutes	$ 15.13	48
Practitioner Level 4, Out-of-Clinic	H0038 U4 U7	15 minutes	$ 24.36	48
Practitioner Level 5, Out-of-Clinic	H0038 U5 U7	15 minutes	$ 18.15	48
Practitioner Level 4, Group, In-Clinic	H0038 HF HQ U4 U6	1 hour	$ 17.72	5
Practitioner Level 5, Group, In-Clinic	H0038 HF HQ U5 U6	1 hour	$ 13.20	5
Practitioner Level 4, Group, Out-of-Clinic	H0038 HF HQ U4 U7	1 hour	$ 21.64	5
Practitioner Level 5, Group, Out-of-Clinic	H0038 HF HQ U5 U7	1 hour	$ 16.12	5
Practitioner Level 4, In-Clinic	H0038 HF U4 U6	15 minutes	$ 20.30	48
Practitioner Level 5, In-Clinic	H0038 HF U5 U6	15 minutes	$ 15.13	48
Practitioner Level 4, Out-of-Clinic	H0038 HF U4 U7	15 minutes	$ 24.36	48
Practitioner Level 5, Out-of-Clinic	H0038 HF U5 U7	15 minutes	$ 18.15	48
Health and Wellness Supports (Behavioral Health Prevention Education Service (Delivery Of Services With Target Population To Affect Knowledge, Attitude And/Or Behavior)				
Practitioner Level 4, In-Clinic	H0025 U4 U6	15 minutes	$ 20.30	6
Practitioner Level 5, In-Clinic	H0025 U5 U6	15 minutes	$ 15.13	6
Practitioner Level 4, Out-of-Clinic	H0025 U4 U7	15 minutes	$ 24.36	6
Practitioner Level 5, Out-of-Clinic	H0025 U5 U7	15 minutes	$ 18.15	6
Service Area = Assertive Community Treatment				
Assertive Community Treatment				
Practitioner Level 1, In-Clinic	H0039 U1 U6	15 minutes	$ 32.46	60
Practitioner Level 2, In-Clinic	H0039 U2 U6	15 minutes	$ 32.46	60
Practitioner Level 3, In-Clinic	H0039 U3 U6	15 minutes	$ 32.46	60
Practitioner Level 4, In-Clinic	H0039 U4 U6	15 minutes	$ 32.46	60
Practitioner Level 5, In-Clinic	H0039 U5 U6	15 minutes	$ 32.46	60

Description	Procedure Code	Unit	Rate	Max Units per Day
Practitioner Level 1, Out-of-Clinic	H0039 U1 U7	15 minutes	$ 32.46	60
Practitioner Level 2, Out-of-Clinic	H0039 U2 U7	15 minutes	$ 32.46	60
Practitioner Level 3, Out-of-Clinic	H0039 U3 U7	15 minutes	$ 32.46	60
Practitioner Level 4, Out-of-Clinic	H0039 U4 U7	15 minutes	$ 32.46	60
Practitioner Level 5, Out-of-Clinic	H0039 U5 U7	15 minutes	$ 32.46	60
Practitioner Level 1, Via interactive audio and video telecommunication systems	H0039 GT U1	15 minutes	$ 32.46	60
Practitioner Level 1, Via interactive audio and video telecommunication systems	H0039 GT U2	15 minutes	$ 32.46	60
Practitioner Level 3, Group, In-Clinic	H0039 HQ U3 U6	15 minutes	$ 6.60	20
Practitioner Level 4, Group, In-Clinic	H0039 HQ U4 U6	15 minutes	$ 4.43	20
Practitioner Level 5, Group, In-Clinic	H0039 HQ U5 U6	15 minutes	$ 3.30	20
Multidisciplinary Team Meeting	H0039 HT	15 minutes	$ 0.00	60
Practitioner Level 3, In-Clinic	H0039 TN U3 U6	15 minutes	$ 30.01	60
Practitioner Level 4, In-Clinic	H0039 TN U4 U6	15 minutes	$ 20.30	60
Practitioner Level 5, In-Clinic	H0039 TN U5 U6	15 minutes	$ 15.13	60
Practitioner Level 3, Out-of-Clinic	H0039 TN U3 U7	15 minutes	$ 36.68	60
Practitioner Level 4, Out-of-Clinic	H0039 TN U4 U7	15 minutes	$ 24.36	60
Practitioner Level 5, Out-of-Clinic	H0039 TN U5 U7	15 minutes	$ 18.15	60
Service Area = Community Living Supports				
Level I	H0019 TG	1 day	$99.23	1
Level II	H0019 TF	1 day	$64.13	1
Level III	H0019	1 day	$46.43	1
Level IV	H2021	15 minutes	$13.96	10
Service Area = Task-Oriented Services				
Practitioner Level 4, Out-of-Clinic	H2025 U4 U7	15 minutes	$ 24.36	8
Practitioner Level 5, Out-of-Clinic	H2025 U5 U7	15 minutes	$ 18.15	8

With respect to Assertive Community Treatment, the State Mental Health Agency, as designated by law and on behalf of the State Medicaid agency, will require that the entity furnish to the Medicaid agency on an annual basis the following:

a. data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate; and

b. cost information by practitioner type and by type of service actually delivered within the service unit.

The Medicaid Agency will base future rates on information obtained from the providers.

With respect to Community Living Supports (CLS), there are four intensity levels of service delivery. No rate includes any room and/or board. Rates use the detail stated earlier in this document specific to Practitioner Costs and Service Costs as a base and then are calculated on the assumptions below to create units for each level:

- **CLS Level I** is intensive and provides 24/7/365 awake staff support generally in a licensed community-living setting (in no case exceeding 16 beds). In order to directly support the individual, there will be a minimum of five hours weekly of skills training, community integration activities, and/or personal services provided to the person if indicated on the individual supports plan. This skills training is provided by one or more Community Living Supports specialists who may be practitioner Level 3, 4 or 5.
- **CLS Level II** is intensive and provides 24/7/365 staff support generally in a licensed community-living setting (in no case exceeding 16 beds). In order to directly support the individual, there will be a minimum of five hours weekly of skills training, community integration activities, and/or personal services provided to the person if indicated on the individual supports plan. This skills training is provided by one or more Community Living Supports specialists who may be practitioner Level 3, 4 or 5.
- **CLS Level III** is semi-independent support which provides 36 hours per week staff support generally in a licensed community-living setting (in no case exceeding 16 beds). In order to directly support the individual, there will be a minimum of three hours per week of skills training, community integration activities, and/or personal services provided to the person if indicated on the individual supports plan. This skills training is provided by one or more Community Living Supports specialists who may be practitioner Level 4 or 5.
- **CLS IV** is support to provide a minimum of one face-to-face contact and an average of 10 15-minute units per week of skills training, community integration activities, and/or personal services provided to the person as indicated on the individual supports plan. A Community Living Supports specialist is a practitioner Level 5 operating on 65% productivity and is on call and available to consumers 24/7/365.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

B. Clinic Services (continued)

3. Federally Qualified Health Centers (FQHC) (COMMUNITY HEALTH CENTERS SERVICES (CHCS)

In accordance with Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, effective January 1,2001, reimbursement is provided for "core" services and other ambulatory services (excluding in- house pharmacy services) at a prospective payment rate (PPS) per encounter. The rates will be calculated on a per visit basis and will reflect 100 percent of the average FQHC's reasonable cost of providing Medicaid-covered services including other ambulatory services cost during FY 1999 and FY 2000. Those costs will be adjusted to take into account any increase (or decrease) in the scope of services furnished by the FQHC during FY 2001 for services that only occurred in calendar year 2000. Cost reports for the FQHC's FY 1999 and FY 2000 periods will be used to establish the baseline rate for each FQHC effective January 1, 2001. The baseline rate will be calculated by dividing the sum of the total reasonable cost of providing Medicaid covered services during FY 1999 and FY 2000 by the total Medicaid visits during the two fiscal years. Until the baseline rates are established, FQHCs will be paid their interim rate effective December 31, 2000. When the baseline rates and are established, they will be paid retroactive to January 1, 2001.

The baseline rates effective January 1, 2001 will be adjusted by the Medicare Economic Index (MEI) effective for dates of service on and after October 1,2001 based on the MEI and for changes in the FQHC's scope of services during January 1, 2001 through September 30, 2001. For Federal Fiscal Year (FFY) 2002 and FFYS thereafter, per visit rate will be calculated by adjusting the previous year's rate by the MEI for primary care, and for changes in the FQHC's scope of services during the prior FFY.

For newly qualified FQHCs that participate in FY 2000 only, the Department will use the FY 2000 cost for calculating the baseline PPS rate effective January 1,2001. Centers that qualify after fiscal year 2000 will have their initial rates established by a statewide average of similar centers. After the initial year, payment will be set using the MEI and change of scope methods used for other clinics.

For purposes of this plan, a change in scope of services is defined as a change in the type, intensity, duration and/or amount of services. It is the center's responsibility to recognize any changes in their scope of services and to notify the Department of these changes and to provide the Department with documentation and projections of the cost and volume impact of the change.

If an FQHC provides core services pursuant to a contract between the center and a managed care entity (as defined in section 1932(a)(1)(B)), the State shall provide payment of a supplemental payment equal to the amount (if any) by which the PPS rate calculated above exceeds the amount of the payments provided under the contract. These supplemental payments shall be made pursuant to a payment schedule of four months or less agreed to by the State and the Federally Qualified Health Center.

Effective for dates of service July 1, 1994, and after, a $2.00 recipient co-payment is required on all Federally Qualified Health Center Services (FQHC) Community Health Center Services (CHC). Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care participants are not subject to the co-payment. Emergency services and family planning services are also exempt from a co-payment.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
FOR OTHER TYPES OF CARE OR SERVICES

B. Clinical Services (continued)

4. Dialysis Services

a. Physician Services
The Department will pay physicians the lower of the submitted charge or the statewide monthly capitation payment (MCP) as determined by Medicare. Reimbursement for the MCP is not to exceed the Medicare reimbursement for those services. Physicians will receive the MCP each month for each enrolled patient (member) under their care. Physicians enrolled in this program will receive the MCP for professional services. Professional services include the monthly supervision of medical care, dietetic services, social services and procedures directly related to End Stage Renal Disease.

b. Technical Services
Facilities enrolled in this program will be paid per visit for technical services including routine laboratory work, and the cost of supplies and equipment as described in the policy manual. Facilities will be reimbursed the lower of the submitted charge or the statewide fixed per visit rate. The monthly aggregate of per visit reimbursement is not to exceed the monthly aggregate Medicare reimbursement for these services. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of technical dialysis services and the fee schedule and any annual/periodic adjustments to the fee schedule are published in state plan amendments, Georgia Medicaid policy manuals and provider correspondence.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

c. Dental Services

Payments are ,made for specific authorized procedures on a statewide basis and are limited to the lower of:

(1)` The dentist's actual charge for the service; or

(2) The statewide reimbursement rate in effect on the date of services.

Reimbursement will be made on a per procedure basis.

Reimbursement to providers of dental services is made on an established fee schedule not to exceed prevailing charges in the state.

Reimbursement will be provided on a per procedure basis. The current reimbursement rates will be based on a percentage of usual and customary reimbursement, not to exceed 100 percent. The usual and customary reimbursement will be determined using regional data on a periodic basis.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

Citation
42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions (PPC)

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions (OPPC)

The State identifies the following Other Provider-Preventable Conditions for non-payment under Attachment 4.19-B of this State plan.

_X_ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

On and after May 17, 2012, Medicaid will make zero payments to providers for Other Provider-Preventable Conditions which includes Never Events (NE) as defined by the National Coverage Determination (NCD). The Never Events (NE) as defined in the NCD includes Inpatient Hospitals, Outpatient Hospitals, Ambulatory Surgical Centers (ASC) and practitioners, and these providers regardless of the healthcare setting will be required to report NEs. Reimbursement for conditions described above is defined in Attachment 4.19-B, Page 1.002 of this State Plan.

A. Dates of service beginning on or after May 17, 2012:
   1. The claims identified with provider-preventable conditions through the claims payment system will be reviewed.
   2. When the review of claims indicates an increase of payment to the provider for an identified provider-preventable condition, the amount for the provider-preventable condition will be excluded from the providers' payment.

B. No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

C. Reductions in provider payment may be limited to the extent that the following apply:
   1. The identified provider-preventable conditions would otherwise result in an increase in payment.
   2. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.
   3. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

D. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

Payment for Hospital Acquired Conditions:

Effective May 17, 2012 and in accordance with Title XIX of the Social Security Act – Sections 1902, 1903 and 42 CFRs 434, 438, and 447, Medicaid will make no payment to providers for services related to Provider Preventable Conditions (PPCs) which includes Never Events (NE), Other Provider Preventable Conditions (OPPCs) and Additional Other Provider-Preventable Conditions (AOPPCs).

In accordance with GA State Plan, Attachment 3.1-B payments are allowed except for the following conditions outlined below.

Never Events (NE) are defined by the National Coverage Determination (NCD) manual for Outpatient Hospitals, Ambulatory Surgical Centers (ASC) and practitioners, and these providers will be required to report NEs. Outpatient Hospital claims must bill all non-payment/zero services on the same professional 1500 claim as a separate detail line-entry or as designated by the National Uniform Bill Committee for non-payment. All non-payment services found in claims adjudication from NEs, PPCs, and AOPPCs will be subject to post medical records review and recoupment.

The provider may file a professional claim for the same Medicaid recipient with the same dates of service to include the allowable charges for reimbursement. Providers must identify and report NE occurrences. All NEs services will pend for retrospective review.

Prohibition on payments for NE, OPPC, and AOPPC shall not result in a loss of access to care or services for Medicaid beneficiaries. This policy applies to all Medicaid reimbursement provisions contained in 4.19B.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
FOR OTHER TYPES OF CARE OR SERVICES

d. Prescribed Drugs

1. Medicaid pays for prescribed legend and non-legend drugs authorized under the program. Reimbursement for covered multiple source drugs shall not exceed the lowest of:

(a) The federal mandated upper limit for certain multiple source drugs as established and published by CMS plus a reasonable dispensing fee as established in item 2; or
(b) The Georgia Maximum Allowable Cost (GMAC) as established by the Division for additional multiple source drugs plus a reasonable dispensing fee as established in item 2 below; or
(c) The Georgia Estimated Acquisition Cost (GEAC) for multiple source drugs plus a reasonable dispensing fee as established in item 2 below; or
(d) The usual and customary charge as defined below by the Division for the prescription or
(e) The submitted ingredient cost plus the submitted dispensing fee.

Reimbursement for covered drugs other than multiple source drugs shall not exceed the lower of:

(a) The GEAC for all other drugs plus a reasonable dispensing fee as established in item 2 below or
(b) The usual and customary charge as defined by the Division for the prescription; or
(c) The Select Specialty Pharmacy Rate (SSPR) as established by the Division for select specialty drugs plus a reasonable dispensing fee as established in item 2 below; or
(d) Most Favored Nations rate submitted by the provider and accepted by the Department.

GEAC is defined as the average wholesale price (AWP) of the drug less an 11% discount for all drugs

The Division defines usual and customary as the lower of the lowest price reimbursed to the pharmacy by other third party payers (including HMOs); or the lowest price routinely offered to any segment of the general public. Donations or discounts provided to charitable organizations, or fees charged to or paid by federal or state funded programs are not considered usual and customary charges.

Select Specialty Pharmacy Rate (SSPR)

SSPR - Disease State and Pharmaceutical Inclusion

Selected pharmaceuticals that meet any of the following criteria are candidates for inclusion in the SSPR:

1. used to treat a Georgia Medicaid SSPR identified disease state;
2. available through limited distribution channels;
3. part of a complex care regimen;
4. carry a predicted annual cost of $5000 or more per year; or
5. manufactured as a biological or large molecular product.

The SSPR applies to selected pharmaceuticals used to treat selected disease states that are rare and/or complex in nature and are treated by a pharmaceutical product that meets the Georgia Medicaid SSPR criteria. Georgia Medicaid SSPR identified disease states include the following:

1. Rheumatoid Arthritis
2. Crohn's Disease
3. Psoriasis
4. Multiple Sclerosis
5. Neutropenia
6. Anemia
7. Growth Hormone Deficiency
8. Cystic Fibrosis
9. Respiratory Syncytial Virus (RSV) Prevention
10. Pulmonary Hypertension
11. Hemophilia
12. Cancer
13. Orphan Diseases

SSPR - Rate Setting

The SSPR is an Estimated Acquisition Cost (EAC) for select specialty pharmaceuticals based on the product dispensed and the State's ability to ensure access to the medication at that reimbursement level. All other established lesser of payment methodologies and rules in the approved State Plan continue to apply.

The rate setting methodology will be an on-going process and incorporate the following components:

1. The specific drugs and corresponding disease states are identified
2. No later than thirty (30) days prior to the end of the quarter, publicly available specialty pharmacy reimbursement rates of other payers will be reviewed. This will include:
    a. A review of publicly available specialty pharmacy reimbursement rates paid by up to two (2) other state Medicaid agencies pursuant to a CMS-approved state plan will be reviewed.
    b. A review of specialty pharmacy reimbursement levels publicly available paid by up to two (2) commercial payers will be conducted.
3. The proposed specialty rates will be compared to the Most Favored Nation Rates for providers currently dispensing the specialty pharmaceutical products
4. The above elements will be considered and the pricing point set at a level no lower than where providers in the marketplace are currently providing the product.
5. Fifteen (15) calendar days prior to the end of the quarter, the specialty pharmacy reimbursement levels will be finalized by the Department.
6. No less than one (1) week prior to the end of the quarter the new rates will be published in the Pharmacy Services Manual.

7. Appeal Process: On an ongoing basis, providers are allowed to submit a request for reimbursement review.
    a. Provider submits a Reimbursement Review Request Form
        i. Provider submits two (2) most recent wholesaler invoices. If this is the first time a provider has dispensed said product within the last three (3) months, then one (1) invoice will be accepted..
        ii. The Provider will attest to that product is not available to the provider in the market at the published rate.
    b. The Department will review the invoices and compare to other dispensing providers within a geographical location.
        i. The Department will work with wholesalers and other providers to discern the availability of the product at the specialty pharmacy reimbursement rate in the marketplace.
        ii. The Department will identify any other provider in the geographic area that are accepting the specialty pharmacy reimbursement rate and coordinate access to those providers for any affected members.
        iii. Absent other providers accepting the specialty pharmacy reimbursement rate, the Department will adjust the specialty pharmacy reimbursement rate.
    c. The provider will be notified within five (5) business days of the determination of the request for Reimbursement Review.
8. Any resulting adjustment in the specialty pharmacy reimbursement rate will be updated in the claims processing system within ten (10) business days of the determination**.**

2. The dispensing fee for profit and non-profit community pharmacies is based on periodic surveys of pharmacy operating costs including professional salaries and fees, overhead costs and reasonable profit. Between these periodic surveys, the Division, in consultation with the Governor's Office of Planning and Budget, reviews the fee. When appropriate, the fee is adjusted based on an inflation factor. The Medicaid dispensing fee shall be $4.63 for profit pharmacies and $4.33 for non-profit pharmacies. The dispensing fee paid by the Division shall be subject to the usual and customary charge as defined by the Division above and shall not exceed the lower of submitted charges.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
FOR OTHER TYPES OF CARE OR SERVICES

d. Prescribed Drugs (continued)

3. No dispensing fee is allowed to the physician dispensing drugs.

4. Payment for special approved drugs as requested by the prescribing physician is determined as in item 1 above.

5. Prescriptions supporting Medicaid claims must be initiated and recorded in accordance with State and Federal laws. The maximum quantity payable for a prescription or its refill will be one (1)-month supply unless the drug delivery system or package size is such that the smallest dispensable unit provides greater than a one month supply.

6. Effective with the date of service on or after June 1, 2001, the Department will impose a co-payment for each non-preferred drug dispensed to a Medicaid recipient based on the typical payment by the Department for the prescription as follows:

Cost to State	Co-Payment
$10.00 or less	$0.50 co-payment
$10.01 to $25.00	$1.00 co-payment
$25.01 to $50.00	$2.00 co-payment
$50.01 or more	$3.00 co-payment

Recipients under age twenty-one (21), pregnant women, institutionalized individuals, hospice care, QMB dual eligible, and Breast and Cervical Cancer Program participant recipients are not required to pay this co-payment. Emergency services, family planning services, are also exempt from this co-payment.

The Department will impose a nominal co-payment of $.50 for each preferred prescribed drug dispensed by the pharmacy.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE AND SERVICES

E. Durable Medical Equipment Services

The maximum reimbursement for providers of medical equipment to Medicaid and PeachCare members is limited to the lower of:

(a) the usual and customary charges for the item; or

(b) 80% of the 2007 Medicare DME rate for the Atlanta area.

Reimbursement for delivery mileage is limited to 100 miles, one way.

Effective for dates of service July 1, 1994 and after, a $3.00 recipient co-payment is required on all Durable Medical Equipment and a $1.00 co-payment for all Durable Medical Equipment Supplies and Rentals.

Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care recipients are exempt from the co-payment. Emergency services and family planning services are also exempt from a co-payment.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

F. HEALTH CHECK (EPSDT) SERVICES

Reimbursement to Health Check (EPSDT) screening providers is based on the lower of submitted charges or the state's maximum allowable rate. Vaccine costs and administration fees are reimbursed separately at established rates dependent on the source of the vaccine. Vaccines provided by the Vaccines for Children (VFC) program have an administration only reimbursement rate as specified in the Part II Policy and Procedure Manual for Health Check. Georgia Medicaid will reimburse for the administration and cost of vaccines purchased outside of the VFC program when used to immunize eligible Medicaid members. Medically necessary non-institutional and institutional services which are not otherwise covered under the State Plan require prior approval and will be reimbursed under the respective program using that program's established reimbursement methodology as described on Supplement 1 to Attachment 4.19-B, Page 1.

For Health Check screenings and tests, the state's maximum allowable rates are published in the Georgia Department of Community Health Policy and Procedure Manual for Health Check and other appropriate Georgia Department of Community Health Policy and Procedure manuals.

Immunizations will be provided per the Department of Community Health's periodicity schedule and recommendations of the Advisory Committee on Immunization Practices (ACIP). The state's maximum allowable rates for immunizations and administration fees are published in the Georgia Department of Community Health Policy and Procedure Manual for Health Check as well as the Georgia Department of Community Health Policy and Procedure Manual for Physician's Injectable Drug List.

Except as otherwise noted in the plan or Part II Policy and Procedure Manual for Health Check Services, state-developed fee schedule rates are the same for both governmental and private providers of EPSDT services. The agency's fee schedule rate was set as of 7/1/2006 and is effective for services provided on or after that date. All rates are published on the www.ghp.georgia.gov website.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
FOR OTHER TYPES OF CARE OR SERVICES

G. HOME HEALTH SERVICES

The Department will reimburse each Home Health Agency a specific rate per visit for covered services. The specific rate per visit is the total of the agency's inflated base rate, any efficiency incentive applicable to the agency, and a supply rate. Base rates, efficiency incentives, and supply rates are subject to ceilings. Rates, incentives, and ceilings are determined as follows:

(a) Each agency's base rate is calculated using data contained in the as-filed or audited Medicaid cost report for that agency's base period. An inflation percentage is applied to base period date and the resulting inflated base period cost per visit is the agency's base rate. The inflation percentage and base period are set by the Department.

(b) Each agency is classified into one of the following categories; hospital-based, freestanding urban, and freestanding rural. For each category the 75th percentile of inflated base period cost per visit is determined. This amount is the base rate ceiling for agencies in the category.

(c) An efficiency incentive may be added to the base rate for an agency as follows:

If an agency's base rate is less than or equal to the base rate ceiling in the agency's category, the difference between the base rate and the ceiling is multiplied by 20%, and the product (not to exceed $1.76) is added to the base rate. The total of base rate plus incentive shall not exceed the base rate ceiling for the agency's category.

(d) The supply cost per visit for each agency is based on data contained in the as-filed or audited Medicaid cost report for the agency's base period. An inflation percentage is applied to base-period data to determine each agency's inflated supply cost per visit. The inflation percentage and base period for supply costs are set by the Department. Inflated base period supply costs per visit for each agency are arrayed on a statewide basis and the 75th percentile cost from that array is the supply rate. The supply rate is added to each agency's base rate plus any applicable efficiency incentive.

(e) The reimbursement rate for each freestanding agency shall not exceed the base rate ceiling for that agency's category plus the supply rate. The reimbursement rate for each hospital-based agency will be calculated as noted in paragraphs (a) through (d), and shall not exceed the maximum rate noted in paragraph (f) below.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
FOR OTHER TYPES OF CARE OR SERVICES

(f) For purposes of setting the maximum rate per visit for hospital-based agencies, the Department has established two subcategories: Urban hospital-based and rural hospital-based. The maximum rate per visit for each agency in these subcategories is determined by adding a hospital-based adjustment amount to the freestanding urban and freestanding rural based rate ceilings. The adjustment is calculated as follows:

> The mean of the agencies' inflated base period cost per visit will be calculated for each of the subcategories. A percentage of the mean for each subcategory will be calculated and added to the base rate ceiling for the corresponding freestanding urban or rural category, plus the supply rate to establish the maximum rate for hospital-based agencies in that subcategory.

Each hospital-based agency will be reimbursed the lesser of its rate calculated as noted in paragraphs (a) through (d), or the maximum rate per visit for its subcategory.

Assignment to a subcategory is determined according to the criteria outlined in the section labeled classification of agencies.

(g) Reimbursement rates will be adjusted for home health agencies which provide certain home-delivered services to community-care recipients. The rate adjustment will be calculated using the home health reimbursement methodology in paragraphs (a) through (f) above, and the calculation will include both home health and home delivered services utilization data for the base period.

Reimbursement rates will be adjusted only for those agencies currently enrolled and providing services in the community care home-delivered services program and for which at least nine months of cost and utilization data exists for the base period. Home health agencies which discontinue

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the provision of home-delivered services will be subject to a reduction in their reimbursement rate.

(h) Effective for dates of service July 1, 1994 and after, a $3.00 recipient co-payment is required on all home health visits. Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care recipients are not required to pay the co-payment. Emergency services and family planning services are also exempt from a co-payment.

Cost Reports

Each agency must submit a copy of its as-filed Medicare cost report and a completed Medicaid Cost Data Form (supplied by the Department) to the Department. These documents must be received by the Department within one hundred fifty (150) days after each agency's fiscal year end. If the Medicare and Medicaid reports have not been received after this one hundred fifty (150) day period, a rate reduction of 10% on the current rate will be imposed. This rate reduction will remain in effect through the final day of the month in which the cost information is received. If the information is received after any fraction of a month beyond the one hundred fifty (150) day period, the rate reduction of 10% will be applied for the entire month. If an agency's cost information is not received by the time the Department establishes individual provider rates and determines the percentiles and rate ceilings, that agency will be assigned the lesser of its current rate or the lowest rate in the State for the appropriate category, less applicable incentive, as established by the rate-setting process. If the agency's cost information is received after rates are established, the Department will calculate a rate based on the

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

information received and retroactively and prospectively adjust the agency's previously assigned rate only if it is greater than the calculated rate. The agency's rate will remain in effect until the next rate adjustment period, as determined by the Department. Failure to submit cost information may result in suspension or termination of the agency from the Medicaid Home Health program.

An agency's Medicaid cost report is subject to review or audit by the Department or its agent(s) in accordance with HCFA-15 principles of reimbursement and Medicaid policies and procedures. The agency's reimbursement rate will be adjusted (if necessary) for the period for which the rate was effective as a result of the review or audit performed. Percentile and rate ceilings as initially established will not be adjusted based upon subsequent audits. An agency may appeal any audit adjustments and rates resulting therefrom using the administrative review procedures outlined in the home health policy manual.

Nonallowable Costs

Effective for the determination of reasonable costs used in the calculation of rates initially established on and after April 1, 1991, the costs outlined below are nonallowable for Medicaid purposes:

(a) 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;

(b) Memberships in civic organizations;

(c) 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;

(d) 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);

(e) 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 transport is nonallowable;

(f) Fifty percent (50%) of professional dues for national, state, and local associations.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

(g) 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.

(h) 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.

Information on these nonallowable costs will be obtained by the Department or its agent at the time of review or audit of the agency.

The agency's reimbursement rate will be adjusted (if necessary) for the period for which the rate was effective as a result of the review or audit performed. Percentile and rate ceilings as initially established will not be adjusted based upon subsequent audits. An agency may appeal any audit adjustments and rates resulting therefrom using the Department's Administrative Review Procedures.

New Agencies

a) A new agency will be reimbursed a rate equal to the statewide average reimbursement rate for the appropriate category, as of the effective date of enrollment of the new agency. This new agency rate will be reimbursed until a cost report for a base period (minimum nine months) on which an agency-specific rate per visit can be based, is received by the Department. There will not be a cash settlement determination for new agencies.

b) A new agency is defined as an agency established by the initial issuance of a Certificate of Need (CON), Medicare certification and state license; it is reimbursed as described in paragraph a) above. An agency formed as a result of a merger, acquisition, other change of ownership, business combination, etc. is not a new agency. Each agency of this type will maintain the reimbursement rate it was assigned prior to the transaction. When rates are subsequently adjusted, the appropriate cost report for the base period (as determined by the Department) will be used as a basis for determining the agency's rate.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

Agencies With Insufficient or Unauditable Cost Data

If an existing agency submits costs data for its fiscal year that corresponds to the base period and the fiscal year is for an insufficient period of time (as determined by the Department but usually a period of less than nine (9) months), that cost data will not be used in establishing the percentile and rate ceilings for the appropriate category and in calculating the statewide supply rate per visit. However, the data will be used to calculate a rate per visit using the methodology previously described. A freestanding agency's actual reimbursement rate in this instance will be the lesser of the calculated rate per visit (including applicable incentive) or the 75th percentile for the appropriate category, calculated exclusive of the agency's insufficient cost data, plus the statewide supply rate per visit, also calculated exclusive of the agency's insufficient cost data. A hospital-based agency's actual reimbursement rate in this instance will be the lesser of the calculated rate per visit (including applicable incentive) or the maximum rate per visit for the appropriate hospital-based subcategory, calculated exclusive of the agency's insufficient cost data, plus the supply rate per visit, also calculated exclusive of the agency's insufficient cost data. There will be no cash settlement for existing agencies with insufficient cost data for the base year.

Existing agencies with cost data which cannot be audited for the fiscal year that corresponds to the base period will be omitted from the rate setting process and assigned the lowest rate in the state for the applicable category until the appropriate records are made available to verify (audit) the cost information.

Amended Medicare and Medicaid Cost Data

An agency may submit an amended Medicare cost report and Medicaid Cost Data Form after the initial submission for the most recent fiscal year. An amended report and cost data form must be received by the Department no later than ninety (90) days after the due date of the initial report and form, or ninety (90) days after any due date extension granted by the Department. The amended Medicare report must support the amended Medicaid cost data form. The due date of the initial report and cost data form is contained in the cost report section.

Classification of Agencies

For reimbursement purposes Home Health agencies will be classified as follows:

(a) Urban - Agency located in a Metropolitan Statistical Area, as evidenced by documentation on file with the Department, including, but not limited to, the address on the Medicare cost report received by the Department or fiscal intermediary.

POLICY AND METHODS FOR ESTABLISING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

b) Rural - An agency located in a non-Metropolitan Statistical Area, as evidenced by documentation on file with the Department, including, but not limited to, the address on the Medicare cost report received by the Department or fiscal intermediary.

c) Hospital-based - An agency classified as hospital-based for Medicare purposes will be considered hospital-based for Medicaid purposes. Hospital-based agencies will be further categorized as urban or rural using the criteria in (a) and (b) above. Agencies retrospectively classified as hospital-based by Medicare will not be classified retrospectively as hospital-based by the Department. The agency will be notified of the prospective effective date.

Agencies which submit Medicare cost reports with addresses different from the address on the Statement of Participation on file with the Department will have their cost reports returned for verification. If the agency uses the address on the Medicare cost report for Medicare purposes, this same address will be utilized in designation of a location for rate setting purposes for the Department.

H. **EPSDT Private Duty (Continuous) Nursing Services**

The maximum reimbursement for public and private providers of private duty nursing services is limited to the lower of:

a) The actual charges for the service; or

b) The statewide rate in effect on the dates of services is based on a survey of seven (7) states conducted in 1999. Another state survey will be conducted when legislatively mandated.

POLICY AND PROCEDURES FOR ESTABLISHING
PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

H. INDEPENDENT LABORATORY AND X-RAY SERVICES

Payments are made for specific authorized procedures on a statewide basis and are limited to the lower of:

(a) the actual charge for the procedure, or

(b) the statewide rate in effect on the date of service.
Reimbursement for laboratory services performed by an independent laboratory will not exceed the upper limit of payment established by Medicare for the same clinical laboratory test.

I. ORTHOTICS AND PROSTHETICS SERVICES

The maximum reimbursement amount for it5ems and services will not exceed rates established by the State Agency based upon the usual and customary charge for the items and services.

Effective for dates of service July 1, 1994 and after, a $3.00 recipient co-payment is required on Orthotics and Prosthetics services.

Pregnant women, recipients under twenty-one years of age, , nursing home residents, and hospice services are not required to pay a co-payment. Emergency services and family planning are also exempt from a co-payment.

J. PHYSICIAN SERVICES (Includes Physicians, Podiatrists, Optometrists and Psychologists)

Payments are made for specific authorized procedures on a statewide basis and are limited to the lower of:

(a) The actual charge for the services; or

(b) The statewide rate in effect on the date of services.

(c) If the recipient is referred in writing by the surgeon to an optometrist for post-cataract surgery follow-up care, the surgeon's fee will be reduced by an amount equal to the maximum allowable reimbursement for the post-cataract surgery follow-up care.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

J. PHYSICIAN SERVICES (Includes Physicians, Podiatrists, Optometrists and Psychologists)

Professional Services:

Payments for certain professional services rendered in a hospital, outpatient, or Ambulatory Surgical Center setting which are normally performed in a physician's private office or clinic, are made on a statewide basis and are limited to the lower of:

(a) The actual charge for the service; or

(b) The statewide rate in effect with the appropriate site of service differential on the date of service.

Services that are primarily performed in office settings will be subject to a reimbursement reduction when performed in an inpatient, outpatient, emergency, or ambulatory surgical setting. The reduced reimbursement is calculated at 90% of the Resource Based Relative Value Scale (RBRVS) facility-setting rate as specified by the current Medicare Fee Schedule.

Injectable Drugs:

Effective for dates of services on or after September 1, 2009, the maximum allowable reimbursement for physician's injectable drugs administered by a provider or appropriate designee, in an office or outpatient setting, to the lower of:

a) Usual and customary charge, or

b) Average Sales Price (ASP) plus 6% as defined January 1st of each year or upon the drug's initial availability in the marketplace which ever is later; or

c) Average Wholesale Price (AWP) minus 11%, for drugs that do not have a published ASP price until such time ASP pricing becomes available and ASP plus 6% pricing can be utilized.

All agency rates for injectable drugs are published on the Physician's Injectable Drug List (PIDL), which is published on the agency's website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

POLICY AMD NETJPDS FPR ESTABLISHING
PAMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

J. **PHYSICIAN SERVICE** (Includes Physicians, Podiatrists, Optometrists and Psychologists)(continued)

*Descriptions:

AA	Anesthesia services personally performed by an Anesthesiologist
QK	Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individual(s) [i.e., Certified Registered Nurse Anesthetists (CRNAs) or Physician Assistant Anesthesiology Assistants (PAAAs)] by an Anesthesiologist
QX	CRNA and PAAA performing anesthesia services under the direct supervision of an anesthesiologist
QY	Single (one) medically directed anesthesia service performed by an Anesthesiologist
QZ	Non-medically directed CRNAs
78	Return trip to the operating room

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

J. PHYSICIAN SERVICES (Includes Physicians, Podiatrists, Optometrists and Psychologists)

Professional Services:

Payments for certain professional services rendered in a hospital, outpatient, or Ambulatory Surgical Center setting, which are normally performed in a provider's private office or clinic, are made on a statewide basis and are limited to the lower of:

(a) The actual charge for the service; or

(b) The statewide rate in effect with the appropriate site of service differential on the date of service.

Services that are primarily performed in office settings will be subject to a reimbursement reduction when performed in an inpatient, outpatient, emergency, or ambulatory surgical setting. The reduced reimbursement is calculated at 90% of the Resource Based Relative Value Scale (RBRVS) facility-setting rate as specified by the current Medicare Fee Schedule.

Injectable Drugs:

Effective for dates of services on or after September 1, 2009, the maximum allowable reimbursement for physician's injectable drugs administered by a provider or appropriate designee, in an office or outpatient setting, to the lesser of:

a) Usual and customary charge, or

b) Average Sales Price (ASP) plus 6% as defined January 1st of each year or upon the drug's initial availability in the marketplace which ever is later; or

c) Average Wholesale Price (AWP) minus 11%, for drugs that do not have a published ASP price until such time ASP pricing becomes available and ASP plus 6% pricing can be utilized.

All agency rates for injectable drugs are published on the Physician's Injectable Drug List (PIDL), which is published on the fiscal agent's website[1]. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

[1]The fiscal agent's website is assessable via Georgia Medicaid's website at www.dch.georgia.gov; *click on the "Georgia Medicaid" link, then click on the fiscal agent, Georgia Health Partnership's link (Hewlett Packard (HP) after July 1, 2010).*

Providers subject to this change include but may not be limited to: Physicians, Physician assistants, Nurse Midwives, Advanced Nurse Practitioners, Podiatrists, Oral Maxillofacial Surgeons, and related providers eligible to administer injectable drugs.

J. PHYSICIAN SERVICES cont'd (Includes Physicians, Podiatrists, Optometrists and Psychologists)

Vaccine Administration:

Effective for dates of services on and after October 9, 2009, the maximum allowable reimbursement to providers administering the H1N1 influenza vaccine to adults over 19 years of age, where the vaccine is supplied at no cost to the provider, shall be paid at the lesser of (a) the usual and customary charge or b) the statewide maximum allowable reimbursement amount allowed for the procedure code reflecting the service rendered.

The agency's rates were set as of October 9, 2009, and are effective for services on or after that date. All rates are published on the agency's fiscal agent's website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.
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Anesthesia Services:

Payments to physicians for anesthesia services performed by the physician or the mid level providers supervised by the physician are paid based on the calculated anesthesia formula in effect on the date of service.

The sum of Base Units plus Time Units plus Special Condition Units, if applicable, is multiplied times the conversion factor for anesthesia services.

The conversion factor service dates beginning on or after January 1, 1992, is 16.00 for all geographic areas when filing modifier* AA or 78.

For modifiers* QK and QY, the conversion factor is 5.58 and modifiers* QX and QZ conversion factors are 10.42 and 15.84, respectively.

If a CPT procedure is non-covered, anesthesia for that service is also non-covered.

Descriptions:

AA Anesthesia services personally rendered by an Anesthesiologist

QK Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individual(s) [CRNA's] or [PAAA's] by an anesthesiologist.

QX Medically Directed—salaried employee of Anesthesiology

QY Medical direction of on anesthesia procedure involving a qualified individual [CRNA's] or [PAAA's] by anesthesiologist

QZ Non medically Directed—self employed

78 Return to the operating room

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

J. PHYSICIAN SERVICES (Includes Physicians, Podiatrists, Optometrists and Psychologists)

For physician services provided in a hospital or hospital-based clinic on and after October 1, 2005, faculty practices affiliated with governmental teaching hospitals will be eligible for a supplemental payment. All physician services provided on and after August 1, 2006, by faculty practices affiliated with governmental teaching hospitals located in Metropolitan Statistical Areas (MSAs) will he eligible for a supplemental payment.

Eligible physician faculty practices consist of those affiliated with the following:
Medieal College of Georgia Hospital
Floyd Medical Center
Grady Memorial Hospital
Medical Center of Central Georgia
Memorial Health University Medical Center
Phoebe Putney Memorial Hospital
Satilla Regional Medical Center
The Medical Center

The methodology for calculating physician supplemental payments will be the difference between the Medicare equivalent of the average commercial rate and the Medicaid payment. For anesthesia services, the supplemental payment will be the difference between the Medicare rate and the Medicaid rate. Only the physician component of a procedure is eligible for a supplemental payment.

Base data will be calculated from each eligible practice but the Medicare equivalent of the average commercial rate will be grouped by hospital affiliation. For practices associated with Grady Memorial Hospital, the Medicare equivalent of the average commercial rate will be practice specific.

The Medicare equivalent of the average eommercial rate will be determined as follows based on a per affiliation calculation (except as noted above):

1. Medicaid paid claim data for physician professional services will be used for a defined base period (April 2005 to March 2006) for each faculty practice eligible for a physician supplemental payment. The paid elaim data will be compiled to identify the number of procedures and payment amounts included

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POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

in the paid claims, sorted by procedure code for services provided in a hospital setting.

2. For the same base period as used to identify Medicaid paid claims data, each faculty practice will identify the average payment (including patient share amounts) per procedure code for the practice's five largest commercial payers or all payers. The top five commercial payers will be determined by total billed charges reported by eligible practices.

3. The base period average commercial payment will be calculated by multiplying the average commercial rate per procedure by the number of times each procedure code was rendered in the base period and paid to eligible practices on behalf of Medicaid beneficiaries as reported from the MMIS. The sum of the product for all procedure codes shall determine the base period's average commercial payment ceiling. If sufficient commercial-equivalent payment data is not available for a faculty practice, average ratios for other practices in the applicable geographic market will be used.

4. For the same base period as used to identify Medicaid claim data and average payments per procedure code for commercial payers, the Medicare fee schedule for physician services will be used to identify the Medicare equivalent payment rates.

5. The base period Medicare payment ceiling will be calculated for each of the procedure codes used to determine the average commercial payment by multiplying the base period non-facility, Medicare allowed rate by the number of times each procedure code was rendered in the base period and paid to eligible practices on behalf of Medicaid beneficiaries as reported from MMIS. The sum of the product for all procedure codes shall represent the base period Medicare equivalent payment ceiling.

6. The base period Medicare equivalent of the average commercial rate will be calculated by dividing the base period average commercial payment ceiling by the base period Medicare payment ceiling. If an average commercial payment rate or Medicare-equivalent payment rate is not available for a particular procedure code, paid claim data for the procedure code will be excluded from the aggregate values.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

7. Periodic update to the base period Medicare equivalent of the average commercial rate -- The State shall periodically update this ratio at least every three years. Average commercial ratios are subject to revision, if necessary, based on the Department's review of provider-reported data regarding commercial payment rates.

Determination of the Supplemental Payment

8. The supplemental payment will be determined by multiplying the Medicare equivalent of the average commercial rate by the applicable Medicare non facility rate per procedure code. The product is then multiplied by Medicaid volume per code (as reported through the MMIS paid claims data) for the payment period The products for all codes are summed to determine the maximum payment amount for the payment period.

9. The Medicaid supplemental payment for each practice shall equal the payment period maximum amount at the Medicare equivalent of the average commercial rate less all Medicaid payments, including enhanced payments for procedure codes rendered in the payment period and paid to eligible physician practices on behalf of Medicaid beneficiaries as reported from the MMIS paid claims data.

10. Payment will be made quarterly not prior to the delivery of services and will be based on individual CPT codes associated with physician services reported through the State's MMIS paid claims data.

11. Supplemental payment is not available for non-physician services such as, but not limited to, diagnostic laboratory services and the non-physician, technical component of bundled radiology services.

12. Based on the above calculation, the following Medicare equivalent of the average commercial ratios will be used:

Practice / hospital	hospital only	All services
Emory Children's Center	1.460	1.445
Emory Medical Care Foundation	1.557	1.557
The Emory Clinic	1.603	1.561
Morehouse Medical Associates	1.237	1.214

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

Practice / hospital	hospital only	All services
Medical College of Georgia	1.231	1.231
Memorial Health University	1.592	1.523
Medical Center of Central Georgia	1.319	1.306
The Medical Center	1.110	1.099
Phoebe Putney	1.767	1.645
Floyd Medical Center	1.295	1.300
Satilla Regional Medical Center	1.295	

13. For anesthesia serviees paid on the same basis as Medicare, supplemental payments will be the difference between Medicare equivalent payments and Medieaid payments. Calculated as follows:

    i. For the payment period, multiply the Medieare rate for anesthesia by the number of Medieaid units (base plus time) per procedure eode. The Medicare rate should be adjusted depending on the proeedure modifier to determine the appropriate Medicare conversion factor.

    ii. Sum the products of the above step to determine total Medieare equivalent payments. This represents the payment eeiling for anesthesia services paid on the same basis as Medicare.

    iii. For the same codes and payment period, subtract the total Medicaid payments from the payment ceiling. This amount represents the total amount eligible for a supplemental payment.

14. For anesthesia services paid on a fixed fee, supplemental payments will be the differenee between Medicare equivalent payments and Medicaid payments. Calculated as follows:

    i. MMIS data for a sample period (October 2005 to September 2007) will be used to determine the average number of units (base plus time) per proeedure eode and by modifier for eligible physieian faeulty praetiees. For the payment period, multiply the Medieare rate by the average number of units per procedure code and by the number of times that the proeedure code was paid by Medicaid. The Medicare rate should be adjusted depending on the procedure modifier to determine the appropriate Medicare conversion factor.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

ii. Sum the products of the above step to determine total Medicare equivalent payments. This represents the payment ceiling for anesthesia services paid on the same basis as Medicare.

iii. For the same code and payment period, subtract total Medicaid payment from the payment ceiling. This amount represents the total amount eligible for a supplemental payment.

15. All supplemental payments will be determined on a retrospective basis and will not be subject to subsequent adjustment.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYES OF CARE OR SERVICE

M(2) Specialized Transportation for Medicaid eligible Children under age 21, an with Individual Education Programs (IEP)

1. Reimbursement for specialized transportation will be based on a flat rate.
2. The statewide rate will be established using the average historic cost of providing specialized transportation services in the school districts.
3. The cost of non-school provided transportation will be excluded form the calculation and will not be paid by Medicaid.
4. The Department will consider periodic inflationary adjustments to the rate.
5. The reimbursement authority to pay for specialized transportation services provided in schools will end effective June 30, 2008.

A trip, for Medicaid billing purposes is defined as a trip for a Medicaid eligible student requiring special transportation services, picked up at home or school, delivered to a location where an approved Medicaid service is provided, or delivered back to home or school from the Medicaid service. This definition is consistent with Section 3.1 a/b of the State Plan.

The school districts will maintain daily transportation logs and provide data related to the number of specialized transportation trips per student. These data will include the number of special transportation students transported and the number of days transported.

Medicaid will be billed only for children who have been determined eligible for Medicaid. In this way the total costs of specialized transportation will be allocated between Medicaid and Non-Medicaid. A specialized transportation claim will only be accepted if the school district can document that the child received specialized transportation service on the same day that a Medicaid covered IEP service was provided.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

N. **CASE MANAGEMENT SERVICES**

(a) Case Management services will be reimbursed on a negotiated rate basis not to exceed actual costs, which meets all requirements of the Office of Management and Budget Circular A-97 dated January 15, 1981.

(b) Perinatal Case Management Services will be reimbursed on a fee-for-service basis billed monthly on the HCFA 1500 form.

For private providers, payments are limited to the lesser of the submitted charges or the established fees as determined for public providers below.

Fees-for-service will be prospective, based on the actual cost of public providers and will be evaluated annually to reflect actual cost.

POLICY AND METHODS FOR ESTABLISHING RATES FOR OTHER TYPES OR CARE OR SERVICE

PERINATAL CASE MANAGEMENT (PCM) NEW PATIENT, COMPREHENSIVE: Service to a new patient whose case management and administrative records need to be established. This service will be completed within 30 days of enrollment into case management services. A comprehensive level of service will be provided including an assessment and individualized plans for 1) medical, 2) nutritional, 3) psychosocial and 4) health educational needs of the client. A problem list will be developed based on this comprehensive assessment and priorities set. Initial linkages will be made with required services for no less than the top three priorities. For example:

* A prenatal care provider who accepts Medicaid clients will be located and an appointment made.

* A nutritional assessment will be done and/or an appointment made for WIC enrollment and nutritional counseling.

* Arrangements for any necessary transportation will be made.

This unit of service will be billed once per pregnancy.

PERINATAL CASE MANAGEMENT FOLLOW-UP: Services to an established patient. All contacts with the client, by professional or paraprofessional staff, must be documented by level of service to receive reimbursement. Reimbursement is limited to a maximum of (8) eight follow-up services per pregnancy in any combination (e.g., one brief or one extended follow-up unit per month.) Dates of service must be after the date of the comprehensive assessment and before the date of delivery.

The level of service billed will be based on the patient's individualized assessment and need for Case Management assistance as defined below:

Brief follow-up: Consists of at least one (1) minimal contact (direct or indirect) to ensure the recipient is complying with the established plan for care. A tracking system will be maintained for monitoring monthly follow-up of the recipient's established plan.

Extended follow-up: Consists of a minimum of one direct contact to reevaluate or reassess the individualized plan for medical, nutritional, psychosocial and health education needs due to complications of pregnancy or change in environmental factors.

TRANSMITTAL 89-14
APPROVED 8-21-90
EFFECTIVE 4-1-89
SUPERSEDES (NEW)

POLICY AND METHODS FOR ESTABLISHING RATES FOR OTHER TYPES OR CARE OR SERVICE

PERINATAL CASE MANAGEMENT, POSTPARTUM FOLLOW-UP: Services provided to an established patient after the delivery. Assessments, plans and initial linkages will be made based on the mother's needs for postpartum, family planning and other services, and to assist her with obtaining Medicaid enrollment, WIC, EPSDT and other services needed by her infant. Service will be provided by professional staff and may be supported by paraprofessional staff. Final case management services will be completed within 60 days after delivery and can not be later than the last day of Medicaid eligibility. This unit of service will be billed once per pregnancy.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

N. (c) Early Intervention Case Management services will be reimbursed directly to the providers of case management services on a negotiated rate basis not to exceed actual costs, which meets all requirements of the Office of Management and Budget Circular A-87 dated January 15, 1981.

TRANSMITTAL 91-20
APPROVED 12-5-91
EFFECTIVE 5-21-91
SUPERSEDES NEW

POLICY AND METHODS FOR ESTABLISHING PAYMENTS RATES FOR OTHER TYPES OF CARE OR SERVICES

N. (d.) Children At-Risk Case Management Services will be billed monthly on the HCFA 1500 form and be reimbursed on a prospective fee-for service basis. Payments to providers are limited to the lesser of the submitted charge or the established rate. The established statewide rates are based on the median cost per visit of providers currently enrolled in the program. Cost will be evaluated periodically and reimbursement rates will be adjusted to reflect cost.

NEW CHILD, COMPREHENSIVE ASSESSMENT: Service to a new child whose care management records must be established. This service will be completed within 30 days of enrollment into case management services. A comprehensive level of service will be provided including an assessment and individualized service plan for the health, educational, social, psychological, and other needs of each youth. A problem list will be developed based upon the comprehensive assessment and service priorities established, initial linkages will be made with providers of the needed identified services for at least the top three priorities. For example:

1. Those children assessed as being in need of health care will be referred to an EPSDT provider for EPSDT services.

2. A referral will be made to the County Department of Family and Children Services to assist children living in abusive family situations.

3. Arrangements will be made for any necessary transportation.

This unit of service will be billed only once for each eligible child served.

CASE MANAGEMENT FOLLOW-UP: Services to an established service recipient. All contacts with the recipient and/or his/her family by Family Connection Case Management personnel must be documented by level of service to receive reimbursement. Reimbursement is ~~limited to a maximum of 12 visits annually~~. ~~Dates of service must occur after the comprehensive assessment~~.

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POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

limited to a maximum of 12 visits annually. Dates of service must occur after the comprehensive assessment.

The level of service billed will be based on the service recipient's individual service plan and the need for case management assistance as defined below.

Brief follow-up: Consist of at least one (1) minimal contact with the recipient, the family or the service provider to ensure that the recipient is complying with the established service delivery plan.

Extended follow-up: Consist of a minimum of one direct contact with the recipient and the family to reevaluate or reassess the individual service delivery plans due to changes in recipient's personal or family factors.

TRANSMITTAL 92-01
APPROVED 5-12-92
EFFECTIVE 2-1-92
SUPERSEDES (NEW)

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

N. (e.) Dropout Recovery Case Management Services will be billed monthly on the HCFA 1500 form and be reimbursed on a prospective fee-for-service basis. Payments to public and private providers are limited to the lesser of the submitted charge or the established fees based on the actual cost of public providers as determined by time studies conducted pursuant to methodology approved by HCFA, Region IV. Costs will be evaluated annually and fees adjusted to reflect actual cost.

NEW CLIENT, COMPREHENSIVE ASSESSMENT: Service to a newly recovered dropout whose case management records must be established. This service will be completed within 30 days of enrollment into case management services. A comprehensive level of service will be provided including an assessment and individualized service plan for the health, educational, social, psychological, and other needs of each youth. A problem list will be developed based upon the comprehensive assessment and service priorities established. Initial linkages will be made with providers of the needed identified services for at least the top three priorities. For example:

1. Those recovered dropouts assessed as being in need of health care will be referred to an EPSDT provider for EPSDT services.

2. A referral will be made to the County Department of Family and Children Services to assist recovered dropouts living in abusive family situations.

3. A referral will be made to the Public School System or GED providers to assist recovered dropouts to complete a planned secondary educational program.

This unit of service will be billed only once for each eligible child served.

TRANSMITTAL 92-31
APPROVED 10-27-92
EFFECTIVE 10-15-92
SUPERSEDES (NEW)

CASE MANAGEMENT FOLLOW-UP: Services to an established service recipient. All contacts with the recipient and/or his/her family by Dropout Recovery Case Management personnel must be documented by level of service to receive reimbursement. Reimbursement is limited to a maximum of 12 visits annually. Dates of service must occur after the comprehensive assessment.

The level of service billed will be based on the service recipient's individual service plan and the need for case management assistance as defined below.

Brief follow-up: Consist of at least one (1) minimal contact with the recipient, the family or the service provider to ensure that the recipient is complying with the established service delivery plan.

Extended follow-up: Consist of a minimum of one direct contact with the recipient and the family to reevaluate or reassess the individual service delivery plans due to changes in recipient's personal or family factors.

TRANSMITTAL 92-31
APPROVED 10-27-92
EFFECTIVE 10-15-92
SUPERSEDES (New)

Policy and Methods for Establishing Payment Rates for other Types of Care or Services

N.(f) Case Management Services for Adults with AIDS will be billed monthly on the DMA-1500C (4/92) form and will be reimbursed on a prospective fee-for-service basis.

Payments to private providers are limited to the lesser of the submitted charge or the established fee(s) based on actual cost as determined by time studies conducted pursuant to methodology approved by the Health Care Financing Administration.

Public providers of case management services will be reimbursed directly on a negotiated rate basis not to exceed actual cost.

Costs will be evaluated annually and fees adjusted to reflect actual cost.

New Client Comprehensive Assessment:

Service to a new client whose case management records must be established. This service must be initiated within 48 hours of the request for services and must be completed within 30 days of enrollment into case management.

A comprehensive level of service shall be provided including obtaining a medical assessment from the client's primary physician, conducting a psychosocial assessment, developing an individualized service plan for the client's medical, nutritional, social, educational, psychological transportation, housing, legal, financial, and other needs. A problem list shall be generated based on the comprehensive assessment and service priorities shall be established. Initial linkages shall be made with providers of the needed identified services. This unit of service may be billed only once for each client served.

Case Management Follow-Up:

Services to an established service recipient. All contacts with the recipient, his or her family members, significant others, and service providers must be documented to receive reimbursement. Reimbursement is limited to a maximum of 12 follow-up services annually. Providers may not bill for an extended and a brief follow-up performed in the same month. Providers may bill for no more than three (3) extended follow-up services annually. Dates of follow-up services must occur after the comprehensive assessment.

The level of service (brief or extended) billed shall be based on the recipient's individual service plan and the descriptions of case management follow-up found below.

Brief Follow-Up:

Consists of at least one (1) contact with the recipient AND, if appropriate, his or her significant other, family member, or service provider to ensure that the recipient is complying with the established service delivery plan.

Extended Follow-Up:

Consists of at least one (1) direct contact with the recipient to re-evaluate or reassess the individual service delivery plan due to crisis resulting from changes in recipient's medical condition, loss of social support, employment, or housing, legal problems, or other significant events.

TRANSMITTAL 92-40
APPROVED 1-28-93
EFFECTIVE 10-1-92
SUPERSEDES (NEW)

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
FOR OTHER TYPES OF CARE OR SERVICES

N.(g) The results of a time study were applied to projected costs for each of the prospective providers and statewide rates for the first year were established based on an arraying of the costs of the 50th percentile. Cost reports from all providers will be evaluated annually after the first year of implementation to determine subsequent statewide rates. Payments to public and private providers will be limited to the lesser of the submitted charge or established fee based on cost reports from providers. Payment to providers may not exceed actual cost of providing services.

At-Risk of Incarceration Case management Services will be reimbursed on a fee- for-service basis billed monthly on the HCFA 1500 form.

The Department will reimburse one unit of case management service per month per beneficiary. The specific service component (billing unit) covered under the At-Risk of Incarceration program is *Basic Case Management.*

Basic Case Management

"Basic Case Management" must be provided by a qualified provider to a child in the care of the Department of Juvenile justice. It must include at least one (1) contact with the recipient, family or service provider to ensure that services are being delivered in accordance with the established service delivery plan. It includes one or more of the following activities:

A. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the child.

B. Assisting the child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.

C. Monitoring the child and service providers to determine that the services received are adequate in meeting the child's needs.

D. Reassessment of the child to determine services needed to resolve any crisis situation resulting from divorce, death, separation, changes in family structure or living conditions, or other events.

Extended Follow-up

The extended follow-up consists of at least one (1) direct contact with the beneficiary and a family member or provider to re-evaluate the individual service plan due to changes in the beneficiary's personal or family factors.

The extended follow-up will require additional documentation if billed more than three (3) times during a calendar year. If subsequent visits are billed, documentation of necessity of the service must be attached to each claim. The Department will either approve or deny the claim.

Only one (1) brief or one (1) extended follow-up may be billed each month with a maximum of twelve (12) follow-up services per year.

Dates of service for case management follow-up must occur after the initial assessment.

In the event of multiple types of targeted case management, only one type will be reimbursed during the calendar month for each beneficiary.

STATE: Georgia

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

N. (h) Perinatal Case Management Services/Area C will be billed monthly on the HCFA 1500 form and be reimbursed on a prospective fee-for-service basis. Payments to public and private providers are limited to the lesser of the submitted charge or the established fees based on the actual cost of public providers as determined by time studies conducted pursuant to methodology approved by HCFA, Region IV. Costs will be evaluated annually and fees adjusted to reflect actual cost.

PREGNANT WOMAN, COMPREHENSIVE ASSESSMENT: Service to a newly pregnant woman whose case management records must be established. This service will be completed within 30 days of enrollment into case management services. A comprehensive level of service will be provided including an assessment and individualized service plan for the health, educational, social, psychological, and other needs of each pregnant woman. A problem list will be developed based upon the comprehensive assessment and service priorities established. Initial linkages will be made with providers of the needed identified services for at least the top three priorities. For example:

1. Pregnant women will be referred to a prenatal care provider.

2. Pregnant women will be referred to the County Department of Health for nutritional assessment and for WIC benefits.

3. Arrangements will be made for any necessary transportation to prenatal care appointments.

This unit of service will be billed once for each eligible pregnant woman.

NEWBORN, COMPREHENSIVE ASSESSMENT: Service to a newborn whose case management records must be established. This service will be completed within 30 days of birth. A comprehensive level of service will be provided including an assessment and individualized service plan for the health, social, psychological, and other needs of each newborn. A problem list will be developed based upon the comprehensive assessment and service priorities established. Initial linkages will be made with providers of the needed identified services for at least the top three priorities. For example:

1. Newborns will be referred to an EPSDT provider for EPSDT services.

2. Newborns will be referred to the County Department of Health for nutritional assessment and for WIC benefits.

3. A referral will be made to the County Department of Family and Children Services to assist newborns living in abusive family situations.

This unit of service will be billed one for each eligible newborn.

TRANSMITTAL 93-020
APPROVED 5-4-94
EFFECTIVE 4-1-93
SUPERSEDES NEW

STATE: Georgia

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

CASE MANAGEMENT FOLLOW-UP: Services to an established service recipient. All contacts with the recipient and/or recipient's family by Case Management personnel must be documented by level of services to receive reimbursement. Reimbursement is limited to a maximum of 12 visits annually. Dates of service must occur after the comprehensive assessment.

The level of service billed will be based on the service recipient's individual service plan and the need for case management assistance as defined below.

Brief Follow-up: Consist of at least one (1) minimal contact with the recipient, the family or the service provider to ensure that the recipient is complying the established service delivery plan.

Extended Follow-up: Consist of a minimum of one direct contact with the recipient and the family to reevaluate or reassess the individual service delivery plans due to changes in recipient's personal or family factors.

TRANSMITTAL 93-020
APPROVED 5-4-94
EFFECTIVE 4-1-93
SUPERSEDES NEW

Policy and Methods for Establishing Payment Rates For Other Types of Care or Services

N.(i) Reimbursement rates will be established based on cost as determined by the quarterly Social Services Random Moment Sample Study. Rates will be adjusted annually based on the results of the previous four quarters. The Random Moment Sample Study must provide an audit trail that identifies each client whose case is included in the data used for rate formulation.

A maximum of one unit of case management services will be reimbursed per month for each eligible recipient. However, if a family has more than one child in the home with the parent and no children have been placed outside of the home, the Department will only reimburse for one child within the family unit. Services will be reimbursed only for eligible recipients.

A unit of case management service is defined as at least one telephone or face-to-face contact with the recipient, a family member, significant other, or agency from which the client receives or may receive services. All contacts must be for the coordination or linkage of services.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

N.(j) Reimbursement rates will be established based on cost as determined by the quarterly Social Services Random Moment Sample Study. Rates will be adjusted annually based on the results of the previous four quarters. The Random Moment Sample Study must provide an audit trail that identifies each client whose case is included in the data used for rate formulation.

A maximum of one unit of case management services will be reimbursed per month for each eligible recipient. A unit of case management service is defined as at least one telephone or face-to-face contact with the recipient, a family member, significant other, or agency from which the client receives or may receive services. All contacts must be for the coordination or linkage of services for a specific recipient.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

Rural Health Clinic Services (RHC)

In accordance with Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, effective January 1, 2001, reimbursement is provided for "core" services and other ambulatory services (excluding in-house pharmacy services) at a prospective payment rate (PPS) per encounter. The rates will be calculated on a per visit basis and will reflect 100 percent of the average of the RHC's reasonable cost of providing Medicaid-covered services including other ambulatory services cost during FY 1999 and FY2000., Those costs will be adjusted to take into account any increase (or decrease) in the scope of services furnished by the RHC during FY2001for services that only occurred in calendar year 2000. Cost reports for the RHC's FY 1999 and FY 2000 periods will be used to establish the baseline rate for each RHC effective January 1, 2001. The baseline rate will be calculated by dividing the sum of the total reasonable cost of providing Medicaid covered services during FY 1999 and FY 2000 by the total Medicaid visits during the two fiscal years. Until the baseline rates are established, RHCs will be paid their interim rate effective December 31,2000. When the baseline rates are established, they will be paid retroactive to January 1,2001.

The baseline rates effective January 1,2001 will be adjusted by the Medicare Economic Index (MEI) effective for dates of service on and after October 1, 2001 based on the MEI and for changes in the RHC's scope of services during January 1, 2001 through September 30, 2001. For Federal Fiscal Year (FFY) 2002 and FFYs thereafter, the per visit rate will be calculated by adjusting the previous year's rate by the MEI for primary care, and for changes in the RHC's scope of services during the prior FFY.

For newly qualified RHCs that participate in FY 2000 only, the Department will use the FY 2000 cost for calculating the baseline PPS rate effective January 1,2001. Clinics that qualify after fiscal year 2000 will have their initial rates established by a statewide average of similar centers. After the initial year, payment will be set using the MEI and change of scope methods used for other clinics.

For purposes of this plan, a change in scope of services is defined as a change in the type, intensity, duration and/or amount of services. It is the clinic's responsibility to recognize any changes in their scope of services and to notify the Department of those changes and to provide the Department with documentation of and projections for the cost and volume of the change.

If a RHC provides core services pursuant to a contract between the center and a managed care entity (as defined in section 1932(a)(1)(B)), the State shall provide payment of a supplemental payment equal to the amount (if any) by which the PPS rate calculated above exceeds the amount of the payments provided under the contract. These supplemental payments shall be made pursuant to a payment schedule of four months or less agreed to by the State and the Rural Health Clinic.

An alternative payment methodology is established for services furnished in Rural Health Clinics located at Critical Access Hospitals. The reimbursement methodology will follow the provisions established in Attachment 4.19-B, Page 8a.1 (Outpatient Hospital). All clinics affected by this methodology have agreed and their payments will at least equal the amount they would have received under the PPS methodology. .

Effective for dates of service July 1, 1994, and after, a $2.00 recipient co-payment is required on all Rural Health Clinic Services (RHC). Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care participants are not subject to the co-payment. Emergency services and family planning services are also exempt from a co-payment

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

Non-Emergency Transportation Services

Non-Emergency Transportation is reimbursed according to the following methods, depending on type of vehicle and number of passengers for exceptional travel or the number of Medicaid eligibles in a region. Upper reimbursement limits shall not exceed charge determined to be reasonable by the State.

(a) The Broker is reimbursed a monthly capitated rate for each Medicaid member residing in the region.

(b) For exceptional travel, the Department of Family and Children Services is reimbursed a mileage rate per passenger for automobile services; commercial and public transportation are reimbursed at the usual and customary rate; escorts, meals and lodging are also reimbursed at the usual and customary rate.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

N (k) Services Coordination for Children with Individualized Education Programs (IEPs)

- Reimbursement for service coordination will be on a fee-for-service basis billable monthly on a HCFA 1500.
- The initial statewide maximum allowable rates will be established using comparable service coordination activities and rates paid in other existing targeted case management programs (i.e. Children at Risk).
- The Division will collect and evaluate cost data after the first year of service and periodically thereafter from participating local education agencies (LEA) to determine the actual cost of providing this service and establish a statewide fee structure.
- If the initial statewide maximum allowable rates exceed the actual cost of providing this service, the cost data will be utilized to set the maximum allowable rates. If the statewide maximum allowable rates are lower than the actual cost, the Division will periodically consider an increase subject to the availability of funds.

Service Categories

Ongoing monthly special education service coordination activities will be billed based on the child's IEP and the need for service coordination case management services as defined below:

1) Initial IEP
The initial IEP requires that the service coordinator integrate all evaluation data into a description of status that highlights the overall pattern of strengths and weaknesses of the student. Goals and objectives must be developed to address specific weaknesses. Supplementary aids and services to address those goals, in the least restrictive environment, must be considered. Input from the IEP Multidisciplinary Team, a schedule of required services, along with goals and objectives for each, must be determined and documented.

- This service can be billed as one (1) per lifetime for each Medicaid eligible child with an IEP.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

N (k) Services Coordination for Children with Individualized Education Programs (IEPs) (continued)

2) IEP Review
The compilation of progress reports and updated testing information by the service coordinator supports the required annual review of the IEP goals, objectives and services. The service coordinator must integrate this data so that a service schedule can be developed. This review must be done more often if the parent or a professional serving the student request a consideration of a change in services by the IEP Multi-disciplinary Team.

- This service can be billed as one (1) minimal contact or a maximum of three (3) per year.

3) Triennial IEP
Every three years the service coordinator must undertake a comprehensive analysis of available and relevant assessment information on the student. Necessary evaluations must be scheduled and a new IEP per child developed and adopted by the IEP Multi-disciplinary Team.

- This service can be billed as one (1) review every 3 years.

4) On-going Service Coordination
The ongoing contact (billable intervals) of the service coordinator in coordinating and monitoring follow-up with the child, the family, or the service providers (private and public agencies), to ensure access and compliance, as developed and adopted by the IEP Multi-disciplinary Team.

- This service can be billed at intervals of one (1) unit, which equals 15 minutes.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
FOR OTHER TYPES OF CARE OR SERVICES

o. Ambulatory Surgical Center Services and Birthing Center Services

1. Reimbursement for surgical procedures performed in the center is limited to the ASC facility fee as determined by Medicare with the exception of dental procedures that are reimbursed at Medicaid designated rates.

2. Reimbursement for the facility vaginal delivery fee will not exceed the amount that Medicare would reimburse. The facility fee payment for delivery services is made at the Group Four (4) ASC surgical reimbursement rate for the geographical area in which the billing facility is located. Rate adjustments are based on changes made in the ASC facility fee assigned for the group. The payments for related services provided by dentists, physicians or physician extenders are made under other Medicaid service programs.

3. Effective for dates of service July 1, 1994 and after, a $3.00 recipient co-payment is required on all ASC facility services. Pregnant women, recipients under twenty-one (21) years of age, nursing home residents, and hospice care recipients, are not required to pay the co-payment. Emergency services and family planning services are exempt from a co-payment.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

Ø. Hospice Services

S/b P. The Department reimburses hospices for hospice services in accordance with hospice payment rates defined at Section 4306.3 of the State Medicaid Manual. The Department will continue the payment rates which were in effect on October 1, 1990, through the end of the calendar year. There will be no reduction as required by Section 4007 of the Omnibus Budget Reconciliation Act of 1990 applicable to the Medicare program. Payment for physicians' professional services is in accordance with the usual Georgia Medicaid reimbursement policy for physicians' services.

The Department pays an additional per diem amount for routine home care and continuous home care days for hospice care that is furnished to an individual living in a nursing facility. This additional amount is for "room and board" which includes performance of personal care services, including assistance in the activities of daily living, socializing activities, administration of medications, maintaining the cleanliness of a resident's room, and supervision therapies. This amount is 95% of the per diem that would have been paid to the nursing facility for that individual in that facility under the State Plan. This rate is in addition to the routine home rate or the continous home care rate. The hospice retains full responsibility of the professional management of the individual's hospice care and the nursing facility agrees to provide "room and board" to the individual.

TRANSMITTAL 90-46
APPROVED 8-15-91
EFFECTIVE 10-1-90
SUPERSEDES (NEW)

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE SERVICES

Freestanding Birth Center Services

1. The Agency's rates were set as of July 1, 2003, and are effective for services on or after that date. Except as otherwise noted in the plan, the statewide maximum allowable reimbursement rate is 84.645% of the 2000 Resource Based Relative Value Scale as specified by Medicare for Georgia Area 1 (referred to as, "RBRVS") and is the same for both governmental and private providers.

2. Medicaid covers and reimburses for services rendered by providers administering prenatal labor and delivery or postpartum care in freestanding birth care centers such as physicians, nurse midwives and other providers of such services as recognized under Title 43 of the Official Code of Georgia Annotated. Practitioners furnish other covered mandatory services in accordance with Attachment 3.1-A, Page 4a-3.

3. Pregnant women, recipients under twenty-one (21) years of age, nursing home residents, and hospice care recipients, are not required to pay-the co-payment. Emergency services and family planning services are exempt from co-payments.

TN No. NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SE URITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE: GEORGIA

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
FOR OTHER TYPES OF CARE OR SERVICES

Item: Q . Payment of Title XVIII Part A and Paart B Deductible/Coinsurance

Except for a nominal recipient copayment, if applicable, the Medicaid agency may use the following method:

	Medicare-Medicaid Individual	Medicare-Medicaid/QMB Individual	Medicare-QMB Individual
Part A Deductible	X Limited to State Plan Rate*	x Limited to State Plan Rate*	X Limited to State Plan Rate*
	___ Full Amount	___ Full Amount	___ Full Amount
Part A Coinsurance	X Limited to State Plan Rate*	X Limited to State Plan Rate*	X Limited to State Plan Rate*
	___ Full Amount	___ Full Amount	___ Full Amount
Part B Deductible	X Limited to State Plan Rate*	X Limited to State Plan Rate*	X Limited to State Plan Rate*
	___ Full Amount	___ Full Amount	___ Full Amount
Part B Coinsurance	X Limited to State Plan Rate*	X Limited to State Plan Rate*	X Limited to State Plan Rate*
	___ Full Amount	___ Full Amount	___ Full Amount

* For those Title XVIII services not otherwise covered by the Title XIX State Plan, the Medicaid agency has established reimbursement methodologies as described in Items 2 and 3, specified on page 1 of Attachment 4.19-B.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

R. OUTPATIENT HOSPITAL SERVICES

1. Outpatient services by Georgia hospitals are reimbursed on a determination of allowable costs. The determination of allowable costs is made retrospectively and is based on an appropriate CMS Form 2552 cost report submitted by the hospital and audited by the Department or its agents. Only costs incurred in providing patient care are eligible for reimbursement. Fees paid to the Department of Community Health pursuant to the Provider Payment Agreement Act of 2010 shall be considered allowable cost but will not be included in the retrospective cash settlement and reconciliation of the providers cost report.

   Allowable costs will not include costs that are in excess of charges. Allowable costs are documented costs that are ordinary and necessary in the delivery of a cost-effective service. Allowable costs shall be determined in accordance with the CMS Provider Reimbursement Manual 15, except as may be modified in this plan or modified in the Department's "Policies and Procedures for Hospital Services" as published on January 1, 2008.

   The amount of interim payment is calculated as a percentage of covered charges. This payment rate is defined by covered as allowable outpatient costs divided by outpatient charges. An interim payment rate cannot exceed one hundred percent of covered charges and is subject to cash settlement determination after an audited cost report is received, reviewed and accepted.

   Clinical diagnostic laboratory services performed for outpatients and non-hospital patients are reimbursed at the lesser of the submitted charges or at the Department's fee schedule rates used for the laboratory services program.

2. The Department will provide for appropriate audit to assure that payments made to providers for outpatient hospital services meet the requirements of reasonable cost.

3. Outpatient services provided by non-participating non-Georgia hospitals are reimbursed at 45% of covered charges.

4. The maximum allowable payment for outpatient services will be 85.6% of the hospital specific inpatient per case rate, which includes the base rate amount

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

plus Capital add-on, Graduate Medical Education add-on, Newborn add-on and the Hospital Provider Fee rate add-on, for enrolled Georgia hospitals. This case rate for enrolled non-Georgia hospitals does not include the Hospital Provider Fee add-on amount.

5. Emergency room visits for minor and non-acute illnesses which are not considered as true or potential medical emergencies will be reimbursed at an all-inclusive rate of $50.00.

6. The maximum allowable payment to enrolled Georgia and non-Georgia hospitals for Medicare outpatient coinsurance (crossover claims) will be 85.6% of the hospital-specific Medicaid per case rate. The maximum allowable payment to non-Georgia hospitals not enrolled the Georgia Medicaid program for Medicare outpatient crossover claims will be 85.6% of the average hospital-specific inpatient per case rate for enrolled non-Georgia hospitals.

7. For the determination of reasonable and reimbursable costs, the costs listed below are non-allowable (this list is not exhaustive):

   a) 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;

   b) Memberships in civic organizations;

   c) 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;

   d) Vehicle depreciation or vehicle lease expense in excess the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles; provided, however, such limit shall not apply to specialized patient transport vehicles(e.g., ambulances);

   e) 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

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

patient transport, the portion of cost that is unrelated to patient care staff or patient transport is non-allowable;

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

g) 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; and

h) 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.

8. When the outpatient cost-based settlements are made, claims for outpatient services which were paid at the per case rate will be excluded from the settlement calculations.

9. Hospital-based physicians services will not be reimbursed if billed to the Hospital program. These services must be billed to the Physician program in order to be reimbursed by the Department.

10. The Department will limit payment on outpatient Medicare crossover claims as using the following steps:

(a) multiply the allowable deductible and coinsurance amount by the hospital-specific percent of charges rate in effect on the date of payment;
(b) compare the dollar amount from (a) to the hospital's inpatient per case rate in effect on the date of payment and,
(c) reimburse the lower of these two amounts.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

11. A $3.00 recipient co-payment is required on all non-emergency outpatient hospital visits. Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospital care recipients are not subject to the co-payment. Emergency services and family planning services are exempt from co-payment. When the outpatient cost-based settlements are made for hospital services, the co-payments plus Medicaid and certain third party payments will be compared to the allowable cost to determine the amount of final settlement.

12. The Department shall exclude from paid claims data used to calculate settlement claims for which a third party paid at or in excess of the amount Medicaid would pay. Third party payments which were below the Medicaid payment amount will be included in the interim payment amounts that are compared to reimbursable costs. The paid claims data used in the initial determination of outpatient settlements will be used when such settlements are adjusted.

13. Effective July 1, 2010, in order to recognize the Medicaid share of a facility's cost of paying fees under the Hospital Provider Payment Agreement Act, an adjustment will be added to the hospital outpatient payment rate. Critical Access Hospitals (CAHs) Psychiatric Hospitals and State-Owned / State-Operated Hospitals are exempt from the provider fee and the rate increase. Trauma hospitals will participate in the provider fee but at a lower percentage than other participating hospitals. The table below shows the provider fee and associated rate adjustment for different classes of hospitals.

Provider Type	Provider Fee Percent	Rate Increase Percent
Participating Acute Care Hospitals and Specialty Hospitals	1.45%	11.88%
Trauma Hospitals	1.40%	11.88%
Critical Access Hospitals, State-Owned and State-Operated Hospitals, Out-of-	N/A	N/A

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

State Hospitals		

In order to partially offset the 1.45% and 1.40% hospital fee rates levied by Georgia HB 1055 (the Provider Payment Agreement Act), a new Base Rate Change factor will be created. This new base rate change will be a multiplier, which will be expressed as a constant percentage of the Allowed Charge. There will be three different values for this Base Rate Change factor. One will be used for Inpatient Medicare Crossover claims. The second will apply to Outpatient Medicare Crossover claims. The Third will apply to non-Crossover Hospital claims.

When calculating the Final Allowed Charge, the addition of this new Base Rate Change factor will be the final step before any cutbacks are considered. The dollar amount will be calculated as a percentage of the Allowed Charge at that point in adjudication.

Outpatient Cost-to-Charge Ratio Base Payment is Calculated as:

CCR Base Payment = Total Calculated Allowed Charge** x Cost-To-Charge Ratio (CCR)* percent

CCR Base Payment + Cap/GME Add-on + Newborn Add-on = Allowed Charge
Allowed Charge x .1188 (PPA %) = PPA Add-on (Base Rate Change)
Allowed Charge + PPA Add-on – deductions (Copay, COB, Patient Liability) = Reimbursement Amount
The payment is the lower of the reimbursement amount or the inpatient per case rate plus PAA add on.

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*The system finds the provider's Cost-To-Charge Ratio (CCR) percent on the reference institutional rate table using the provider number and the claim's admission date.

**Calculation of the Allowed Charge occurs for each claim line. The total of the claim line Allowed Charges is used to calculate the cost-to-charge ratio (CCR) base payment.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

Effective for dates of service on and after July 1, 2010, through June 30, 2013, the payment method is modified as follows:

a. For enrolled hospitals other than those identified in items b and c below, the reimbursement rate is 95.77% of costs.

b. For out-of-state enrolled hospitals, payments are made at the statewide average percentage of charges paid to Georgia hospitals that are reimbursed at 85.6% of costs and are not subject to cost settlement. The payment rate for out-of-state enrolled hospitals will not exceed 65% of covered charges.

c. For hospitals that are designated as a Critical Access Hospital, a historically minority-owned hospital, or as a state-owned hospital, the reimbursement rate continues at 100% of costs.

Example settlement calculation for critical access, historically minority owned hospital, or state-owned hospitals:

Percentage of charges paid on interim basis	60%
Charges for services provided during cost report period	$1,000,000
Interim payments	$600,000
Retrospective determination of allowable costs*	$585,000
% of allowable costs reimbursed	100%
Retrospective determination of reimbursable costs	$585,000
Settlement amount due from hospital	$15,000

Example settlement calculation for all other enrolled Georgia hospitals:

Percentage of charges paid on interim basis	52%
Charges for services provided during cost report period	$1,000,000
Interim payments	$520,000
Retrospective determination of allowable costs*	$585,000
% of allowable costs reimbursed	95.77%
Retrospective determination of reimbursable costs	$560,250
Settlement amount due from hospital	$24,750

* amount would not exceed charges for services

14. Governmental facilities and Critical Access eligible hospitals which meet departmental requirements will be eligible for rate payment adjustments. The rate adjustment payments are intended to provide supplemental funding for Medicaid services to these facilities that based on their governmental status,

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

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:

- All amounts paid for services provided to Medicaid patients including interim Medicaid claim payments and estimated Medicaid cost report settlement amounts, based on data from cost report worksheet E-3 Part III, and
- Estimated payment amounts for such services if payments were based on Medicare payment principles. Costbased and rate payment measures (for clinical diagnostic lab services) will be used to determine Medicare payment amounts.

Comparisons of 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 determine facility-specific rate adjustment payments. If an individual facility cannot be paid a portion of its full rate adjustment payment due to a facility-specific charge limit, this rate adjustment amount can be allocated to other facilities that are eligible to receive additional rate adjustment payments without exceeding facility-specific charge limits. These rate payment adjustments will be made on quarterly or, at least, annual basis and will be determined in a manner that will not duplicate compensation provided from payments for individual patient claims. A sample of how a rate adjustment payment is calculated is presented below.

line	Facility Name	comments	XYZ Hospital
1	base period report period beginning date		9/1/xxxx
2	base period report period ending date		8/31/xxxx+1
3	HS&R processing date for Medicaid data		9/6/xxxx+2
4	adjustment factor (if period not equal to 1 year)		1

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

5	CAH status (1 = yes)		0
	subject to cost settlement		
6	cost of Medicaid covered services		755,769
7	covered charges		2,511,680
8	annual cost of Medicaid covered services	Line 6 x line 4	755,769
9	cost settlement rate		95.77%
10	annual Medicaid payments after cost settlement	Line 8 x line 9	721,382
	fee schedule lab only		
11	payments		102,275
12	annual interim payments	Line 11 x line 4	102,275
13	estimated payments for fee schedule lab services if paid on Medicare Lab fee schedule		244,687
	subject to fixed fee payment		
14	covered charges		223,627
15	payments		26,427
16	annual covered charges	Line 14 x line 4	223,627
17	annual interim payments	Line 16 x line 4	26,427

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

18	annual cost of services	Line 16 x line 6 / line 7	67,290
	subject to limit of inpatient rate		
19	covered charges		137,463
20	payments		48,481
21	annual covered charges	Line 20 x line 4	137,463
22	annual interim payments	Line 21 x line 4	48,481
23	annual cost of services	Line 21 x line 6 / line 7	41,363
	adjustment factors		
24	cost inflation	from cost report to UPL period	1.040

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

28	volume allowance	from cost report to UPL period	1.014
29	adjusted Medicaid annual payments	[(Line 10 x line 24) + (line +] x line 28	763,290
30	adjusted annual cost of services	(Line 8 + line 13 + line 18 + line 23) x line 24 x line 28	1,169,622
31	UPL amount	Line 30 – line 29	406,332

Footnotes for UPL Adjustment Factors:

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

Line 26: Cost Inflation:

DCH uses Global Insight Hospital Market Basket (Table 6.3), as adopted by CMS, for all inflation-related hospital cost estimates. This quarter-by-quarter index provides a breakout of all relevant categories of hospital cost.

Line 30: Volume Allowance

This is primarily eligibility growth. DCH currently predicts Medicaid fee-for-service eligibility in the Aged, Blind and Disabled (ABD) population to grow annually at 1.4%.

15. Effective for dates of service April 1, 1991, and after, the Department will provide payment to enrolled hospitals which offer, either directly or through contract, birthing and parenting classes to Medicaid-eligible pregnant women. Reimbursement will be the lesser of the amount billed for revenue code 942 or the maximum allowable payment amount established by the Department. When the outpatient cost-based settlements are made, claims for outpatient services for birthing and parenting classes will be excluded from the settlement calculations as reimbursement is at a fixed payment rate.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
FOR OTHER TYPES OF CARE OR SERVICES

S. Nurse Practitioner Services

Payments are limited to the lower of:

(a) The submitted charge; or

(b) Ninety percent (90%) of the statewide rate for physician services in effect on the date of service.

(c) Effective with date of service July 1, 1994, a $2.00 recipient co-payment is required on all non-emergency office visit services for nurse practitioner providers. Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care recipients are not required to pay the co-payment. Emergency services and family planning services are also exempt from the co-payment.

EPSDT Nursing Services

Nursing services which includes medication administration and nursing treatment will be reimbursed based on a statewide rates established by the Division. Statewide rates will be based on reasonable cost for the services provided.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
FOR OTHER TYPES OF CARE OR SERVICES

T. Extended Services to Pregnant Women

Postpartum Services

Payment for services shall not exceed the lower of the provider's submitted charge or the statewide maximum allowable rate in effect on the date of service. The statewide maximum allowable rate for postpartum home visits is based on the home health reimbursement composite rate which is calculated by dividing the sum of the home health reimbursement rates for all enrolled agencies by the total number of enrolled agencies.

CHILDBIRTH EDUCATION PROGRAM

Reimbursement for childbirth education classes is based on an average of the fee charged for childbirth education classes provided by local area hospitals.

Instructors will be reimbursed the instructor's usual and customary charge or the maximum allowable, whichever is lower.

TRANSMITTAL 94-03
APPROVED 2-15-95
EFFECTIVE 1-1-94
SUPERSEDES 91-19

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

U. DIAGNOSTIC, SCREENING, AND PREVENTIVE SERVICES

Payments are limited to the lower of:

a) The submitted charge for the procedure; or

b) the statewide rate based on a percentage of Medicare's RBRVS (Resource Based Relative Value Scale) not to exceed the current applicable year.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

u. 1. **Rehabilitative Services**

Payments are made to all providers for specific authorized procedures on a statewide basis and are limited to the lower of:

a. The actual charge for the services; or

b. The statewide rate in effect on the date of service based on the Resource Based Relative Value Scale (RBRVS) for Region I (Atlanta) except for nursing, and counseling services. The rates for Nursing Services and Counseling Services are based on established statewide rates.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

V. Therapy Services: (Includes Physical, Occupational, and Speech Pathology Therapists)

Payments are made for specific authorized procedures on a statewide basis and are limited to the lower of:

a) The actual charge for the service; or

b) The statewide rate in effect on the date of service based on the Resource Based Relative Value Scale (RBRVS) for Region 1 (Atlanta).

TRANSMITTAL 93-050
APPROVED 3-25-94
EFFECTIVE 10-15-93
SUPERSEDES 93-044

4.b. EPSDT Related Rehabilitative Services – Community Based (continued)

- Speech-Language Pathology Services
  Speech-language evaluation of auditory processing, expressive and receptive language and language therapy. Providers' qualifications are in accordance with 42 CFR 440.110, and adhere to the scope of practice as defined by the applicable state licensure board.

- Nutrition Services
  Nutritional assessment, management and counseling to children on special diets due to genetic metabolic or deficiency disorders or other complicated medical problems. Nutritional evaluation and monitoring of their nutritional and dietary status, history and any teaching related to the child's dietary regimen (including the child's feeding behavior, food habits and in meal preparation), biomedical and clinical variables and anthropometric measurements). Development of a written plan to address the feeding deficiencies of the child that is incorporated into the child's treatment program. Providers' qualifications must meet the applicable State licensure and certification requirements, hold a current state license, and adhere to the scope of practice as defined by the applicable licensure board in accordance with the federal requirements in 42 CFR 440.60(a).

Limitations

Provider enrollment is open only to individual practitioners, who are licensed in Georgia under their respective licensing board such as a licensed audiologist, registered nurse, occupational therapist, physical therapist, licensed clinical social worker, licensed counselor, licensed dietician or speech language pathologist. For annual re-enrollment beginning July 1, 1996, all providers must obtain a minimum of one (1) continuing education credit annually in pediatrics in their area of professional practice. Where applicable, providers will be in compliance with federal requirements defined in 42 CFR 440.110 or 42 CFR 440.60(a).

Prior Approval

Services which exceed the limitations as listed in the policies and procedures manual must be approved prior to service delivery.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

V. Therapy Services (Includes Physical, Occupational and Speech Pathology Therapists), Nursing Services, Counseling Services, Nutrition Services and Audiology Services.

1. Reimbursement to Therapy Service providers under the Children's Intervention Services program is based on the lower of submitted charges or the state's maximum allowable rate as listed in the Policies and Procedures for Children's Intervention Services. The state's maximum allowable rate will be based on 84.645% of Medicare's Resource Based Relative Value Scale (RBRVS) for 2000 for Region IV (Atlanta). Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of therapy services and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Georgia Department of Community Health Policies and Procedures Manual for Children's Intervention Services.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

2. Reimbursement to Local Education Agencies (LEAs) under the Children's Intervention School Services program is based on a cost based methodology. Medicaid Services provided under the Children's Intervention School Services program are services that are medically necessary and provided to Medicaid recipients by LEAs in accordance with an Individualized Education Program (IEP) under the Individuals with Disabilities Education Act (IDEA) and defined in Attachment 3.1-A pages 1k – 1o:

    1. Audiology Services Performed by Licensed Audiologists
    2. Counseling Services Performed by Licensed Clinical Social Workers
    3. Nursing Services Performed by Licensed Registered Professional Nurses
    4. Nutrition Services Performed by Licensed Dieticians
    5. Occupational Therapy Services Performed by Licensed Occupational Therapists and/or Occupational Therapist Assistants
    6. Physical Therapy Services Performed by Licensed Physical Therapists and/or Physical Therapists Assistants
    7. Speech-Language Pathology Services Performed by Licensed Speech Language Pathologists and/or Masters Level Speech Language Pathologists (with professional certificate from GA Department of Education or Certificate of Clinical Competence in Speech Language Pathology by ASHA

    On an interim basis, providers will be paid the lower of submitted charges or the state's maximum allowable rate as outlined within Section 4.19B, page 13.1 of the Medicaid state plan and as listed in the Policies and Procedures Manual for Children's Intervention School Services.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

A. Direct Medical Services Payment Methodology

Beginning with the cost reporting period October 1, 2010, the Department of Community Health (DCH) will begin using a cost based methodology for all LEAs. This methodology will consist of a Cost Report, a CMS approved Random Moment Time Study (RMTS) methodology, Cost Reconciliation, and Cost Settlement. If payments exceed Medicaid allowable costs, the excess will be recouped. If payments are less than Medicaid allowable costs, DCH will pay the federal share of the difference to the LEA and submit claims to CMS for reimbursement of that payment.

To determine the Medicaid-allowable direct and indirect costs of providing direct medical services to Medicaid-eligible clients in the LEA, the following steps are performed:

1) Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include the total compensation (i.e., salaries and benefits and contract compensation) to the direct services personnel identified in Section 2 on page 13.2 of Attachment 4.19-B of the Medicaid State Plan for the provision of health services listed in the description of covered Medicaid services delivered by LEAs in pages 1k – 1o of Attachment 3.1-A of the Medicaid State Plan and Section 900 of the GA DCH **Policies and Procedures for Children's Intervention School Services**.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as direct materials, supplies and equipment. Only those direct materials, supplies, and equipment that have been identified and included in the CMS approved DCH Medicaid cost reporting instructions and the Policies and Procedures for Children's Intervention School Services are Medicaid allowable costs and can be included on the Medicaid cost report.

Total direct costs for direct medical services are reduced on the cost report by any federal funding source resulting in direct costs net of federal funds.

These direct costs net of federal funds are accumulated on the annual cost report, resulting in total direct costs net of federal funds. The cost report contains the scope of cost and methods of cost allocation that have been approved by CMS.

2) The net direct costs for each service are calculated by applying the direct medical services percentage from the CMS approved time study to the direct costs from Item 1.

The RMTS incorporates a CMS approved methodology to determine the percentage of time medical service personnel spend on IEP related medical services, and general and administrative time. This time study will assure that there is no duplicative claiming relative to claiming for administrative costs.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

3) Indirect costs are determined by applying the LEA's specific unrestricted indirect cost rate to its net direct costs. Georgia LEAs use predetermined fixed rates for indirect costs. The Georgia Department of Education is the cognizant agency for LEAs, and approves unrestricted indirect cost rates for LEAs for the United States Department of Education. Only Medicaid-allowable costs are certified by LEAs. LEAs are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate.

4) Net direct costs and indirect costs are combined.

5) Medicaid's portion of total net costs is calculated by multiplying the results from Item 4 by the IEP ratio. The numerator will be the number of Medicaid IEP students in the LEA who have an IEP and received direct medical services as outlined in their IEP and the denominator will be the total number of students in the LEA with an IEP who received direct medical services as outlined in their IEP. Direct medical services are those services billable under the FFS program as defined in pages 1k through 1o of Attachment 3.1-A and in the Policies and Procedures for Children's Intervention School Services.

B. Certification of Funds Process

Each LEA will submit Certification of Public Expenditure Forms to DCH on an annual basis. On an annual basis, each LEA will certify through its cost report its total actual, incurred Medicaid allowable costs/expenditures, including the federal share and the nonfederal share. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

C. Annual Cost Report Process

For Medicaid services provided in schools during the state fiscal year (July 1 through June 30), each provider must complete an annual cost report. The cost report is due on or before September 15 following the reporting period each year. At the discretion of DCH, providers may be granted extensions up to three months.

Providers that fail to fully and accurately complete Medicaid cost reports within the time period specified by DCH or that fail to furnish required documentation and disclosures for Medicaid cost reports required under this Plan within the time period specified by the Department, may be subject to penalties for non-compliance.

The primary purposes of the LEA provider's cost report are to:

1) Document the LEA provider's total CMS approved Medicaid-allowable costs of delivering Medicaid coverable services using a CMS approved cost allocation methodology.

2) Reconcile the annual interim payments to the LEA provider's total CMS approved, Medicaid-allowable costs using a CMS approved cost allocation methodology.

The annual Children's Intervention School Services (CISS) Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual CISS Cost Reports are subject to desk review by DCH or its designee.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

D. The Cost Reconciliation Process

The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual CISS Cost Report. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the LEA provider's Medicaid interim payments delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

For the purposes of cost reconciliation, the state may not modify the CMS-approved scope of costs, the CMS approved cost allocation methodology procedures, or its CMS-approved RMTS for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or RMTS for cost-reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

E. The Cost Settlement Process

EXAMPLE: For services delivered for the initial period covering October 1, 2010, through June 30, 2011, the annual CISS Cost Report is due on or before September 15, 2011, with the cost reconciliation and settlement processes completed no later than September 15, 2013.

For all future years starting July 1, 2011, services delivered during the period covering July 1 through June 30, the annual CISS Cost Report is due on or before September 15 of that same year (i.e. services delivered July 1, 2011 through June 30, 2012 would be included in the annual cost report due September 15, 2012), with the cost reconciliation and settlement processes completed within twenty-four months of the cost report due date.

If the LEA provider's interim payments exceed the actual, certified costs for the delivery of school based health services to Medicaid clients, the LEA provider will return an amount equal to the overpayment. DCH will submit the federal share of the overpayment to CMS in the federal fiscal quarter following receipt of payment from the provider.

If the LEA provider's actual, certified costs exceed the interim payments, DCH will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
FOR OTHER TYPES OF CARE OR SERVICES

W. Psychological Services:

Payments are limited to the lower of:

(a) The submitted charge, or

(b) The statewide rate as based on a percentage of Medicare's RBRVS (Resource Based Relative Value Scale) not to exceed the current applicable year.

X. Counseling Services:

Counseling services are reimbursed based on statewide rates established by the Division. These rates were established by surveying states in the region and private insurance companies. Currently, the reimbursement is based on Georgia specific codes (based on reasonable cost for the services provided) that will be cross-walked to national codes. Once these codes are nationally approved, the counseling services will be reimbursed on the Resource Based Relative Value Scale (RBRVS).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item ___ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item 1-5 of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item ___ of this attachment (see 3. above).

MR Chiropractor
MR Licensed Clinical Social Worker

NR Nursing Facilities
NR Swing-Beds
NR Outpatient Hospital
NR Inpatient Hospital
NR Ambulance

SP Rural Health Clinics
SP Federally Qualified Health Centers
SP Laboratory and X-Ray
SP Physician Services
SP Podiatrist Services
SP Optometrist Services
SP Nurse Practitioners
SP Home Health
SP Durable Medical Equipment

SP Mental Health Clinics
SP Dialysis Services
SP Dental Services
SP Prescribed Drugs
SP Prosthetic Devices
SP Nurse Midwife Services
SP Hospice Services
SP Extended Services to Pregnant Women
SP Other Diagnostic, Preventive, Screening and Rehabilitative Services
SP Physical Therapy
SP Occupational Therapy
SP Speech Therapy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A	X	Deductibles	X Coinsurance
	Part B	X	Deductibles	X Coinsurance
Other Medicaid Recipients	Part A	X	Deductibles	X Coinsurance
	Part B	X	Deductibles	X Coinsurance
Dual Eligible (QMB Plus)	Part A	X	Deductibles	X Coinsurance
	Part B	X	Deductibles	X Coinsurance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

1. Nursing Facilities

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 service 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 except for QMBs PI HCFA 6-9-92 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.

2. Swing-Bed Services

When a Medicaid recipient also has Medicare Part A coverage, payment for swing-bed services for up to one hundred days may be allowed by Medicare. In this instance, the swing-bed services must be billed to Medicare prior to billing the Department. The Medicare intermediary reimburses for the first through the twentieth day of coverage at 100% of the Medicare per diem rate. For the twenty-first through the one-hundredth day, the Medicare intermediary pays a reduced amount and Medicaid pays the applicable coinsurance amount. When Medicare Part A swing-bed benefits, i.e., skilled nursing facility care, are exhausted for these recipients, charges for days in excess of Medicare covered days may be submitted to the Department for reimbursement at the Medicaid per diem rate.

3. Outpatient Hospital Services

Effective with dates of payment on and after November 1, 1991, the Department will limit payment on outpatient Medicare crossover claims as follows: (a) multiply the allowable deductible and coinsurance amount by the hospital-specific percent of charges rate in effect on the date of payment; (b) compare the product from (a) to the hospital's inpatient per case rate in effect on the date of payment; and (c) reimburse the lower of the two amounts in (b).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SE URITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE: GEORGIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
FOR OTHER TYPES OF CARE OR SERVICES

Payment of Medicare Part A and Paart B Deductible/Coinsurance

4. Inpatient Hospital Services

Effective with dates of payment of October 16, 2000 and after, the maximum allowable payment to enrolled Georgia and non-Georgia hospitals for Medicare inpatient deductibles and coinsurance (crossover claims) will be the hospital-specific Medicaid DRG rate. The maximum allowable payment to non-Georgia hospitals not enrolled in the Georgia Medicaid program for Medicare inpatient crossover claims will be the weighted average hospital-specific inpatient per case rate for enrolled non-Georgia hospitals.

5. Ambulance Services

For Medicare crossover claims, no payment will be made by Medicaid unless the Medicaid maximum allowable for the service exceeds the payment made by Medicare.

STATE: Georgia

METHODS FOR ESTABLISHING PAYMENT RATES FOR MEDICALLY NECESSARY SERVICES FOR EPSDT RECIPIENTS WHEN SUCH SERVICES ARE NOT NORMALLY COVERED UNDER THE PLAN

	Service	Place	Provider	Methodology
1.	Private Duty Nursing	Home	RN or LPN	The rate established for nursing services under the Waivered Services Program.
2.	Physical Therapy, Speech Therapy	Hospital, Home	Licensed Physical Therapist, Licensed Speech Therapist	According to the methodology used and rates established in the Home Health Services Program (Attachment 4.19-A, Item G), Outpatient Hospital Services (Attachment 4.19-B, Item R) and Physician Services (Attachment 4.19-B, Item J) wherein these services are Reimbursed.
3.	Occupa-tional Therapy	Home Hospital	Licensed Occupa-tional Therapist	According to the methodology used and rates established in the Community Care Services Program and Outpatient Hospital Services (Attachment 4.19-B, Item R).
4.	Respiratory Care Services	Home	Licensed Respiratory Therapist	The rate established for respiratory care under the Model Waiver Services Program.
5.	Chiropractor	Office, Hospital	D.C.	50th percentile of sample charges.
6.	Child and Adolescent Mental Health Services	Home, School, Therapeutic Foster Care, Child Caring Institutions (IMDs excluded)	Community Mental Health Centers and other providers who meet the standards of participation	Reimbursement for Community Mental Health Centers will be based on pre-established flat rates in a fee schedule by procedure code. Reimbursement for other providers will be based on reasonable costs from cost reports submitted annually by participating providers. The base period will be a state fiscal year. Rates will be set not to exceed actual costs adjusted for inflation. The inflation rate will be based on the DRI McGraw Hill Health costs: Regional Forecasts Tables.

PAYMENT FOR RESERVED BEDS

Regular state payment is permitted for reserving beds during a recipient's absence from an inpatient facility with the following limitations:

1. The patient's plan of care provides for absences, other than hospitalization.

2. Seven (7) days per hospitalization for Medicaid patients who are hospitalized during a stay in the nursing home.

3. Planned therapeutic home visits.

    - For nursing facility residents up to eight (8) days in any calendar year with no limit on the number of days per visit

    - For ICF-MR residents up to thirty (30) days per calendar year with no limit on the number of days per visit

Payments for reserved beds are made at 75% of the rate paid for days when a patient is onsite at a facility. Because payments for reserved beds are not subject to the nursing home provider fee, the payment rate for reserved beds excludes any compensation for the provider fee.

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). Complete documentation is found in the Policies and Procedures for Nursing Facility Services provider manual (Manual), Chapter 1000, effective July 1, 2009, located at the Georgia Health Partnership web portal at https://www.ghp.georgia.gov/wps/portal.

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.

   (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 30 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.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – NURSING FACILITY SERVICES

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.

   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.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – NURSING FACILITY SERVICES

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 CMS-15-1 as a guide, the Department describes specific cost allowability in the Policies and Procedures for Nursing Facility Services manual, Chapter 1000. The following paragraphs offer a general discussion of allowability of costs.

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;

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – NURSING FACILITY SERVICES

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 organizations and costs on the State's uniform cost report.

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 4 13.80. 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.

- 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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – NURSING FACILITY SERVICES

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 nonallowable;

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

- 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;

- 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

- The cost of home office vehicle expense.

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

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The 2006 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. Nursing Facility and ICF/MR Methods and Standards

The methods and standards for the determination of reimbursement rates to nursing facilities, and intermediate care facilities for the mentally retarded is as described in Chapter 1000 of the Manual effective July 1, 2009.

2. Prospective Rates

Payment rates to nursing facilities and ICF/MRs are determined prospectively using costs for a base period. The cost reports are updated periodically according to Part I, Chapter 400 and Appendix I of the Manual effective July 1, 2009. For dates of service beginning July 1, 2009, the 2006 Cost Report is the basis for reimbursement.

3. Determination of Payment Classes

Classes are determined in accordance with Section 1002 of the Manual effective July 1, 2009.

4. Additional Details

Detailed information regarding this methodology is maintained on file in the State Agency as Chapter 1000 of the Manual effective July 1, 2009.

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.

F. Provider Participation

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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 arc 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 in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

K. Reimbursement Methodology

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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. The Actual Reimbursement Rate is always subject to prospective adjustment to effectuate the policies described in provisions of Part II – Appendix 1 of the Manual.

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

For dates of service beginning July 1, 2009, the 2006 Cost Report is the basis for reimbursement. 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.

Standard Per Diem =

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

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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 shall 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 efficiency incentive payments 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. For the Dietary cost center, the Maximum Percentile is the sixtieth percentile for Hospital-Based Nursing Facility group and the ninetieth percentile for the Freestanding 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).

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 on June 30, 2007. Standards effective July 1, 2009, 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:

Routine and Special Services Maximum Percentile at 90%

Nursing Home Net Per Diems for 10 nursing homes from lowest to highest:

$90, $95, $95, $100, $115, $120, $120, $130, $135, $140

Maximum Percentile Standard Determination

(10 net per diems) X (90th percentile) = 9th position or $135

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Administrative and General Maximum Cost at 105% of Median

Nursing Home Net Per Diems for 11 nursing homes from lowest to highest:

$90, $95, $95, $100, $115, $120, $120, $130, $135, $140, $150

Maximum Cost Standard Determination at 105% of Median

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

$120 x 105% = $126

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

Nursing Home Net Per Diems for 10 nursing homes from lowest to highest:

$90, $95, $95, $100, $115, $120, $120, $130, $135, $140

Maximum Cost Standard Determination at 105% of Median

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

$118 x 105% = $124

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

For the purpose of determining the Standard Per Diem and the Allowed Per Diem for each cost center, a facility is grouped according to the type facility (e.g., nursing facility, hospital-based nursing facility, or

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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, as indicated above, 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.

Allowed Per Diem =

Summation of the Net Per Diem or Standard Per Diem, whichever amount is less. This applies to the allowed per diem for the Dietary, Laundry and Housekeeping, Plant Operations and Maintenance and Administrative and General cost centers. For the Property and Related cost centers, the methodology described in the Section N (Property and Related Reimbursement) shall apply. The Allowed Per Diem for Taxes and Insurance shall be equal to the Net Per Diem for this cost center. 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.

Efficiency Per Diem =

The Efficiency Per Diem is calculated by summing the Standard Per Diem minus 75% of the Net Per Diem , to arrive at the Maximum Efficiency Per Diem for each of the four Non-Property Cost Centers.

Growth Allowance =

Summation of 1.19% of the Allowed Per Diem for each of the four Non-Property and Related cost centers (Routine and Special Services; Dietary; Laundry and Housekeeping and Operation and Maintenance of Plant; and Administrative and General).

Further explanation of these terms is included below:

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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 (as defined in Section 1002 in the Manual under "cost center") 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 by the Manual, 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; as defined in the Manual. These modifications define what expenses are attributable to the care received and the allowable expenses that are attributable to care. See Appendix I of the Manual 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 of the Manual 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

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Historical Routine and Special Services (Schedule B, Lines 5 plus 7, Column 4) divided by (Total Patient Days, Schedule A, Line 13, Column 6); 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 of the manual. The method by which a case mix index score is calculated is described in Appendix D (Uniform Chart Of Accounts, Cost Reporting, Reimbursement Principles And Other Reporting Requirements) of the manual.

ICF-MR Routine Services and Special Services 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 7.

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 Cost, (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)

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Dietary Net Per Diem =

Historical Dietary, Schedule B (Medicaid Cost Report), 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 (Medicaid Cost Report), Lines 9 plus 10, Column 4, Divided By Total Patient Days

Administrative and General Net Per Diem =

Historical Administrative and General, Schedule B (Medicaid Cost Report),, Line 11, Column 4, Divided By Total Patient Days

Property and Related Net Per Diem =

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 facility's 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 but will also be no less than the property per diem 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 any otherwise previously approved property reimbursement per diem.

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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.

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:

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Nursing Facility

Intermediate Care Facility for the Mentally Retarded

Property and Related Standard Per Diem

There is no standard per diem for this cost center.

c. The Efficiency Per Diem represents the summation of the Efficiency Per Diem for each of the four Non-Property 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 0.75. 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

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M. 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

1. If the Department 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 Appendix D2(h) of the manual.)

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 unauditable cost reports.

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

The Property and Related Net Per Diem referred to in subsections (a) through (c) above is equal to the Fair Rental Value Rate as determined under Section N.

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d) In all other instances where the Department determines that a cost report cannot be used to set a reimbursement rate, the Total Allowed Per Diem Billing Rate will be resolved as described in the provisions discussed below for unauditable cost reports. If the Department determines that a cost report which was to be used to set a reimbursement rate is unauditable (i.e., the Department's auditors cannot render an opinion using commonly accepted auditing practices on the filed cost report, either on the desk audit or on-site audit), or unreliable (See Appendix D2(h) of the manual), the Department may reimburse the facility the lower of the following:

- The last Total Allowed Per Diem Billing Rate issued prior to the reimbursement period to be covered by the unauditable cost report;
- The Total Allowed Per Diem Billing Rate calculated from the unauditable cost report; or
- 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.

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 will use the average score for all facilities.

N. Property and Related Reimbursement

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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 is reimbursed on the basis of the estimated 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)

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compared to the number of licensed beds times 700 square feet (the maximum allowable 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 (N)(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 by15% to approximate the cost of land.

(f) A Rental Amount is calculated by summing the facility's Depreciated Replacement Value and the Land Value and multiplying this 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
A	Facility Name	XYZ Nursing Home	Department Data
B	Medicaid Provider ID	12345678A	Department Data
C	Rate Setting Year	2009	Department Criteria

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D	Adjusted Base Year	1989	Based on Initial Age adjusted by Bed Additions and Facility Renovations
E	Licensed Nursing Facility Beds	138	Department Data
F	Nursing Facility Square Footage	68,857	Department Data
G	Nursing Facility Zip Code	30312	Department Data
H	Total Patient Days	48,552	Department Data
I	Per Bed Square Footage Limit	700	Department Criteria
J	Maximum Allowable Square Footage	96,600	E x I
K	Allowed Total Square Footage	68,857	lesser of F or J
L	Rate Year RS Means Cost per Square Foot	$141.10	RS Means lookup based on Rate Year
M	RS Means Location Factor	0.9	RS Means lookup based on Zip Code (G)
N	Construction Cost Index	1	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	E x Q x R
T	Facility Value Excluding Land	$9,572,150	P + S
U	Bed Additions and Facility Renovations	-	Separate calculations affecting the Nursing Facility Age (see D and V)
V	Nursing Faciity 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
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	T x X x Y
AA	Depreciated Replacement Value	$5,743,290	T - Z
AB	Land Percentage	15.00%	Department Criteria
AC	Land Value	$1,311,623	P x AB
AD	Depreciated Replacement Value & Land	$7,054,913	AA + AC
AE	Rental Rate	9.00%	Department Criteria
AF	Rental Amount	$634,942	AD x AE

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AG	Minimum Occupancy Percentage	85.00%	Department Criteria
AH	Bed Days at Minimum Occupancy	42,815	E x 365 x AG
AI	Total Allowed Patient Days	48,552	higher of H or AH
AJ	Fair Rental Value Per Diem	$13.08	AF / AI
AK	06/30/09 Property and Related Net Per Diem	$5.43	Department Data (Dodge Index)
AL	Property and Related Net Per Diem	$13.08	Greater of AJ or AK, but not more than a 150% increase of AK

3. The Property and Related Net Per Diem initially established under (N)(2) shall be updated annually on July 1, effective for dates of service on and 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 age adjusted based on the methodology proscribed for a renovation.

4. A Renovation Construction Project shall mean a capital expenditure (as defined in Section (N)(4)(a)) that exceeds $500 per existing

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licensed bed and has been filed with the Office of Health Planning as a New Construction Project under the authority of O.G.C.A. § 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 each 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 (N)(5)(a) 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.

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(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 (N)(3)(a). 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 for 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	123456789A	Department Data
C	Year Bed Additions were Completed	1981	Department Criteria
D	Base Year Prior to Additions	1970	Based on Initial Age adjusted by Prior Bed Additions and Facility Renovations
E	Existing Beds prior to Bed Additions	130	Department Data
F	Number of Beds Added	8	Department Data
G	Age of Existing Beds when Additions were Completed	11	C - D

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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 (N)(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 depreciated bed replacement value.

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

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A	Facility Name	XYZ Nursing Home	Department Data
B	Medicaid Provider ID	12345678A	Department Data
C	Rate Setting Year	2009	Department Data
D	Year Renovation was Completed	2003	Department Data
E	Base Year Prior to Renovation	1981	Based on Initial Age Adjusted by Prior Bed Additions and Facility Renovations
F	Licensed Nursing 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	Department Data
J	Renovation Year RS Means Cost Index	132.00	RS Means lookup based on Year Renovation Completed
K	Rate Year RS Means Cost Index	185.90	RS Means lookup based on Rate Year
L	Facility Age Index Factor	0.7101	J / K
M	Rate Year RS Means Cost per Square Foot	$141.10	RS Means lookup based on Rate Year
N	Maximum Square Feet per Bed	700	Department Criteria
O	Allowed Facility Square Footage	40,060	Lesser of G or (F x N)
P	Facility Cost Prior to Adjustments	$5,652,466	M x O
Q	RS Means Location Factor	0.77	RS Means lookup based on Zip Code (H)
R	Adjusted facility Cost	$3,090,461	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	R x U x V
X	Adjusted Bed Replacement Cost	$12,541	(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	Weighed 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)

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O. 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, exceed the facility's customary charges to the general public for those services reimbursed by the Division.

P. 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 of the Nursing Facility Manual.

Q. Other Rate Adjustments

1. 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 will 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 of the manual.

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 will 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%

c. A quality incentive adjustment may be added to a facility's rate utilizing the following set of indicators.

1. Clinical Measures

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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 Inner View (MIV) Quality Profile. The values used from MIV Quality Profile will be compared to 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.

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(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 measures, 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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2. Other Adjustments to Rates

(a) 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.

(a) Effective July 1, 2003, in order to recognize the Medicaid share of a facility's cost of paying fees for Georgia's the Nursing Home Provider Fee Act, an adjustment equal to the fee payable for each Medicaid patient day will be added to a 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.

(b) 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 these 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:

- All amounts paid for services provided to Medicaid patients and
- Estimated payment amounts for such services if payments were based on Medicare payment principles. Either cost based or rate payment measures may be used as Medicare payment principles.

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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 by the end of the quarter following the 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.

Comparisons 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 determine facility-specific rate adjustment payments. These rate payment adjustments will be made on a monthly, quarterly or annual basis and will be determined in a manner that 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.

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Provider Name: XYZ Nursing Home

		Quarter Ending 09/30/05	Quarter Ending 12/31/05	Quarter Ending 03/31/06	Quarter Ending 06/30/06
Medicare UPL Rate					
Line 1	PPS rate based on Medicaid patients for each quarter [1]	157.92	149.92	149.92	149.92
Line 2	Adjustment for change in case mix	1.0150	1.0150	1.0150	1.0150
Line 3	Adjusted Medicare rate for UPL	160.29	152.17	152.17	152.17
Medicaid UPL Rate					
Line 4	Medicaid rate without provider fee [1]	89.63	86.90	85.63	90.69
Line 5	Provider Fee adjustment	9.15	9.15	9.15	9.15
Line 6	Statewide average payment for other services [1]	14.11	14.11	14.11	14.11
Line 7	Adjusted Medicaid rate for UPL	112.89	110.16	108.89	113.95
Medicare UPL rate minus Medicaid UPL rate					
Line 8		47.40	42.01	43.28	38.22
Medicaid Patient Days					
Line 9	Medicaid days reported in SFY 2005 cost report	22,026	22,026	22,026	22,026
Line 10	Portion of year for each quarter	25%	25%	25%	25%
Line 11	Adjusted Medicaid patient days for UPL	5,507	5,507	5,507	5,507
Facility-Specific UPL calculation					
Line 12		261,032	231,349	238,343	210,478
Facility-Specific UPL calculation for 7-1-05 to 06-30-06					941,202

[1] Data for the UPL rate period will be used if available. If such data is not available, amounts for payment periods may be determined by use of data from prior periods with adjustments for expected changes that are reasonable and appropriately documented. If applicable, projected changes in Medicaid payment rates would be based on budgeted changes.

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facility name: XYZ ICF-MR Nursing Home

	line description	comments	amount
1	total cost per day for SFY2004	after audit adjustments	267.70
2	capital cost per day for SFY2004	after audit adjustments	9.44
3	routine services cost per day for SFY2004	col 1 - col 2	258.26
4	projected routine service cost per day for SFY2006	col 3 x 1.06181	274.22
5	12% of projected routine service cost per day for SFY2006	col 4 x 0.12	32.91
6	Medicaid ICF-MR patient days from SFY 6-30-2004	after audit adjustments	29,415
7	available UPL calculation for SFY2006	col 5 x col 6	968,048

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2. 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.

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- the additional reimbursement is determined by a replacement cost appraisal (however, at the Division's discretion, for capital items not affecting the entire facility, multiple, competitive arm's length bids by contractors can be used instead of replacement cost appraisals).

- the provider could not with reasonable diligence ascertain that the renovation would be required by the Georgia Department of Human Resources Standards and Licensure Unit. Reasonable diligence will include but is not limited to obtaining an inspection and its resulting report by the Architect of the Standards and Licensure Section specifically for the purpose of determining what repairs, renovations or other actions will be required of the facility to meet all applicable physical plant requirements, as well as all other inspections and deficiency reports on file at the Georgia Department of Human Resources Standards and Licensure Unit for that facility.

(ii) If the facility was being reimbursed under the provisions of paragraphs (a) through (g), reimbursement for additions and expansions will be subject to limitations described in paragraphs (b) through (f). If the addition or expansion does not add beds, there will be no additional reimbursement. If beds are added, the addition will be treated in a manner similar to a new facility to determine a separate property rate sub-component for the addition.

1002.6 Overall Limitations on Total Allowed Per Diem Billing Rate

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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 2.50 actual working hours.

1003.2 Failure to Comply

a) The minimum standard for nursing hours is 2.50.
b) Facilities found not in compliance with the 2.50 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.

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

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not be subsequently adjusted due to subsequent per diem rate adjustments. This section is also included in Chapter 1100 of the Manual.

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APPENDIX D

UNIFORM CHART OF ACCOUNTS, COST REPORTING, REIMBURSEMENT PRINCIPLES AND OTHER REPORTING REQUIREMENTS

General

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

1. Uniform Chart of Accounts

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

Should a facility elect to maintain its books of original entry or ledgers in a manner other than that specified in the Uniform Chart of Accounts, the facility is required to have available a detailed description of how its

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accounting system differs. This description of differences must be used by the facility for converting the output of its reporting system into the format specified in the Uniform Chart of Accounts. This description of differences and conversion of reporting information into the proper format are considered to be essential components of a facility's accounting records. When such information is needed but not maintained, a facility's cost report will be determined to be unacceptable for fulfilling reporting requirements and penalties described in Section 2.b and 2.g of this appendix will be imposed.

2. Cost Reporting

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

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

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

c. If a cost report is received by the Division prior to September30th 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

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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

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auditable records of charges to all patients as required by cost report instructions.

f. All nursing facilities are required to submit to the Division 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.

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 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 Dodge Index property rate. If the new

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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 workpapers or letters of explanation should be attached.

l. All cost reports and correspondence concerning these cost reports are to be mailed to the following address:

Division of Medical Assistance
Nursing Home Services Unit

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2 Peachtree Street, N.W.
Atlanta, Georgia 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.

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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 will be processed as adjustments to rate calculations in a subsequent period. If a prospective correction would otherwise result in excess or advance payments of material amounts, with materiality determined by the amount or percentage of payment, the Division will process the correction by a retrospective adjustment to prior payments.

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

5. Nursing Hours and Patient Day Report

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Except for ICF-MR and state owned facilities, each 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.

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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 Rehab / ADL 6-10	IB2	1.061	1.082
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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – NURSING FACILITY SERVICES

	Category	Classification	Code	Case Mix Index for All Patients	Case Mix Index for Medicaid Patients
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 / ADL 4-5	PA2	0.637	0.637
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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – NURSING FACILITY SERVICES

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:

AA8a, b – Reasons for assessment as reported in section AA8 of the MDS

Section a, primary reason for assessment
1 = admission assessment
2 = annual assessment
3 = significant change in status assessment
4 = significant correction of prior full assessment
5 = quarterly review assessment
6 = discharged – return not anticipated
7 = discharged – return anticipated
8 = discharged prior to completing initial assessment
9 = reentry
10 = significant correction of prior quarterly assessment
0 = none of the above

Section b, codes for assessments required for Medicare PPS or the State
1 = Medicare 5 day assessment
2 = Medicare 30 day assessment
3 = Medicare 60 day assessment
4 = Medicare 90 day assessment
5 = Medicare readmission/return assessment
6 = other state required assessment
7 = Medicare 14 day assessment
8 = other Medicare required assessment

Resident Name – Self explanatory

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – NURSING FACILITY SERVICES

SSN- Resident's social security number

Effective Date (R2b) – For assessments, this is the date completed as reported in section R2b of the MDS. For discharge tracking, this is the date of discharge. For re-entry tracking, this is the date of re-entry.

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

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

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

CPS Score – 5 MDS measures (related to coma, decision-making, impairment count, severe impairment count and total dependent eating) are used to classify a resident's condition into one of the following Cognitive Performance Scale categories: intact, borderline impairment, mild impairment, moderate impairment, moderately severe impairment, severe impairment or very severe impairment.

Payment Source – Primary source of payment for services to resident 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.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – NURSING FACILITY SERVICES

Number and % of Residents Included in CPS Add-On – The number and percentage of Medicaid residents with CPS classifications of moderately severe impairment, severe impairment or very severe impairment

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – NURSING FACILITY SERVICES

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 these 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:

- All amounts paid for services provided to Medicaid patients and
- Estimated payment amounts for such services if payments were based on Medicare payment principles. Either cost based or rate payment measures may be used as Medicare payment principles.

Comparisons 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 determine facility-specific rate adjustment payments. These rate payment adjustments will be made on a monthly, quarterly or annual basis and will be determined in a manner that will not duplicate compensation provided from payments for individual patient claims.

A sample of how a rate adjustment payment is calculated is presented on the following pages.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – NURSING FACILITY SERVICES

Provider Name: XYZ Nursing Home

		Quarter Ending 09/30/05	Quarter Ending 12/31/05	Quarter Ending 03/31/06	Quarter Ending 06/30/06
Medicare UPL Rate					
Line 1	PPS rate based on Medicaid patients for each quarter [1]	157.92	149.92	149.92	149.92
Line 2	Adjustment for change in case mix	1.0150	1.0150	1.0150	1.0150
Line 3	Adjusted Medicare rate for UPL	160.29	152.17	152.17	152.17
Medicaid UPL Rate					
Line 4	Medicaid rate without provider fee [1]	89.63	86.90	85.63	90.69
Line 5	Provider Fee adjustment	9.15	9.15	9.15	9.15
Line 6	Statewide average payment for other services [1]	14.11	14.11	14.11	14.11
Line 7	Adjusted Medicaid rate for UPL	112.89	110.16	108.89	113.95
Medicare UPL rate minus Medicaid UPL rate					
Line 8		47.40	42.01	43.28	38.22
Medicaid Patient Days					
Line 9	Medicaid days reported in SFY 2005 cost report	22,026	22,026	22,026	22,026
Line 10	Portion of year for each quarter	25%	25%	25%	25%
Line 11	Adjusted Medicaid patient days for UPL	5,507	5,507	5,507	5,507
Facility-Specific UPL calculation					
Line 12		261,032	231,349	238,343	210,478
Facility-Specific UPL calculation for 7-1-05 to 06-30-06					941,202

[1] Data for the UPL rate period will be used if available. If such data is not available, amounts for payment periods may be determined by use of data from prior periods with adjustments for expected changes that are reasonable and appropriately documented. If applicable, projected changes in Medicaid payment rates would be based on budgeted changes.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – NURSING FACILITY SERVICES

facility name XYZ ICF-MR Nursing Home

	line description	comments	amount
1	total cost per day for SFY2004	after audit adjustments	267.70
2	capital cost per day for SFY2004	after audit adjustments	9.44
3	routine services cost per day for SFY2004	col 1 - col 2	258.26
4	projected routine service cost per day for SFY2006	col 3 x 1.06181	274.22
5	12% of projected routine service cost per day for SFY2006	col 4 x 0.12	32.91
6	Medicaid ICF-MR patient days from SFY 6-30-2004	after audit adjustments	29,415
7	available UPL calculation for SFY2006	col 5 x col 6	968,048

CLAIM NUMBER	TYPE OF CLAIM	DEFINITION
01 (UB-82)	Hospital (Inpatient & Outpatient) Hospice Dialysis (Facilities) Swing-Beds	All services for one recipient within one bill or document.
02 (HCFA 1500)	Physicians' Physician Assistants Laboratories Nurse Midwives Birthing Centers Nurse Practitioners Podiatrists Psychologists Rural Health Clinics Community Health Centers Ambulatory Surgical Centers Orthotics or Prosthetics Durable Medical Equipment Case Management – Perimatal Case Management – Mental Health Mental Health Clinics Vision Care Home Health Services Community Care Services Wavered Services	All services for one recipient within one bill or document.
03 08 09 10 14 16 17 18 19 ADA 1999 version 2000	Family Planning (Tape) Anesthesia Ambulance NET EPSDT Cross-Over: Inpatient Cross-Over: Outpatient Cross-Over: Nursing Home Cross-Over: Other Dental Services	All services for one recipient within one bill or document
13 15	Pharmacy Nursing Home	A line item of service

Citation	Condition or Requirement
	4.19-F Disease Management Enhanced Primary Care Case Management Fee
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	Disease Management Enhanced Primary Care Case Management is designed to incorporate a disease management component to Georgia Better Health Care (GBHC), as an enhancement to the basic Primary Care Providers. Through this Enhanced Primary Care Case Management Program the health outcomes of the population will improve, while medical cost will decrease. The Enhanced Primary Care Case Management organization will facilitate and maintain contact with enrolled members to promote their self-management of their disease/condition; patient and provider adherence to evidence-based clinical guidelines; twenty-four hour call nurse; and stratify management programs for members to determine at least three levels of intervention that will be applied to the entire population. The reimbursement payment rate for case management services is a provider-specific monthly amount that is applicable for each eligible for which services are provided during a month. The rate is determined by the lower of the vendor's competitive bid or the rate established based upon an actuarially sound evaluation of services to be provided, including both face-to-face and ancillary contacts. This rate may be updated periodically.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

Requirements for Third Party Liability -
Identifying Liable Resources

The State agency takes reasonable measures to determine the legal liability of third parties to pay for services under the Plan.

The State provides for assignment of rights to benefits and cooperation in establishing paternity and obtaining medical support and payments as a condition of Medicaid eligibility.

The State has a written agreement with the Department of Human Resources (DHR) and Social Security Administration (SSA) which provides for collection and updating information regarding third party resources during the initial and redetermination processes, respectively. The applicant or recipient is required to furnish health insurance information to identify legally liable third party resources so that claims may be processed under third party liability payment provisions.

Data collected includes health insurance information when benefits are available to the recipient. Health insurance information may consist of the name of the policyholder, the relationship of the policyholder to the recipient or applicant, the Social Security Number (SSN) of the policyholder, the name and address of the insurance company and the policy number. This information collected during the initial and redetermination eligibility process is forwarded to the State Medicaid Agency for review and verification by phone or letter. Once verified, this information is added to the TPL Data Base. Additionally, the names and SSNs of absent or custodial parents of Medicaid recipients are collected to the extent that such information is available and is incorporated into the TPL Data Base to identify potential third party resources through data exchange activities.

The State agency, under written agreement, conducts quarterly data exchanges with the following agencies to identify Medicaid recipients and obtain information on absent or custodial parents of Medicaid recipients who are employed and their employer(s):

1. The Georgia Department of Labor (DOL), the State Wage Information Collection Agency (SWICA);

2. Beneficiary Earnings Exchange Record (BEER), to obtain the SSA wage and earning file information;

3. Child Support and Recovery Unit (CSRU), and

4. The State Workers' Compensation Agency

The State Agency conducts data exchanges with the Defense Enrollment Eligibility Reporting System (DEERS) yearly.

The State agency obtains health insurance information from the Title IV-A Agency, the Department of Human Resources (DHR), on case referral forms which are completed on each Medicaid applicant or recipient during the eligibility intake or redetermination process, respectively. Referral forms also provide the names(s) and social security number(s) on absent or custodial parents of Medicaid recipients which are incorporated in the third party liability data base to identify potential health insurance resources through employment leads obtained from data exchange activities.

Due to the absence of common identifying elements (names and social security numbers) which are needed to conduct data exchange activities, the State agency obtains a quarterly State motor vehicle accident report file from the Georgia Department of Public Safety. The report provides an alphabetical listing of names of persons injured in accidents involving motor vehicles and is used to research positive leads involving these types of injuries to establish the existence of legally liable third parties.

Diagnosis and trauma code edits are conducted in each weekly claims processing cycle to identify those paid claims for Medicaid recipients that contain diagnosis codes 800 through 999 (ICD 9-CM) except for diagnosis code 994.6.

The State agency conducts, within 45 days, follow-up activity to identify and verify the existence of health insurance resources on leads obtained from data exchanges with the Department of Labor (DOL); the Beneficiary Earnings Exchange Record (BEER); the Child Support Recovery Unit (CSRU); and the Defense Enrollment Eligibility Reporting System (DEERS). Letters are prepared and mailed to the employer(s) to verify the availability of health insurance. Verified health insurance information is incorporated into the eligibility casefile, the third party resource data files and the third party recovery file within 30 days from the date the State agency receives health insurance coverage verification.

Timeliness of follow-up activity is measured from the date the State agency receives the lead to the date the State agency initiates action to validate the existence of the TPL resource. Verified TPL information is incorporated into the TPL data base within 30 days after receipt of verified TPL information.

The State agency conducts within 60 days follow-up activity to identify legally liable third parties on leads obtained from Title IV-A referrals and data exchanges with the State Board of Workers' Compensation. Timeliness of follow-up activity is measured from the date the State agency receives the lead to the date the State agency receives verified health insurance coverage. Insurance information is incorporated into the eligibility case file and third party data base and recovery file within 30 days from the date the agency receives third party resource verification, so that claims may be processed under the third party liability provision specified in 433.139(b) through (f).

TRANSMITTAL 89-39
APPROVED 7-30-90
EFFECTIVE 10-1-89
SUPERSEDES 87-8

Accident questionnaires are mailed weekly to Medicaid members on all paid claims which involve trauma or accident related diagnosis codes. Follow-up actions are conducted within 60 days of receipt of responses to questionnaires which establish the probable existence of a liable third party. This information is incorporated into the case file; eligibility file and third party resource file within 30 days after verification of the third party's ongoing responsibility.

The State agency maintains a listing of all closed case data which reflects the primary trauma diagnosis and the amount of third party collections. The data compiled is reviewed semi-annually to identify those trauma codes that yield the highest third party collections to prioritize follow-up activities.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

Requirements for Third Party Liability
Payment of Claims

The State uses a cost avoidance method of claims processing when third party liability is established at the time a claim is filed. A coverage specific matrix is utilized to cost avoid claim payment for categories of service covered by third party resources. Claims are rejected and returned to the provider if the service being billed is probably covered by the type of resource identified on the data base. There are no thresholds used to trigger the cost avoidance process. An exception to cost avoidance is the payment for such services as EPSDT, prenatal or preventive pediatric care, and all claims covered by absent parent maintained insurance under Part D of Title IV of the Act. The State shall make payment in accordance with their usual payment schedule under the plan for these services without regard to any third party liability of payment. In title IV-D court-ordered medical support situations, the Department did not elect the option to require providers to wait for 30 days before submitting claims to the Medicaid agency. Therefore, no method to determine provider compliance is necessary due to the use of the Pay and Chase recovery methodology.

The State seeks reimbursement from insurance carriers through a monthly system generated post-payment billing process when the existence of third party liability is not known at the time of billing. A threshold of $100.00 per member or what is deemed cost effective by the Department must be met prior to seeking reimbursement from Health insurance resources.

The State seeks reimbursement from verified liable third parties on claim payments involving accidental injuries when total potential recovery is $250.00 or greater. Liens are filed if the recovery amount involves $500.00 or more in Medicaid expenditures. No threshold is applied to the identification of paid claims with trauma diagnoses.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

SEE ATTACHED

Georgia Department of Medical Assistance
Cost Effective Determination
Alternative Guidelines
Attachment to Att. 4.22-C

I. The State of Georgia uses the following methods to determine the cost effectiveness of paying group health insurance premiums for Medicaid recipients:

1. Cost Effectiveness Based on Expenditure Projection

The determination of cost effectiveness is based on the comparison of the amount of the annual premium, deductibles, coinsurance, policyholder cost sharing obligations, and additional administrative costs against the average annual cost of Medicaid expenditures for the recipient's eligibility aid category on a statewide basis. It is used as an initial screening step for all Medicaid recipients who have group health insurance benefits to determine whether it is cost effective to purchase. The Medicaid Management Information System (MMIS) is utilized to obtain the average annual Medicaid costs statewide by aid category. A client's case is determined as cost effective if the amount of the premium, deductibles, coinsurance, cost sharing obligation, and administrative costs are less than the Medicaid expenditures for an equivalent set of services.

2. Cost Effectiveness Based on Client Diagnosis

The determination of cost effectiveness is based on the comparison of premium amounts and policyholder obligations against the actual claims experience of the recipient. Documentation of actual expenditures consists of Explanation of Benefits (EOB's) from the recipient's health carrier for previous charges relating to a specific diagnosis or Medicaid expenditures for previous periods of the client's eligibility. This method is used when the method described in #1 above does not prove to be cost effective. Such diagnoses would include cancer, chronic heart disease, congenital heart disease, end stage renal disease and AIDS. This list will be expanded as diagnoses associated with long term care are identified. This method of cost effective determination is also appropriate for short term high expense treatments. A client's case is considered as cost effective when actual claim expenditures associated with the diagnosis exceed the premium amounts and policyholder obligations.

TRANSMITTAL 94-009
APPROVED 10-6-94
EFFECTIVE 7-1-94
SUPERSEDES New

II. Because Federal Financial Participation (FFP) is available for the payment of premiums for Medicaid recipients enrolled in a cost effective group health plan:

1. Medicaid will pay the health insurance premiums for Medicaid recipients with policies likely to be cost effective to the Medicaid program. Payments shall be made directly to the insurer providing the coverage, the employer or to the Medicaid recipient or guardian.

2. Medicaid will pay the Medicaid allowable amount for all items and services provided the Medicaid recipient under the State Plan that are not covered under the group health plan.

3. Medicaid will provide for the payment of premiums when cost effective for non-eligible family members to enroll a Medicaid eligible family member in the group health plan.

4. Medicaid will treat the group health plan as a third party resource in accordance with Georgia Medicaid TPL cost avoidance policies.

5. The health carrier, employer, recipient or non-Medicaid eligible family member will immediately notify this agency of any event that might affect the policyholder status of the cost effectiveness of the Health Insurance policy.

6. Medicaid will receive referrals for potential candidates for the payment of premiums. Referral systems have been established through high cost hospital providers, AID Atlanta and the local Department of Family and Children Services.

TRANSMITTAL 94-009
APPROVED 10-6-94
EFFECTIVE 7-1-94
SUPERSEDES New

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

State/Territory: GEORGIA

Citation	Sanctions for Psychiatric Hospitals
1902(y)(1), 1902(y)(2)(A), and Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2))	(a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
1902(y)(1)(A) of the Act	(b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.
1902(y)(1)(B) of the Act	(c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may: 1. terminate the hospital's participation under the State plan; or 2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or 3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.
1902(y)(2)(A) of the Act	(d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

STATE PLAN UNDER TITLE III OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

INCOME AND ELIGIBILITY VERIFICATION SYSTEM
PROCEDURES REQUESTS TO OTHER STATE AGENCIES

The Department of Community Health matches with the Social Security Administration through the BENDEX and SDX processes. These matches have been performed for several years and are not required to be modified by the IEVS requirements as the Department contracts with the Social Security Administration and the Department of Human Services for the determination of eligibility.

The Department of Human Services, Division of Family and Children Services, conducts the following matches as part of the eligibility process:

1. Social Security Administration

   a) BENDEX matches are completed for enumeration purposes and to obtain TITLE II information. Match is completed monthly for new applications and on individuals for who ss-5's have been completed. An annual match is conducted for all active individuals.

   b) BEER matches are completed for income and wage information. Match is completed monthly for new application and annually on all recipients.

   c) The State has an eligibility system that provides for quarterly data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including Federal, Veterans Affairs and matching with medical assistance programs operated by other States for the purpose of eligibility determinations of public programs. The information that is requested will be exchanged with other States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

2. Internal Revenue Services matches are completed for unearned income (interest and dividends) information. Match is done monthly on all applications and annually for all recipients.

3. Department of Labor (DOL) wage and unemployment compensation benefit (UCB) matches are excluded from follow-up because the data available through IVES has previously been made available through on-line computer matches.

   Georgia DOL wage and UCB files are accessed on-line through Clearinghouse during the application process and at each standard and alternate review. Excluding matches in which IVES information has been made available through on-line matches eliminates duplication of effort and maximizes staff effectiveness.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS TO HOMELESS INDIVIDUALS

Medicaid eligibility cards are mailed through the United States Postal Service to the mailing addresses specified by the Social Security Administration or the Department of Family and Children Services. The following are considered acceptable mailing addresses:

General delivery at a United States Post Office;

A box or other rented space at a United States Post Office;

Residence of a guardian or representative payee; or

Location of a temporary shelter administered by a religious or service organization.

Eligibility cards returned by the Postal Service, including those considered undeliverable, are kept on file in each county office of the Department of Family and Children Services. Eligible individuals can appear there in person to receive their eligibility cards.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

The Official Code of Georgia Annotated concerning advance directives is included herein as pages la through 25a of Attachment 4.34-A. Definitions can be referenced at the code cites listed below:

• living will	31-32-2
• durable power of attorney	31-36-2
• witness requirements	31-32-3 and 31-36-5
• proxy designation	31-36-4
• process information	31-32-3 and 31-36-5
• State forms	31-32-3 and 31-36-10
• conscientious objection	31-32-9 and 31-36-7

CHAPTER 32

LIVING WILLS

Sec.	
31-32-1.	Legislative findings.
31-32-2.	Definitions.
31-32-3.	Execution; witnesses; form.
31-32-4.	Patients in hospitals or skilled nursing facilities.
31-32-8.	Conditions precedent to withholding or withdrawal of life-sustaining procedures; physician's failure or refusal to comply with living will.
31-32-9.	Living will as not constituting suicide; effect of living will on insurance; restriction on health care facilities' preparing living wills.
31-32-11.	Effect of chapter on other legal rights and duties.

Law reviews. — For article, "If Nancy Cruzan Had Lived in Georgia: A Summary of Georgia Law Regarding the Right to Die," see 27 Ga. St. B.J. 194 (1991). For article, "Experimenting With the 'Right to Die' in the Laboratory of the States," see 25 Ga. L. Rev. 1253 (1991).

For comment, "Living Will Statutes in Light of Cruzan v. Director, Missouri Department of Health: Ensuring that a Patient's Wishes Will Prevail", see 40 Emory L.J. 1305 (1991).

31-32-1. Legislative findings.

(a) The General Assembly finds that modern medical technology has made possible the artificial prolongation of human life.

(b) The General Assembly further finds that, in the interest of protecting individual autonomy, such prolongation of life for persons with a terminal condition, a coma, or a persistent vegetative state may cause loss of patient dignity and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient.

(c) The General Assembly further finds that there exists considerable uncertainty in the medical and legal professions as to the legality of terminating the use of life-sustaining procedures in certain situations.

(d) In recognition of the dignity and privacy which patients have a right to expect, the General Assembly declares that the laws of the State of Georgia shall recognize the right of a competent adult person to make a written directive, known as a living will, instructing his physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition, a coma, or a persistent vegetative state. (Code 1981, § 31-32-1, enacted by Ga. L. 1984, p. 1477, § 1; Ga. L. 1992, p. 1926, § 1.)

TRANSMITTAL 91-00
APPROVED 4-21-
EFFECTIVE 1-1-9
SUPERSEDES 91-39

The 1992 amendment, effective April 16, 1992, in subsections (b) and (d), inserted ", a coma, or a persistent vegetative state".

Law reviews. — For note on 1992 amendment of this Code section, see 9 Ga. St. U.L. Rev. 270 (1992).

31-32-2. Definitions.

As used in this chapter, the term:

(1) "Attending physician" means the physician who has been selected by or assigned to the patient and who has assumed primary responsibility for the treatment and care of the patient; provided, however, that if the physician selected by or assigned to the patient to provide such treatment and care directs another physician to assume primary responsibility for such care and treatment, the physician who has been so directed shall, upon his or her assumption of such responsibility, be the "attending physician."

(2) "Coma" means a profound state of unconsciousness caused by disease, injury, poison, or other means and for which it has been determined that there exists no reasonable expectation of regaining consciousness. The procedure for establishing a coma is as follows: two physicians, one of whom must be the attending physician, who, after personally examining the declarant, shall certify in writing, based upon conditions found during the course of their examination, that:

(A) The declarant has been in a profound state of unconsciousness for a period of time sufficient for the declarant's physicians to conclude that the unconscious state will continue; and

(B) There exists no reasonable expectation that the declarant will regain consciousness.

(3) "Competent adult" means a person of sound mind who is 18 years of age or older.

(4) "Declarant" means a person who has executed a living will authorized by this chapter.

(5) "Hospital" means a facility which has a valid permit or provisional permit issued under Chapter 7 of this title and which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons.

(6) "Life-sustaining procedures" means any medical procedures or interventions, which, when applied to a patient in a terminal condition or in a coma or persistent vegetative state with no reasonable expectation of regaining consciousness or significant cognitive function, would serve only to prolong the dying process and where, in the

judgment of the attending physician and a second physician, death will occur without such procedures or interventions. The term "life-sustaining procedures" may include, at the option of the declarant, the provision of nourishment and hydration, but shall not include the administration of medication to alleviate pain or the performance of any medical procedure deemed necessary to alleviate pain.

(7) "Living will" means a written document voluntarily executed by the declarant in accordance with the requirements of Code Section 31-32-3 or 31-32-4.

(8) "Patient" means a person receiving care or treatment from a physician.

(9) "Persistent vegetative state" means a state of severe mental impairment in which only involuntary bodily functions are present and for which there exists no reasonable expectation of regaining significant cognitive function. The procedure for establishing a persistent vegetative state is as follows: two physicians, one of whom must be the attending physician, who, after personally examining the declarant, shall certify in writing, based upon conditions found during the course of their examination, that:

(A) The declarant's cognitive function has been substantially impaired; and

(B) There exists no reasonable expectation that the declarant will regain significant cognitive function.

(10) "Physician" means a person lawfully licensed in this state to practice medicine and surgery pursuant to Article 2 of Chapter 34 of Title 43.

(11) "Reasonable expectation" means the result of prudent judgment made on the basis of the medical judgment of a physician.

(12) "Skilled nursing facility" means a facility having a valid permit or provisional permit issued under Chapter 7 of this title and which provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis.

(13) "Terminal condition" means incurable condition caused by disease, illness, or injury which, regardless of the application of life-sustaining procedures, would produce death. The procedure for establishing a terminal condition is as follows: two physicians, one of whom must be the attending physician, who, after personally examining the declarant, shall certify in writing, based upon conditions found during the course of their examination, that:

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(A) There is no reasonable expectation for improvement in the condition of the declarant; and

(B) Death of the declarant from these conditions will occur as a result of such disease, illness, or injury. (Code 1981, § 31-32-2, enacted by Ga. L. 1984, p. 1477, § 1; Ga. L. 1992, p. 1926, § 2.)

The 1992 amendment, effective April 16, 1992, added present paragraph (2); redesignated former paragraphs (2) through (4) as present paragraphs (3) through (5); rewrote former paragraph (5) and redesignated it as present paragraph (6); redesignated former paragraphs (6) and (7) as present paragraphs (7) and (8); added present paragraph (9); redesignated former paragraph (8) as present paragraph (10); added present paragraph (11); redesignated former paragraphs (9) and (10) as present paragraphs (12) and (13); and, in paragraph (13), in the second sentence of the introductory paragraph, inserted ", one of whom must be the attending physician," and added ", that" preceding the colon, and in subparagraph (B), substituted "will occur as a result of such disease, illness, or injury" for "is imminent".

Law reviews. — For annual survey of law of wills, trusts, and administration of estates, see 44 Mercer L. Rev. 445 (1992).

For note on 1992 amendment of this Code section, see 9 Ga. St. U.L. Rev. 270 (1992).

31-32-3. Execution; witnesses; form.

(a) Any competent adult may execute a document directing that, should the declarant have a terminal condition, life-sustaining procedures be withheld or withdrawn. Such living will shall be signed by the declarant in the presence of at least two competent adults who, at the time of the execution of the living will, to the best of their knowledge:

(1) Are not related to the declarant by blood or marriage;

(2) Would not be entitled to any portion of the estate of the declarant upon the declarant's decease under any testamentary will of the declarant, or codicil thereto, and would not be entitled to any such portion by operation of law under the rules of descent and distribution of this state at the time of the execution of the living will;

(3) Are neither the attending physician nor an employee of the attending physician nor an employee of the hospital or skilled nursing facility in which the declarant is a patient;

(4) Are not directly financially responsible for the declarant's medical care; and

(5) Do not have a claim against any portion of the estate of the declarant.

(b) The declaration shall l tained.
Any declaration which const intent
shall be honored, regardless Decla-
rations executed on or after finitely

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unless revoked. A declaration similar to the following form or in substantially the form specified under prior law shall be presumed on its face to be valid and effective:

"LIVING WILL

Living will made this _____ day ~~of~~ _____ (month, year).

I, _____, being of sound mind, willfully and voluntarily make known my desire that my life shall not be prolonged under the circumstances set forth below and do declare:

1. If at any time I should (check each option desired):

( ) have a terminal condition,

( ) become in a coma with no reasonable expectation of regaining consciousness, or

( ) become in a persistent vegetative state with no reasonable expectation of regaining significant cognitive function,

as defined in and established in accordance with the procedures set forth in paragraphs (2), (9), and (13) of Code Section 31-32-2 of the Official Code of Georgia Annotated, I direct that the application of life-sustaining procedures to my body (check the option desired):

( ) including nourishment and hydration,

( ) including nourishment but not hydration, or

( ) excluding nourishment and hydration,

be withheld or withdrawn and that I be permitted to die;

2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this living will shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal;

3. I understand that I may revoke this living will at any time;

4. I understand the full import of this living will, and I am at least 18 years of age and am emotionally and mentally competent to make this living will; and

5. If I am a female and I have been diagnosed as pregnant, this living will shall have no force and effect unless the fetus is not viable and I indicate by initialing after this sentence that I want this living will to be carried out. (Initial)

Signed _____

_____ (City), _____ (County), and _____ (State of Residence).

I hereby witness this living will and attest that:

(1) The declarant is personally known to me and I believe the declarant to be at least 18 years of age and of sound mind;

(2) I am at least 18 years of age;

(3) To the best of my knowledge, at the time of the execution of this living will, I:

(A) Am not related to the declarant by blood or marriage;

(B) Would not be entitled to any portion of the declarant's estate by any will or by operation of law under the rules of descent and distribution of this state;

(C) Am not the attending physician of declarant or an employee of the attending physician or an employee of the hospital or skilled nursing facility in which declarant is a patient;

(D) Am not directly financially responsible for the declarant's medical care; and

(E) Have no present claim against any portion of the estate of the declarant;

(4) Declarant has signed this document in my presence as above instructed, on the date above first shown.

Witness _____

Address _____

Witness _____

Address _____

Additional witness required when living will is signed in a hospital or skilled nursing facility.

I hereby witness this living will and attest that I believe the declarant to be of sound mind and to have made this living will willingly and voluntarily.

Witness: _____

Medical director of skilled nursing facility or staff physician not participating in care of the patient or chief of the hospital medical staff or staff physician or hospital designee not participating in care of the patient."

(Code 1981, § 31-32-3, enacted by Ga. L. 1984, p. 1477, § 1; Ga. L. 1986, p. 445, § 2; Ga. L. 1989, p. 1182, § 1; Ga. L. 1992, p. 1926, § 3; Ga. L. 1993, p. 91, § 31.)

The 1992 amendment, effective April 16, 1992, in subsection (b), rewrote the introductory language, rewrote paragraphs 1 and 5 of the living will form, and inserted "or hospital designee" near the end of the form.

The 1993 amendment, effective March 22, 1993, in the introductory language of subsection (b), substituted "March 28" for "March 18", in the living will form contained in subsection (b), substituted "paragraphs (2), (9), and (13)" for "paragraphs (2), (9), and (10)", and, in item 1 of the living will form contained in subsection (b), substituted "( ) including nourishment but not hydration, or" for "( ) including hydration but not nourishment, or".

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1992, "above instructed" was substituted for "above-instructed" in paragraph (4) of the witness statement form in subsection (b).

Law reviews. — For note on 1992 amendment of this Code section, see 9 Ga. St. U.L. Rev. 270 (1992).

31-32-4. Patients in hospitals or skilled nursing facilities.

A living will shall have no force or effect if the declarant is a patient in a hospital or skilled nursing facility at the time the living will is executed unless the living will is signed in the presence of the two witnesses as provided in Code Section 31-32-3 and, additionally, is signed in the presence of either the chief of the hospital medical staff, any physician on the medical staff who is not participating in the care of the patient, or a person on the hospital staff who is not participating in the care of the patient designated by the chief of staff and the hospital administrator, if witnessed in a hospital, or the medical director or any physician on the medical staff who is not participating in the care of the patient, if witnessed in a skilled nursing facility. (Code 1981, § 31-32-4, enacted by Ga. L. 1984, p. 1477, § 1; Ga. L. 1989, p. 1182, § 2; Ga. L. 1992, p. 1926, § 4.)

The 1992 amendment, effective April 16, 1992, near the middle of the Code section, substituted a comma for "or" following "medical staff" and inserted after the next comma "or a person on the hospital staff who is not participating in the care of the patient designated by the chief of staff and the hospital administrator,".

Law reviews. — For note on 1992 amendment of this Code section, see 9 Ga. St. U.L. Rev. 270 (1992).

31-32-8. Conditions precedent to withholding or withdrawal of life-sustaining procedures; physician's failure or refusal to comply with living will.

(a) Prior to effecting a withholding or withdrawal of life-sustaining procedures from a patient pursuant to a living will, the attending physician:

(1) Shall determine that, to the best of his knowledge, the declarant patient is not pregnant, or if she is, that the fetus is not viable and that the declarant's living will specifically indicates that the living will is to be carried out;

(2) Shall, without delay after the diagnosis of a terminal condition of the declarant, take the necessary steps to provide for the written certification required by Code Section 31-32-2 of the declarant's terminal condition, coma, or persistent vegetative state;

(3) Shall make a reasonable effort to determine that the living will complies with subsection (b) of Code Section 31-32-3; and

(4) Shall make the living will and the written certification of the terminal condition, coma, or persistent vegetative state a part of the declarant patient's medical records.

(b) The living will shall be presumed, unless revoked, to be the directions of the declarant regarding the withholding or withdrawal of life-sustaining procedures. No person shall be civilly liable for failing or refusing in good faith to effectuate the living will of the declarant patient. The attending physician who fails or refuses to comply with the declaration of a patient pursuant to this chapter shall endeavor to advise promptly the next of kin or legal guardian of the declarant that such physician is unwilling to effectuate the living will of the declarant patient. The attending physician shall thereafter at the election of the next of kin or the legal guardian of the declarant:

(1) Make a good faith attempt to effect the transfer of the qualified patient to another physician who will effectuate the declaration of the patient; or

(2) Permit the next of kin or legal guardian to obtain another physician who will effectuate the declaration of the patient. (Code 1981, § 31-32-8, enacted by Ga. L. 1984, p. 1477, § 1; Ga. L. 1992, p. 1926, § 5.)

The 1992 amendment, effective April 16, 1992, in subsection (a), made the following changes: in paragraph (1), added all of the language following "pregnant"; in paragraph (2), substituted all of the present language following "provide for" for "written certification by said physician of the declarant's terminal condition"; and, in paragraph (4), inserted ", coma, or persistent vegetative state".

Law reviews. — For note on 1992 amendment of this Code section, see 9 Ga. St. U.L. Rev. 270 (1992).

31-32-9. Living will as not constituting suicide; effect of living will on insurance; restriction on health care facilities' preparing living wills.

(a) The making of a living will pursuant to this chapter shall not, for any purpose, constitute a suicide.

(b) The making of a living will pursuant to this chapter shall not restrict, inhibit, or impair in any manner the sale, procurement, issuance, or enforceability of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the making of a living will pursuant to this chapter or by the withholding or withdrawal of life-sustaining procedures from an insured patient, nor shall the making of such a living will or the withholding or withdrawal of such life-sustaining procedures operate to deny any additional insurance benefits for accidental death of the patient in any case in which the terminal condition of the patient is the result of accident, notwithstanding any term of the policy to the contrary.

(c) No physician, hospital, skilled nursing facility, or other health provider and no health care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or nonprofit hospital service plan shall require any person to execute a living will as a condition for being insured for, or receiving, health care services.

(d) No hospital, skilled nursing facility, or other medical or health care facility shall prepare or offer to prepare living wills unless specifically requested to do so by a person desiring to execute a living will. For purposes of this article, a person in the custody of the Department of Corrections shall not be deemed to be a patient within the meaning of this article, nor shall a correctional facility be deemed to be a hospital, skilled nursing facility, nor any other medical or health care facility. (Code 1981, § 31-32-9, enacted by Ga. L. 1984, p. 1477, § 1; Ga. L. 1985, p. 455, § 1; Ga. L. 1992, p. 1926, § 6.)

The 1992 amendment, effective April 16, 1992, in the first sentence of subsection (d), substituted "shall prepare or offer to prepare" for "shall prepare, offer to prepare, or otherwise provide forms for"; and added the second sentence of subsection (d).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1992, "this article" was substituted for "this Article" twice in subsection (d).

Law reviews. — For note on 1992 amendment of this Code section, see 9 Ga. St. U.L. Rev. 270 (1992).

31-32-11. Effect of chapter on other legal rights and duties.

(a) Nothing in this chapter shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this chapter are cumulative.

(b) Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing or to permit any affirmative or deliberate act or omission to end life other than to permit the process of dying as provided in this chapter. Furthermore, nothing in this chapter shall be construed to condone, authorize, or approve abortion.

(c) This chapter shall create no presumption concerning the intention of an individual who has not executed a declaration to consent to the use or withholding of life-sustaining procedures in the event of a terminal condition, a coma, or a persistent vegetative state.

(d) Unless otherwise specifically provided in a durable power of attorney for health care, a declaration under this chapter is ineffective and inoperative as long as there is an agent available to serve pursuant to a durable power of attorney executed in accordance with the provisions of Chapter 36 of this title, the "Durable Power of Attorney for Health Care Act," which grants the agent authority with respect to the withdrawal or withholding of life-sustaining or death-delaying treatment under the same circumstances as those covered by a declaration under this chapter. (Code 1981, § 31-32-11, enacted by Ga. L. 1984, p. 1477, § 1; Ga. L. 1992, p. 1926, § 7.)

The 1992 amendment, effective April 16, 1992, at the end of subsection (c), added ", a coma, or a persistent vegetative state"; and added subsection (d).

Law reviews. — For note on 1992 amendment of this Code section, see 9 Ga. St. U.L. Rev. 270 (1992).

CHAPTER 36

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Sec.	
31-36-1.	Short title.
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31-36-3.	Definitions.
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31-36-8.	Immunity from liability or disciplinary action; death not constituting suicide or homicide.
31-36-9.	Penalties for violations.
31-36-10.	Form of power of attorney for health care; authorized powers.
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31-36-12.	Prior agency or act of agent not affected.
31-36-13.	Construction of chapter in relation to Title 53.

Effective date. — This chapter became effective July 1, 1990.

Cross references. — Living wills, Title 31, Chapter 32. Cardiopulmonary resuscitation, Title 31, Chapter 39.

31-36-1. Short title.

This chapter shall be known and may be cited as the "Durable Power of Attorney for Health Care Act." (Code 1981, § 31-36-1, enacted by Ga. L. 1990, p. 1101, § 1.)

31-36-2. Legislative findings.

(a) The General Assembly recognizes the right of the individual to control all aspects of his or her personal care and medical treatment, including the right to decline medical treatment or to direct that it be withdrawn. However, if the individual becomes disabled, incapacitated, or incompetent, his or her right to control treatment may be denied unless the individual, as principal, can delegate the decision-making power to a trusted agent and be sure that the agent's power to make personal and health care decisions for the principal will be effective to the same extent as though made by the principal.

(b) This recognition of the right of delegation for health care purposes must be stated to make it clear that its scope is intended to be as broad as the comparable right of delegation for property and financial matters. However, the General Assembly recognizes that powers con-

cerning health care decisions are more sensitive than property matters and that particular rules and forms are necessary for health care agencies to ensure their validity and efficacy and to protect health care providers so that they will honor the authority of the agent at all times. Nothing in this chapter shall be deemed to authorize or encourage euthanasia, suicide, or any action or course of action that violates the criminal laws of this state or the United States.

(c) In furtherance of these purposes, the General Assembly enacts this chapter, setting forth general principles governing health care agencies, as well as a statutory short form durable power of attorney for health care, intending that when a power in substantially the form set forth in this chapter is used, health care providers and other third parties who rely in good faith on the acts and decisions of the agent within the scope of the power may do so without fear of civil or criminal liability to the principal, the state, or any other person. However, the form of health care agency set forth in this chapter is not intended to be exclusive, and other forms of powers of attorney chosen by the principal that comply with Code Section 31-36-5 may offer powers and protections similar to the statutory short form durable power of attorney for health care. (Code 1981, § 31-36-2, enacted by Ga. L. 1990, p. 1101, § 1.)

31-36-3. Definitions.

As used in this chapter, the term:

(1) "Attending physician" means the physician who has primary responsibility at the time of reference for the treatment and care of the patient.

(2) "Health care" means any care, treatment, service, or procedure to maintain, diagnose, treat, or provide for the patient's physical or mental health or personal care.

(3) "Health care agency" or "agency" means an agency governing any type of health care, anatomical gift, autopsy, or disposition of remains for and on behalf of a patient and refers to the power of attorney or other written instrument defining the agency, or the agency itself, as appropriate to the context.

(4) "Health care provider" or "provider" means the attending physician and any other person administering health care to the patient at the time of reference who is licensed, certified, or otherwise authorized or permitted by law to administer health care in the ordinary course of business or the practice of a profession, including any person employed by or acting for any such authorized person.

(5) "Hospital" means a facility which has a valid permit or provisional permit issued under Chapter 7 of this title and which is primar-

ily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons.

(6) "Patient" means the principal.

(7) "Skilled nursing facility" means a facility which has a valid permit or provisional permit issued under Chapter 7 of this title and which provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. (Code 1981, § 31-36-3, enacted by Ga. L. 1990, p. 1101, § 1.)

31-36-4. Delegation of health care powers to agent; death of principal; rights regarding life-sustaining or death-delaying procedures.

The health care powers that may be delegated to an agent include, without limitation, all powers an individual may have to be informed about and to consent to or refuse or withdraw any type of health care for the individual. A health care agency may extend beyond the principal's death if necessary to permit anatomical gift, autopsy, or disposition of remains. Nothing in this chapter shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining or death-delaying procedures in any lawful manner, and the provisions of this chapter are cumulative in such respect. (Code 1981, § 31-36-4, enacted by Ga. L. 1990, p. 1101, § 1.)

31-36-5. Execution of agency; health care provider not qualified as agent; limitations on authority of agent.

(a) A health care agency shall be in writing and signed by the principal or by some other person in the principal's presence and by the principal's express direction. A health care agency shall be attested and subscribed in the presence of the principal by two or more competent witnesses who are at least 18 years of age. In addition, if at the time a health care agency is executed the principal is a patient in a hospital or skilled nursing facility, the health care agency shall also be attested and subscribed in the presence of the principal by the principal's attending physician.

(b) No health care provider may act as agent under a health care agency if he or she is directly or indirectly involved in the health care rendered to the patient under the health care agency.

(c) An agent under a health care agency shall not have the authority to make a particular health care decision different from or contrary to the

patient's decision, if any, if the patient is able to understand the general nature of the health care procedure being consented to or refused, as determined by the patient's attending physician based on such physician's good faith judgment. (Code 1981, § 31-36-5, enacted by Ga. L. 1990, p. 1101, § 1.)

31-36-6. Revocation or amendment of agency.

(a) Every health care agency may be revoked by the principal at any time, without regard to the principal's mental or physical condition, by any of the following methods:

(1) By being obliterated, burned, torn, or otherwise destroyed or defaced in a manner indicating an intention to revoke;

(2) By a written revocation of the agency signed and dated by the principal or by a person acting at the direction of the principal; or

(3) By an oral or any other expression of the intent to revoke the agency in the presence of a witness 18 years of age or older who, within 30 days of the expression of such intent, signs and dates a writing confirming that such expression of intent was made.

(b) Unless the health care agency expressly provides otherwise, if, after executing a health care agency, the principal marries, such marriage shall revoke the designation of a person other than the principal's spouse as the principal's agent to make health care decisions for the principal; and if, after executing a health care agency, the principal's marriage is dissolved or annulled, such dissolution or annulment shall revoke the principal's former spouse as the principal's agent to make health care decisions for the principal.

(c) A health care agency which survives disability shall not be revoked solely by the appointment of a guardian or receiver for the principal. Absent an order of a court of competent jurisdiction directing a guardian to exercise powers of the principal under an agency that survives disability, the guardian has no power, duty, or liability with respect to any personal or health care matters covered by the agency.

(d) A health care agency may be amended at any time by a written amendment executed in accordance with the provisions of subsection (a) of Code Section 31-36-5.

(e) Any person, other than the agent, to whom a revocation or amendment of a health care agency is communicated or delivered shall make all reasonable efforts to inform the agent of that fact as promptly as possible. (Code 1981, § 31-36-6, enacted by Ga. L. 1990, p. 1101, § 1.)

31-36-7. Duties and responsibilities of health care provider.

Each health care provider and each other person with whom an agent deals under a health care agency shall be subject to the following duties and responsibilities:

(1) It is the responsibility of the agent or patient to notify the health care provider of the existence of the health care agency and any amendment or revocation thereof. A health care provider furnished with a copy of a health care agency shall make it a part of the patient's medical records and shall enter in the records any change in or termination of the health care agency by the principal that becomes known to the provider. Whenever a provider believes a patient is unable to understand the general nature of the health care procedure which the provider deems necessary, the provider shall consult with any available health care agent known to the provider who then has power to act for the patient under a health care agency;

(2) A health care decision made by an agent in accordance with the terms of a health care agency shall be complied with by every health care provider to whom the decision is communicated, subject to the provider's right to administer treatment for the patient's comfort or alleviation of pain; but, if the provider is unwilling to comply with the agent's decision, the provider shall promptly inform the agent who shall then be responsible to make the necessary arrangements for the transfer of the patient to another provider. A provider who is unwilling to comply with the agent's decision will continue to afford reasonably necessary consultation and care in connection with the pending transfer;

(3) At the patient's expense and subject to reasonable rules of the health care provider to prevent disruption of the patient's health care, each health care provider shall give an agent authorized to receive such information under a health care agency the same right the principal has to examine and copy any part or all of the patient's medical records that the agent deems relevant to the exercise of the agent's powers, whether the records relate to mental health or any other medical condition and whether they are in the possession of or maintained by any physician, psychiatrist, psychologist, therapist, hospital, nursing home, or other health care provider, notwithstanding the provisions of any statute or rule of law to the contrary; and

(4) If and to the extent a health care agency empowers the agent to:

(A) Make an anatomical gift on behalf of the principal under Article 6 of Chapter 5 of Title 44, the "Georgia Anatomical Gift Act," as now or hereafter amended;

(B) Authorize an autopsy of the principal's body; or

(C) Direct the disposition of the principal's remains,

the anatomical gift, autopsy approval, or remains disposition shall be deemed the act of the principal or of the person who has priority under law to make the necessary decisions and each person to whom a direction by the agent in accordance with the terms of the agency is communicated shall comply with such direction to the extent it is in accord with reasonable medical standards or other relevant standards at the time of reference. (Code 1981, § 31-36-7, enacted by Ga. L. 1990, p. 1101, § 1.)

31-36-8. Immunity from liability or disciplinary action; death not constituting suicide or homicide.

Each health care provider and each other person who acts in good faith reliance on any direction or decision by the agent that is not clearly contrary to the terms of a health care agency will be protected and released to the same extent as though such person had dealt directly with the principal as a fully competent person. Without limiting the generality of the foregoing, the following specific provisions shall also govern, protect, and validate the acts of the agent and each such health care provider and other person acting in good faith reliance on such direction or decision:

(1) No such provider or person shall be subject to any type of civil or criminal liability or discipline for unprofessional conduct solely for complying with any direction or decision by the agent, even if death or injury to the patient ensues;

(2) No such provider or person shall be subject to any type of civil or criminal liability or discipline for unprofessional conduct solely for failure to comply with any direction or decision by the agent, as long as such provider or person promptly informs the agent of such provider's or person's refusal or failure to comply with such direction or decision by the agent. The agent shall then be responsible to make the necessary arrangements for the transfer of the patient to another health care provider. A health care provider who is unwilling to comply with the agent's decision will continue to afford reasonably necessary consultation and care in connection with the pending transfer;

(3) If the actions of a health care provider or person who fails to comply with any direction or decision by the agent are substantially in accord with reasonable medical standards at the time of reference and the provider cooperates in the transfer of the patient pursuant to paragraph (2) of Code Section 31-36-7, the health care provider or person shall not be subject to any type of civil or criminal liability or discipline for unprofessional conduct for failure to comply with the agency;

(4) No agent who, in good faith, acts with due care for the benefit of the patient and in accordance with the terms of a health care agency, or who fails to act, shall be subject to any type of civil or criminal liability for such action or inaction;

(5) If the authority granted by a health care agency is revoked under Code Section 31-36-6, a person will not be subject to criminal prosecution or civil liability for acting in good faith reliance upon such health care agency unless such person had actual knowledge of the revocation; and

(6) If the patient's death results from withholding or withdrawing life-sustaining or death-delaying treatment in accordance with the terms of a health care agency, the death shall not constitute a suicide or homicide for any purpose under any statute or other rule of law and shall not impair or invalidate any insurance, annuity, or other type of contract that is conditioned on the life or death of the patient, any term of the contract to the contrary notwithstanding. (Code 1981, § 31-36-8, enacted by Ga. L. 1990, p. 1101, § 1.)

31-36-9. Penalties for violations.

All persons shall be subject to the following sanctions in relation to health care agencies, in addition to all other sanctions applicable under any other law or rule of professional conduct:

(1) Any person shall be civilly liable who, without the principal's consent, willfully conceals, cancels, or alters a health care agency or any amendment or revocation of the agency or who falsifies or forges a health care agency, amendment, or revocation;

(2) A person who falsifies or forges a health care agency or willfully conceals or withholds personal knowledge of an amendment or revocation of a health care agency with the intent to cause a withholding or withdrawal of life-sustaining or death-delaying procedures contrary to the intent of the principal and thereby, because of such act, directly causes life-sustaining or death-delaying procedures to be withheld or withdrawn, shall be subject to prosecution for criminal homicide as provided for in Chapter 5 of Title 16; and

(3) Any person who requires or prevents execution of a health care agency as a condition of ensuring or providing any type of health care services to the patient shall be civilly liable and guilty of a misdemeanor and shall be punished as provided by law. (Code 1981, § 31-36-9, enacted by Ga. L. 1990, p. 1101, § 1.)

31-36-10. Form of power of attorney for health care; authorized powers.

(a) The statutory health care power of attorney form contained in this subsection may be used to grant an agent powers with respect to the principal's own health care; but the statutory health care power is not intended to be exclusive or to cover delegation of a parent's power to control the health care of a minor child, and no provision of this chapter shall be construed to bar use by the principal of any other or different form of power of attorney for health care that complies with Code Section 31-36-5. If a different form of power of attorney for health care is used, it may contain any or all of the provisions set forth or referred to in the following form. When a power of attorney in substantially the following form is used, including the notice paragraph in capital letters at the beginning, it shall have the meaning and effect prescribed in this chapter. The statutory health care power may be included in or combined with any other form of power of attorney governing property or other matters:

"GEORGIA STATUTORY SHORT FORM

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

NOTICE: THE PURPOSE OF THIS POWER OF ATTORNEY IS TO GIVE THE PERSON YOU DESIGNATE (YOUR AGENT) BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU, INCLUDING POWER TO REQUIRE, CONSENT TO, OR WITHDRAW ANY TYPE OF PERSONAL CARE OR MEDICAL TREATMENT FOR ANY PHYSICAL OR MENTAL CONDITION AND TO ADMIT YOU TO OR DISCHARGE YOU FROM ANY HOSPITAL, HOME, OR OTHER INSTITUTION; BUT NOT INCLUDING PSYCHOSURGERY, STERILIZATION, OR INVOLUNTARY HOSPITALIZATION OR TREATMENT COVERED BY TITLE 37 OF THE OFFICIAL CODE OF GEORGIA ANNOTATED. THIS FORM DOES NOT IMPOSE A DUTY ON YOUR AGENT TO EXERCISE GRANTED POWERS; BUT, WHEN A POWER IS EXERCISED, YOUR AGENT WILL HAVE TO USE DUE CARE TO ACT FOR YOUR BENEFIT AND IN ACCORDANCE WITH THIS FORM. A COURT CAN TAKE AWAY THE POWERS OF YOUR AGENT IF IT FINDS THE AGENT IS NOT ACTING PROPERLY. YOU MAY NAME COAGENTS AND SUCCESSOR AGENTS UNDER THIS FORM, BUT YOU MAY NOT NAME A HEALTH CARE PROVIDER WHO MAY BE DIRECTLY OR INDIRECTLY INVOLVED IN RENDERING HEALTH CARE TO YOU UNDER THIS POWER. UNLESS YOU EXPRESSLY LIMIT THE DURATION OF THIS POWER IN THE MANNER PROVIDED BELOW

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OR UNTIL YOU REVOKE THIS POWER OR A COURT ACTING ON YOUR BEHALF TERMINATES IT, YOUR AGENT MAY EXERCISE THE POWERS GIVEN IN THIS POWER THROUGHOUT YOUR LIFETIME, EVEN AFTER YOU BECOME DISABLED, INCAPACITATED, OR INCOMPETENT. THE POWERS YOU GIVE YOUR AGENT, YOUR RIGHT TO REVOKE THOSE POWERS, AND THE PENALTIES FOR VIOLATING THE LAW ARE EXPLAINED MORE FULLY IN CODE SECTIONS 31-36-6, 31-36-9, AND 31-36-10 OF THE GEORGIA 'DURABLE POWER OF ATTORNEY FOR HEALTH CARE ACT' OF WHICH THIS FORM IS A PART (SEE THE BACK OF THIS FORM). THAT ACT EXPRESSLY PERMITS THE USE OF ANY DIFFERENT FORM OF POWER OF ATTORNEY YOU MAY DESIRE. IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

DURABLE POWER OF ATTORNEY made this _____ day of _____, 19___.

1. I, _____
(insert name and address of principal)

hereby appoint _____
(insert name and address of agent)

as my attorney in fact (my agent) to act for me and in my name in any way I could act in person to make any and all decisions for me concerning my personal care, medical treatment, hospitalization, and health care and to require, withhold, or withdraw any type of medical treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to make a disposition of any part or all of my body for medical purposes, authorize an autopsy of my body, and direct the disposition of my remains.

THE ABOVE GRANT OF POWER IS INTENDED TO BE AS BROAD AS POSSIBLE SO THAT YOUR AGENT WILL HAVE AUTHORITY TO MAKE ANY DECISION YOU COULD MAKE TO OBTAIN OR TERMINATE ANY TYPE OF HEALTH CARE, INCLUDING WITHDRAWAL OF NOURISHMENT AND FLUIDS AND OTHER LIFE-SUSTAINING OR DEATH-DELAYING MEASURES, IF YOUR AGENT BELIEVES SUCH ACTION WOULD BE CONSISTENT WITH YOUR INTENT AND DESIRES. IF YOU WISH TO LIMIT THE SCOPE OF YOUR AGENT'S POWERS OR PRESCRIBE SPECIAL RULES TO LIMIT THE POWER TO MAKE AN ANATOMICAL GIFT, AUTHORIZE AUTOPSY, OR DISPOSE

OF REMAINS, YOU MAY DO SO IN THE FOLLOWING PARAGRAPHS.

2. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations (here you may include any specific limitations you deem appropriate, such as your own definition of when life-sustaining or death-delaying measures should be withheld; a direction to continue nourishment and fluids or other life-sustaining or death-delaying treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electroconvulsive therapy, or amputation):

_____

_____

_____

THE SUBJECT OF LIFE-SUSTAINING OR DEATH-DELAYING TREATMENT IS OF PARTICULAR IMPORTANCE. FOR YOUR CONVENIENCE IN DEALING WITH THAT SUBJECT, SOME GENERAL STATEMENTS CONCERNING THE WITHHOLDING OR REMOVAL OF LIFE-SUSTAINING OR DEATH-DELAYING TREATMENT ARE SET FORTH BELOW. IF YOU AGREE WITH ONE OF THESE STATEMENTS, YOU MAY INITIAL THAT STATEMENT, BUT DO NOT INITIAL MORE THAN ONE:

I do not want my life to be prolonged nor do I want life-sustaining or death-delaying treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved, and the quality as well as the possible extension of my life in making decisions concerning life-sustaining or death-delaying treatment.

Initialed _____

I want my life to be prolonged and I want life-sustaining or death-delaying treatment to be provided or continued unless I am in a coma, including a persistent vegetative state, which my attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered such an irreversible coma, I want life-sustaining or death-delaying treatment to be withheld or discontinued.

Initialed _____

I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery, or the cost of the procedures.

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Initialed _____

THIS POWER OF ATTORNEY MAY BE AMENDED OR REVOKED BY YOU AT ANY TIME AND IN ANY MANNER WHILE YOU ARE ABLE TO DO SO. IN THE ABSENCE OF AN AMENDMENT OR REVOCATION, THE AUTHORITY GRANTED IN THIS POWER OF ATTORNEY WILL BECOME EFFECTIVE AT THE TIME THIS POWER IS SIGNED AND WILL CONTINUE UNTIL YOUR DEATH AND WILL CONTINUE BEYOND YOUR DEATH IF ANATOMICAL GIFT, AUTOPSY, OR DISPOSITION OF REMAINS IS AUTHORIZED, UNLESS A LIMITATION ON THE BEGINNING DATE OR DURATION IS MADE BY INITIALING AND COMPLETING EITHER OR BOTH OF THE FOLLOWING:

3. ( ) This power of attorney shall become effective on _____ (insert a future date or event during your lifetime, such as court determination of your disability, incapacity, or incompetency, when you want this power to first take effect).

4. ( ) This power of attorney shall terminate on _____ (insert a future date or event, such as court determination of your disability, incapacity, or incompetency, when you want this power to terminate prior to your death).

IF YOU WISH TO NAME SUCCESSOR AGENTS, INSERT THE NAMES AND ADDRESSES OF SUCH SUCCESSORS IN THE FOLLOWING PARAGRAPH:

5. If any agent named by me shall die, become legally disabled, incapacitated, or incompetent, or resign, refuse to act, or be unavailable, I name the following (each to act successively in the order named) as successors to such agent:

_____

_____

IF YOU WISH TO NAME A GUARDIAN OF YOUR PERSON IN THE EVENT A COURT DECIDES THAT ONE SHOULD BE APPOINTED, YOU MAY, BUT ARE NOT REQUIRED TO, DO SO BY INSERTING THE NAME OF SUCH GUARDIAN IN THE FOLLOWING PARAGRAPH. THE COURT WILL APPOINT THE PERSON NOMINATED BY YOU IF THE COURT FINDS THAT SUCH APPOINTMENT WILL SERVE YOUR BEST INTERESTS AND WELFARE. YOU MAY, BUT ARE NOT REQUIRED TO, NOMINATE AS YOUR GUARDIAN THE SAME PERSON NAMED IN THIS FORM AS YOUR AGENT.

6. If a guardian of my person is to be appointed, I nominate the following to serve as such guardian:

_____

(insert name and address of nominated guardian of the person)

7. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Signed _____
(Principal)

The principal has had an opportunity to read the above form and has signed the above form in our presence. We, the undersigned, each being over 18 years of age, witness the principal's signature at the request and in the presence of the principal, and in the presence of each other, on the day and year above set out.

Witnesses:	Addresses:
_____	_____
	_____
_____	_____
	_____

Additional witness required when health care agency is signed in a hospital or skilled nursing facility.

I hereby witness this health care agency and attest that I believe the principal to be of sound mind and to have made this health care agency willingly and voluntarily.

Witness: _____
Attending Physician

Address: _____

_____

YOU MAY, BUT ARE NOT REQUIRED TO, REQUEST YOUR AGENT AND SUCCESSOR AGENTS TO PROVIDE SPECIMEN SIGNATURES BELOW. IF YOU INCLUDE SPECIMEN SIGNATURES IN THIS POWER OF ATTORNEY, YOU MUST COMPLETE THE CERTIFICATION OPPOSITE THE SIGNATURES OF THE AGENTS.

Specimen signatures of agent and successor(s)	I certify that the signature of my agent and successor(s) is correct.
_____	_____
(Agent)	(Principal)

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(Successor agent)	(Principal)
(Successor agent)	(Principal)"

(b) The foregoing statutory health care power of attorney form authorizes, and any different form of health care agency may authorize, the agent to make any and all health care decisions on behalf of the principal which the principal could make if present and under no disability, incapacity, or incompetency, subject to any limitations on the granted powers that appear on the face of the form, to be exercised in such manner as the agent deems consistent with the intent and desires of the principal. The agent will be under no duty to exercise granted powers or to assume control of or responsibility for the principal's health care; but, when granted powers are exercised, the agent will be required to use due care to act for the benefit of the principal in accordance with the terms of the statutory health care power and will be liable for negligent exercise. The agent may act in person or through others reasonably employed by the agent for that purpose but may not delegate authority to make health care decisions. The agent may sign and deliver all instruments, negotiate and enter into all agreements, and do all other acts reasonably necessary to implement the exercise of the powers granted to the agent. Without limiting the generality of the foregoing, the statutory health care power form shall, and any different form of health care agency may, include the following powers, subject to any limitations appearing on the face of the form:

(1) The agent is authorized to consent to and authorize or refuse, or to withhold or withdraw consent to, any and all types of medical care, treatment, or procedures relating to the physical or mental health of the principal, including any medication program, surgical procedures, life-sustaining or death-delaying treatment, or provision of nourishment and fluids for the principal, but not including psychosurgery, sterilization, or involuntary hospitalization or treatment covered by Title 37;

(2) The agent is authorized to admit the principal to or discharge the principal from any and all types of hospitals, institutions, homes, residential or nursing facilities, treatment centers, and other health care institutions providing personal care or treatment for any type of physical or mental condition, but not including psychosurgery, sterilization, or involuntary hospitalization or treatment covered by Title 37;

(3) The agent is authorized to contract for any and all types of health care services and facilities in the name of and on behalf of the principal and to bind the principal to pay for all such services and facilities, and the agent shall not be personally liable for any services or care contracted for on behalf of the principal;

(4) At the principal's expense and subject to reasonable rules of the health care provider to prevent disruption of the principal's health care, the agent shall have the same right the principal has to examine and copy and consent to disclosure of all the principal's medical records that the agent deems relevant to the exercise of the agent's powers, whether the records relate to mental health or any other medical condition and whether they are in the possession of or maintained by any physician, psychiatrist, psychologist, therapist, hospital, nursing home, or other health care provider, notwithstanding the provisions of any statute or other rule of law to the contrary; and

(5) The agent is authorized to direct that an autopsy of the principal's body be made; to make a disposition of any part or all of the principal's body pursuant to Article 6 of Chapter 5 of Title 44, the "Georgia Anatomical Gift Act," as now or hereafter amended; and to direct the disposition of the principal's remains. (Code 1981, § 31-36-10, enacted by Ga. L. 1990, p. 1101, § 1.)

31-36-11. Applicability of chapter; principal with living will; priority of agent's authority.

This chapter applies to all health care providers and other persons in relation to all health care agencies executed on and after July 1, 1990. This chapter supersedes all other provisions of law or parts thereof existing on July 1, 1990, to the extent such other provisions are inconsistent with the terms and operation of this chapter, provided that this chapter does not affect the provisions of law governing emergency health care. If the principal has a living will under Chapter 32 of this title, as now or hereafter amended, the living will shall not be operative so long as an agent is available who is authorized by a health care agency to deal with the subject of life-sustaining or death-delaying procedures for and on behalf of the principal. Furthermore, unless the health care agency provides otherwise, the agent who is known to the health care provider to be available and willing to make health care decisions for the patient has priority over any other person, including any guardian of the person, to act for the patient in all matters covered by the health care agency. (Code 1981, § 31-36-11, enacted by Ga. L. 1990, p. 1101, § 1.)

31-36-12. Prior agency or act of agent not affected.

This chapter does not in any way affect or invalidate any health care agency executed or any act of an agent prior to July 1, 1990, or affect any claim, right, or remedy that accrued prior to July 1, 1990. (Code 1981, § 31-36-12, enacted by Ga. L. 1990, p. 1101, § 1.)

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31-36-13. Construction of chapter in relation to Title 53.

This chapter is wholly independent of the provisions of Title 53, relating to wills, trusts, and the administration of estates, and nothing in this chapter shall be construed to affect in any way the provisions of said Title 53. (Code 1981, § 31-36-13, enacted by Ga. L. 1990, p. 1101, § 1.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

CRITERIA FOR THE APPLICATION OF SPECIFIED REMEDIES FOR SKILLED NURSING AND INTERMEDIATE CARE FACILITIES
(When and how each remedy is applied, the amounts of any fines, and the severity of the remedies)

See Attached Rules of Department of Medical Assistance, Chapter 350-3. Attachment 4.35-A pages 1a through 1r.

RULES
OF
DEPARTMENT OF MEDICAL ASSISTANCE

CHAPTER 350-3
SANCTIONS FOR NURSING FACILITIES

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350-3-.01 Definitions.

(1) "Complaint Investigation" means a survey or visit to determine the validity of allegations of resident abuse, neglect or misappropriation of resident property, or of other noncompliance with applicable federal and state requirements.

(2) "Deficiency" means a failure of compliance with a Program Requirement. The fact that a deficiency no longer exists at the time of the Survey or complaint investigation which identifies it shall not negate its status as a deficiency for the purpose of imposing a civil monetary penalty or requesting a Plan of Correction.

(3) "Finding" means a determination, as the result of a survey or complaint investigation of the facility, that noncompliance with a Program Requirement could or should have been prevented or has not yet been identified by the facility, is not being corrected by proper action by the facility, or cannot be justified by special circumstances unique to the facility or the resident.

(4) "Initial finding" means the first time that a deficiency or deficiencies is recorded by a surveyor as the result of a survey or complaint investigation. Initial findings may be records of deficiencies that occurred prior to the date of the survey visit even if the deficiencies no longer exist at the time of the current survey.

(5) "Monitor" means a person or organization placed in a facility by the Department or the State Survey Agency for the purpose of overseeing a facility's correction of deficiencies or to ensure orderly closure of a

facility. A monitor shall have practical long-term care experience related to the aspect(s) for which the facility is being monitored.

(6) "Nursing Facility" means an institution (or a distinct part of an institution) which

(a) is primarily engaged in providing to residents

1. skilled nursing care and related services for residents who require medical or nursing care;

2. rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

3. on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and

(b) is not primarily for the care and treatment of mental diseases; and

(c) is enrolled as a provider in the Georgia Medical Assistance program.

(7) "Program Requirement" means any requirement contained in Subsection 1919(b), (c), or (d) of the Social Security Act of 1935, as amended, including but not limited to the provisions implemented by the Omnibus Budget Reconciliation Act of 1987, P.L. 100-203.

(8) "Repeat deficiency" is a deficiency related to resident care which recurs within eighteen (18) months of its citing in an Initial Finding, and which is found at a follow-up visit, complaint investigation, subsequent survey, or otherwise.

(9) "Repeated noncompliance" means a finding of substandard quality of care on three (3) consecutive annual surveys.

(10) "Resurvey" means a follow-up visit to determine whether the deficiencies found in a survey or complaint investigation have been corrected.

(11) "Scope" means the frequency, incidence, or extent of the occurrence of a deficiency in a facility.

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(12) "Severity" is the seriousness of a deficiency, which means the degree of actual or potential negative impact on a resident (as measured by negative outcomes or rights violations) or the degree to which his/her highest practicable physical, mental, or psychosocial well-being has been compromised.

(13) "State Survey Agency" means the Georgia Department of Human Resources.

(14) "Subsequent finding" means a violation or deficiency found on a resurvey. The deficiency must exist at the time of the resurvey or revisit. If a deficiency cited in an Initial Finding is found upon resurvey or revisit, a rebuttable presumption arises that the deficiency continued throughout the period of time between the initial survey or visit and the resurvey or revisit.

(15) "Substandard quality of care" means a finding by the Department or the State Survey Agency of one or more deficiencies, the existence of which limit(s) the facility's ability to deliver adequate care or services.

(16) "Survey" means a review of a case-mix stratified sample of nursing facility residents to determine the quality of care furnished as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities, and social participation, and sanitation, infection control, and physical environment. Such survey shall include an exit interview in which the surveyor and the facility shall attempt to resolve any conflicts regarding findings by the surveyor(s).

(17) "Surveyor" means a professional authorized by the State Survey Agency to conduct surveys or complaint investigations to determine compliance with Program Requirements.

(18) "Termination of the facility's participation" means exclusion of a facility from participation as a provider under the Georgia State Plan for Medical Assistance as a result of one or more deficiencies.

Authority Ga. L. 1977, p. 384, et seq., 394; O.C.G.A. Sec. 49-4-142(a). **Administrative History.** Original Rule entitled "Definitions" was filed on April 11, 1978; effective May 1, 1978. **Amended:** Filed January 8, 1981; effective January 28, 1981. **Repealed:** ER. 350-3-0.3-.01 adopted. F. Oct. 5, 1989; eff. Sept. 29, 1989, the date of adoption, to remain in effect for 120 days or until adoption of a permanent Rule superseding said Emergency Rule, as specified by the Agency. **Repealed:** Permanent Rule of same title adopted. F. Oct. 4, 1989; eff. Nov. 1, 1989, as specified by the Agency.

350-3-.02 Remedies. If the Department finds that a facility does not or did not meet a Program Requirement governing nursing facilities,

it may impose the following remedies, independently or in conjunction with others, subject to the provisions of this Chapter for notice and appeal.

(a) Termination of the facility's participation.

(b) Denial of Medicaid payments for services rendered by the facility to any recipient admitted to the facility after notice to the facility. This remedy shall remain in effect until the Department determines that the facility has achieved substantial compliance with all Program Requirements, or until another remedy is substituted for it. A facility subject to this remedy may request termination of the remedy on the ground that it has achieved substantial compliance with program requirements. The Department shall respond to the request by terminating the remedy, requesting additional information if documentation of substantial compliance is considered insufficient, or conducting a resurvey within twenty (20) days of receipt of the request. This remedy shall not be imposed with respect to temporarily hospitalized recipients previously residing in a facility placed on such notice who return to the facility after the date of notice, or with respect to residents who become Medicaid eligible after the date of notice and who resided in the facility prior to the date of notice.

(c) Civil monetary penalties, as specified in Section .04. When penalties are imposed on a facility, such penalties shall be assessed and collected for each day in which the facility is or was out of compliance with a Program Requirement. Interest on each penalty shall be assessed and paid as specified in Section .04. For individuals, such penalties shall be assessed for each infraction, as described in Section .04(g).

(d) Temporary management as specified in Section .05, to oversee operation of the facility and to assure the health and safety of the facility's residents while there is an orderly closure of facility or while improvements are made in order to bring the facility into compliance with all Program Requirements.

(e) Closure of the facility and/or transfer of recipients to another facility, in the case of an emergency as described in Section .03(e).

(f) Plan of Correction, to be drafted by the facility and submitted within a specified time to the Department. Each proposed Plan shall delineate the time and manner in which each deficiency is to be corrected. The Department shall review the proposed Plan and accept or

reject the Plan by notice to the facility.

(g) Ban on admission of persons with certain diagnoses or requiring specialized care who are covered by or eligible for Medicare or Medicaid. Such bans may be imposed for all such prospective residents, and shall prevent the facility from admitting the kinds of residents it has shown an inability to care for adequately as documented by deficiencies.

(h) Ban on all Medicare and Medicaid admissions to the facility or to any part thereof. Such bans shall remain in effect until the Department determines that the facility has achieved substantial compliance with all Program Requirements, or until another remedy is substituted for it. A facility may request termination of this remedy in the manner described in (b) above. This remedy shall not be imposed with respect to temporarily hospitalized residents previously residing in a facility placed on such notice who return to the facility after the date of notice, or with respect to residents who become Medicaid eligible and who resided in the facility prior to the date of notice.

Authority Ga. L.1977, pp. 384, 387; O.C.G.A. Sec. 49-4-142(a). **Administrative History.** Original Rule, entitled "Policy of Non-Discrimination," was filed on April 11, 1978; effective May 1, 1978. **Repealed:** ER. 350-3-0.3-.02 adopted. F. Oct. 5, 1989; eff. Sept. 29, 1989, the date of adoption, to remain in effect for 120 days or until adoption of a permanent Rule superseding said Emergency Rule, as specified by the Agency. **Repealed:** Permanent Rule entitled "Remedies" adopted. F. Oct. 4, 1989; eff. Nov. 1, 1989, as specified by the Agency.

350-3-.03 Imposition of Remedies. In determining which remedy to impose, the Department shall consider the facility's compliance history, change of ownership, and the number, scope, and severity of the deficiencies. Subject to these considerations, the Department shall impose those remedies described in Section .02 most likely to achieve correction of the deficiencies.

(a) Immediate jeopardy. If the Department finds that the facility's deficiency or deficiencies immediately jeopardize(s) the health or safety of its residents, the Department shall:

1. appoint temporary management and impose one or more of the remaining remedies specified in Section .02; or

2. terminate the facility's Medicaid participation and, at its option, impose one or more of the remaining remedies specified in Section .02.

(b) Absence of immediate jeopardy. If the Department finds that the facility's deficiency or deficiencies do not immediately jeopardize resident health or safety, the Department may impose one or more of the

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remedies specified in Section .02.

(c) Repeated noncompliance. If the Department makes a determination of repeated noncompliance with respect to a facility, it shall deny payment for services to any individual admitted to the facility after notice to the facility. Additionally, the Department shall monitor the facility on-site on a regular, as-needed basis, (as provided in Section .06), until the facility has demonstrated to the Department's satisfaction that it is in compliance with all Program Requirements governing facilities and that it will remain in compliance.

(d) Delayed compliance. If a facility has not complied with any Program Requirement within three (3) months of the date the facility is found to have been out of compliance with such Requirement, the Department shall impose the remedy of denial of payments for services to all individuals admitted after notice to the facility.

(e) Emergencies. When the Department has determined that residents are subject to an imminent and substantial danger, it may order either closure of the facility or transfer of the recipients to another facility. The Department shall give notice of any such proposed remedy to the facility, the residents who will be affected or their representatives, the affected residents' next-of-kin or guardians, and all attending physicians. When either of these remedies is imposed, no Administrative Review shall be available and the provisions of Subsection .09(2) shall apply.

(f) Conflict of remedies. In the case of facilities participating in both Medicare and Medicaid which have been surveyed by both the State Survey Agency and the Health Care Financing Administration, or whose certification documents have been reviewed by both, and for whom the State Survey Agency and the Health Care Financing Administration disagree on the decision to impose a remedy or the choice of a remedy, the decision of the Health Care Financing Administration with regard to Medicare shall apply.

Authority Ga. L. 1977, pp. 384, 394; O.C.G.A. Sec. 49-4-142(a). **Administrative History.** Original Rule entitled "Incorporation of Existing Rules and Regulations" was filed on April 11, 1978; effective May 1, 1978. **Repealed:** ER. 350-3-0.3-.03 adopted. F. Oct. 5, 1989; eff. Sept. 29, 1989, the date of adoption, to remain in effect for 120 days or until adoption of a permanent Rule superseding said Emergency Rule, as specified by the Agency. **Repealed:** Permanent Rule entitled "Imposition of Remedies" adopted. F. Oct. 4, 1989; eff. Nov. 1, 1989, as specified by the Agency.

350-3-.04 Civil Monetary Penalties. Civil monetary penalties shall be based upon one or more findings of noncompliance; actual harm to a resident or residents need not be shown. Nothing shall prevent the

Department from imposing this remedy for deficiencies which existed prior to the survey or complaint investigation through which they are identified. A single act, omission, or incident shall not give rise to imposition of multiple penalties, even though such act, omission, or incident may violate more that one Program Requirement. In such cases, the single highest class of deficiency shall be the basis for penalty. Compliance by the facility at a later date shall not result in the reduction of the penalty amount. Civil monetary penalties and any attorneys' fees or other costs associated with contesting such penalties are not reimbursable Medicaid expenses except in the case where a facility prevails, in which case reasonable attorneys' fees and costs shall be allowable. Whenever such penalties are collected, the Department shall conduct a financial field audit to ensure that there has been, and will be, no Medicaid reimbursement associated with the penalties.

(a) Classification of deficiencies. The three classes of deficiencies upon which civil monetary penalties shall be based are as follows:

1. Class A: A deficiency or combination of deficiencies which places one or more residents at substantial risk of serious physical or mental harm.

2. Class B: A deficiency or combination of deficiencies, other than Class A deficiencies, which has a direct adverse affect on the health, safety, welfare, or rights of residents; or a failure to post notices issued by the Department of imposition of remedies;

3. Class C: A deficiency or combination of deficiencies, other than Class A or B deficiencies, which indirectly or over a period of more than thirty (30) days is likely to have an adverse affect on the health, safety, welfare, or rights of residents.

(b) Amounts. When Civil Monetary Penalties are imposed, such penalties shall be assessed for each day the facility is or was out of compliance. The amounts below shall be multiplied by the total number of beds certified for participation in the Medicare and Medicaid programs according to the records of the State Survey Agency at the time of the survey. Penalties shall be imposed for each class of deficiencies identified in a survey or complaint investigation.

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Class	Initial Finding	Subsequent Finding	Repeat Deficiency
A	$ 10.00	$ 15.00	$ 20.00
B	5.00	7.50	10.00
C	1.00	1.50	3.00

In any ninety (90) day period, the penalty amounts may not exceed the applicable ceiling as described immediately below. The ceiling (Initial, Subsequent, or Repeat) shall be determined by which category has the largest percentage of the deficiencies cited in the survey or complaint investigation.

Bed Size	Initial Finding	Subsequent Finding	Repeat Deficiency
0 - 50	$ 4,000	$ 6,000	$ 8,000
51 - 100	6,000	9,000	12,000
101 - 150	8,000	12,000	16,000
151 or more	10,000	15,000	20,000

(c) Procedure for imposing civil monetary penalties. Civil monetary penalties shall be imposed as follows:

1. Within ten (10) business days of its discovery of a deficiency, the State Survey Agency shall deliver to the Department its recommendation for assessment of a penalty as a result of such deficiency.

2. The decision to assess the penalty shall be made by a person in the Department who is not the surveyor(s) or complaint investigator(s) who reported the deficiency.

(d) Notice. The Department shall give written notice to the facility of its imposition of any such penalty within ten (10) business days of its receipt of a recommendation by the State Survey Agency for the assessment of a penalty. The notice shall inform the facility of the amount of the penalty, the basis for its assessment, and the facility's appeal rights.

(e) Payment. Within fifteen (15) business days from the date the notice is received by the facility, the facility shall pay the full amount of

the penalty or penalties unless the facility requests Administrative Review of the decision to assess the penalty or penalties. The amount of a civil monetary penalty determined through Administrative Review shall be paid within ten (10) business days of the facility's receipt of the Administrative Review decision unless the facility requests an Administrative Hearing. The amount of the civil monetary penalty determined through a hearing shall be paid within ten (10) business days of the facility's receipt of the hearing decision. Interest at the legal rate of interest established by Georgia law shall begin to run on the later of one (1) business day after:

1. the facility's receipt of notice of the penalty; or

2. the date of issuance of the Administrative Review or Hearing decision.

Failure of a facility to pay the entire penalty as specified in this paragraph shall result in an automatic final decision and no further administrative or judicial review or hearing shall be available to the facility.

(f) Collection of civil penalties. If a facility fails or refuses to pay a penalty within the time required, the Department may collect the penalty by subtracting all or part of the penalty amount plus interest from future medical assistance payments to the facility. Additionally, the Department may subtract a fee representing the actual administrative cost of collection. Nothing herein shall prohibit the Department from obtaining judicial enforcement of its right to collect penalties and interest thereon.

(g) Imposition against individuals. Each recipient resident's functional capacity shall be assessed by the facility using an instrument specified by the Department. A civil money penalty of $1,000 per assessment shall be imposed by the Department against any individual who willfully and knowingly certifies a material and false statement in such assessment instrument or other documents used to support the assessment. A civil money penalty of $5,000 per assessment shall be imposed by the Department against any individual who willfully and knowingly causes another individual to certify a material and false statement in such assessment instrument or other documents used to support the assessment. Any such penalty shall be imposed by written notice to the individual according to the same provisions as set forth in Paragraphs (c) through (e) of this Section regarding deficiencies.

(h) Use of civil monetary penalties. The Department may use collected civil monetary penalties for the following purposes:

1. protecting the health or property of residents;

2. paying costs of relocating residents;

3. maintaining the operation of a nursing facility while deficiencies are corrected or the facility is being closed; and

4. reimbursing residents for personal funds lost, which reimbursement shall not adversely affect a person's Medicaid eligibility.

Authority Ga. L. 1977, p. 384, et seq.; O.C.G.A. Sec. 49-4-142(a). **Administrative History.** Original Rule entitled "Procedure for Adoption of Rules" was filed on April 11, 1978; effective May 1, 1978. **Amended:** Filed June 18, 1979; effective July 8, 1979. **Amended:** Filed April 29, 1982; effective May 19, 1982. **Repealed:** ER. 350-3-0.3-.04 adopted. F. Oct. 5, 1989; eff. Sept. 29, 1989, the date of adoption, to remain in effect for 120 days or until adoption of a permanent Rule superseding said Emergency Rule, as specified by the Agency. **Repealed:** Permanent Rule entitled "Civil Monetary Penalties" adopted. F. Oct 4, 1989; eff. Nov. 1, 1989, as specified by the Agency.

350-3-.05 Temporary Management. The Department shall impose the remedy of temporary management in situations where it finds that there is a need to oversee operation of the facilty and to assure the health and safety of the facility's residents while there is an orderly closure of the facility or while improvements are made in order to bring the facility into complaince with all Program Requirements. Temporary management shall not be imposed unless other less intrusive remedies will not result in compliance, have failed to cause the facility to achieve compliance, or the Department has found that the facility's deficiency or deficiencies immediately jeopardize the health or safety of its residents.

(a) Recommendation for appointment of temporary management. Within ten (10) business days of its completion of a survey or complaint investigation, the State Survey Agency shall deliver to the Department its written recommendation for appointment of temporary management if, in the Agency's judgment, such appointment is necessary. The recommendation shall specify the grounds upon which it is based, including an assessment of the capability of the facility's current management to achieve and maintain compliance with all Program Requirements.

(b) The decision to appoint temporary management shall be made by a person, appointed by the Commissioner, who is not the surveyor or complaint investigator who discovered the deficiencies or made the recommendation for appointment.

(c) The Department shall give written notice to the facility of its appointment of temporary management within ten (10) business days of its receipt of a recommendation for appointment from the State Survey Agency, unless the Department determines that temporary management is not necessary. When the Department has determined that the facility's deficiency or deficiencies immediately jeopardize the health or safety of its residents, no Administrative Review shall be available and the provisions of Subsection .09(2) shall apply.

(d) Who may serve. The Commissioner may appoint any person or organization which meets the following qualifications:

1. The temporary manager shall not have any pecuniary interest in or pre-existing fiduciary duty to the facility to be managed.

2. The manager must not be related, within the first degree of kinship, to the facility's owner, manager, administrator, or other management principal.

3. The manager must possess sufficient training, expertise, and experience in the operation of a nursing facility as would be necessary to achieve the objectives of temporary management. The manager must possess a Georgia nursing home administrator's license.

4. The manager must not be an existing competitor of the facility who would gain an unfair competitive advantage by being appointed as temporary manager of the facility.

(e) Powers and duties of the temporary manager.

1. The temporary manager shall have the authority to direct and oversee the correction of Program Requirement deficiencies; to oversee and direct the management, hiring, and discharge of any consultant or employee, including the administrator of the facility; to direct the expenditure of the revenues of the facility in a reasonable, prudent manner; to oversee the continuation of the business and the care of the residents; to oversee and direct those acts necessary to accomplish the goals of the Program Requirements; and to direct and oversee regular accountings and the making of periodic reports to the Department. The temporary manager shall provide reports to the Department no less frequently than monthly showing the facility's compliance status. Should the facility fail or refuse to carry out the directions of the temporary

manager, the Department shall terminate the facility's participation and may, at its discretion, impose any other remedies described in Section .02.

2. The temporary manager shall observe the confidentiality of the operating policies, procedures, employment practices, financial information, and all similar business information of the facility, except that the temporary manager shall make reports to the Department as provided in this section.

3. The temporary manager shall be liable for gross, willful or wanton negligence, intentional acts or omissions, unexplained shortfalls in the facility's funds, and breaches of fiduciary duty. The temporary manager shall be bonded in an amount equal to the facility's revenues for the month preceding the appointment of the temporary manager.

4. The temporary manager shall not have authority to do the following:

(i) To cause or direct the facility or its owner to incur debt or to enter into any contract with a duration beyond the term of the temporary management of the facility;

(ii) To cause or direct the facility to encumber its assets or receivables, or the premises on which it is located, with any lien or other encumbrance;

(iii) To cause or direct the sale of the facility, its assets, or the premises on which it is located;

(iv) To cause or direct the facility to cancel or reduce its liability or casualty insurance coverage;

(v) To cause or direct the facility to default upon any valid obligations previously undertaken by the owners or operators of the facility, including, but not limited to, leases, mortgages and security interests; and

(vi) To incur capital expenditures in excess of $2,000.00 without the permission of the owner or the Commissioner.

(f) Costs. All compensation and per diem costs of the temporary manager shall be paid by the nursing facility. The Department shall bill the facility for the costs of the temporary manager after termination of

temporary management. The costs of the temporary manager for any thirty (30) day period shall not exceed one-sixth of the maximum allowable administrator's annual salary for the largest nursing facility for Medicaid reimbursement purposes. Within fifteen (15) days of receipt of the bill, the facility shall pay the bill or request Administrative Review to contest the costs for which it was billed. Such costs shall be recoverable through recoupment from future medical assistance payments in the same fashion as a benefits overpayment. The costs of temporary management and the attorneys' fees associated with contesting such costs are not reimbursable Medicaid expenses except in the case where a facility prevails in a hearing, in which case reasonable attorneys' fees and costs shall be allowable.

(g) Termination of temporary management. The Commissioner may replace any temporary manager whose performance is, in the Commissioner's discretion, deemed unsatisfactory. No formal procedure is required for such removal or replacement but written notice of any action shall be given the facility, including the name of any replacement manager. A facility subject to temporary management may petition the Commissioner for replacement of a temporary manager whose performance it considers unsatisfactory. The Commissioner shall respond to a petition for replacement within three (3) business days after receipt of said petition. Otherwise, the Department shall not terminate temporary management until it has determined that the facility has management capability to ensure continued compliance with all Program Requirements or until the Department terminates the nursing facility's participation. A facility may petition the Department for termination of temporary management. The Department shall respond to the petition within three (3) business days after receipt.

(h) Nothing contained in this section shall limit the right of any nursing facility owner to sell, lease, mortgage, or close any facility in accord with all applicable laws.

Authority Ga. L. 1977, p. 384, et seq.; O.C.G.A. Sec. 49-4-142(a). **Administrative History.** Original Rule entitled "Adoption of Rules" was filed on April 11, 1978; effective May 1, 1978. **Repealed:** ER. 350-3-0.3-.05 adopted. F. Oct. 5, 1989; eff. Sept. 29, 1989, the date of adoption, to remain in effect for 120 days or until adoption of a permanent Rule superseding said Emergency Rule, as specified by the Agency. **Repealed:** Permanent Rule entitled "Temporary Management" adopted. F. Oct. 4, 1989; eff. Nov. 1, 1989, as specified by the Agency.

350-3-.06 Monitoring.

(1) The Department shall maintain procedures and adequate staff on-site, on a regular, as-needed basis, to monitor the facility's operations, advise the facility in its effort to come into or maintain compliance,

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to report to the licensing agency, and to investigate complaints of violations which are not easily verified on one visit.

(a) One or more monitor(s) shall be placed in the nursing facility:

1. when it has been found on three (3) standard surveys that the nursing facility has provided substandard quality of care;

2. when the facility has been under temporary management;

3. to ensure that Class A & B violations have been and continue to be corrected; or

4. when the Department has reason to question a nursing facility's compliance.

(2) The Department shall bill the facility for the expenses of monitoring at the end of the monitoring process. Within fifteen (15) days of receipt of the bill, the facility shall pay the bill or request Administrative Review to contest the costs for which it was billed. Such expenses shall be recoverable through recoupment from future medical assistance payments in the same fashion as a benefits overpayment.

(3) In the event a monitor is already in a facility pursuant to the provisions of O.C.G.A. § 31-7-2.2(b), the Department may not place a monitor in the facility.

Authority Ga. L. 1977, p. 384, et seq.; O.C.G.A. Sec. 49-4-142(a). **Administrative History.** Original Rule entitled "Imminent Threat" was filed on April 11, 1978; effective May 1, 1978. **Repealed:** ER. 350-3-0.3-.06 adopted. F. Oct. 5, 1989; eff. Sept. 29, 1989, the date of adoption, to remain in effect for 120 days or until adoption of a permanent Rule superseding said Emergency Rule, as specified by the Agency. **Repealed:** Permanent Rule entitled "Monitoring" adopted. F. Oct. 4, 1989; eff. Nov. 1, 1989, as specified by the Agency.

350-3-.07 Notice.

(1) The Department shall give notice of the imposition of any remedy described in this Chapter as follows:

(a) To the facility in writing, transmitted in a manner which will reasonably ensure timely receipt by the facility.

(b) To the public by transmitting printed Notices to the facility. Such Notices shall be at least 11 1/2 inches by 17 1/2 inches in size and of sufficient legibility that they may reasonably be expected to be readable by the facility's residents or their representatives. A printed notice shall

not be transmitted or required to be posted for a Plan of Correction.

(c) To the State Long-Term Care Ombudsman by placing copies with the U. S. Postal Service of all notices to the facility.

(d) To the State Survey Agency in writing.

(2) The facility shall post a sufficient number of the Notices described in Paragraph (1)(b) in places readily accessible and visible to residents and their representatives, including but not limited to entrances, exits, and common areas, to effectively advise all present and prospective residents of the remedies which are being imposed. The Notices shall remain in place until all remedies are officially removed by the Department. Failure of a facility to comply with notice posting requirements shall constitute a Class B deficiency.

(3) A facility shall post a Notice of Administrative Hearing date, time, and location whenever the facility has requested and been granted a hearing on imposition of a remedy. The notice shall be at least 11 1/2 inches by 17 1/2 inches in size and of sufficient legibility that it may reasonably be expected to be readable by the facility's residents or their representatives. The notice shall be placed in an area readily accessible and visible to residents and their representatives.

(4) The Department shall notify the attending physician of each resident with respect to whom a finding of substandard quality of care has been made, as well as the Board of Nursing Home Administrators, by transmitting to them copies of the survey or complaint investigation reports and any notice to the facility that a remedy has been imposed. The Department also may notify any other professional licensing boards, as appropriate.

(5) Failure of the Department to effect notice as required in Subsections (1)(b), (c), (d), or (4) shall not be grounds for the facility to contest any action taken under this Chapter.

(6) All nursing facilities shall advise staff of the penalties for making false statements or causing another person to make false statements in a resident assessment. A facility must document the manner in which staff are advised of the provisions of Rule 350-3-.04(g).

(7) The Department shall compile a list of facilities against which

remedies other than a Plan of Correction have been imposed. The list shall be prepared monthly and be available upon request. The list shall contain the names and addresses of only those facilities which did not contest imposition of remedies or against which imposition was upheld upon appeal, and shall describe the remedies imposed.

Authority Ga. L. 1977, p. 384, et seq.; O.C.G.A. Sec. 49-4-142(a). **Administrative History.** Original Rule entitled "Effective Date of Rules" was filed on April 11, 1978; effective May 1, 1978. **Repealed:** ER. 350-3-0.3-.07 adopted. F. Oct. 5, 1989; eff. Sept. 29, 1989, the date of adoption, to remain in effect for 120 days or until adoption of a permanent Rule superseding said Emergency Rule, as specified by the Agency. **Repealed:** Permanent Rule entitled "Notice" adopted. F. Oct. 4, 1989; eff. Nov. 1, 1989, as specified by the Agency.

350-3-.08 Administrative Review.

(1) Should the facility wish to contest imposition of a remedy, other than a Plan of Correction and except as provided in Sections .03(e) and .05(c), a written request for Administrative Review must be received by the Department within ten (10) days of the facility's receipt of notice of imposition of the remedy. The request shall state specifically each remedy disputed and, for each disputed remedy, the specific basis of the dispute. For imposition of civil monetary penalties, it shall not be a valid basis for dispute that a deficiency no longer exists. The timely filing of a request shall stay imposition of the remedy pending the Administrative Review decision, except where the Department has determined there is immediate jeopardy to the health or safety of the residents in a facility, in which case the Department may impose the remedies described in Subsections .02(b), (g) or (h), as determined appropriate by the Department. If the facility fails to file a timely request, the decision to impose a remedy or remedies shall become final and no further administrative or judicial review or hearing shall be available.

(2) The reviewing official shall be a Department employee appointed by the Commissioner and shall have authority only to affirm the decision, to revoke the decision, to affirm part and to revoke part, to order an immediate survey of the facility, to change the classification of the civil monetary penalty (for example, from A to B), or to request additional information from the State Survey Agency, the facility, or both, the Long-Term Care Ombudsman, or the family or resident council of the facility. Additional information that is requested must be supplied within ten (10) business days from the date of notice to the party of whom it is requested. Reviewing official shall be without authority to compromise the dollar amount of any civil monetary penalty within a deficiency class.

(3) The Department shall issue a written decision within ten (10)

business days of its receipt of the request for Administrative Review. The Review shall be made solely on the basis of the State Survey Agency recommendation, the survey report, the statement of deficiencies, any documentation the facility submits to the Department at the time of its Request, and information received as a result of a request made by the reviewing official. For the purposes of such Review, a hearing shall not be held and oral testimony shall not be taken. Correction of a deficiency or deficiencies shall not be a basis for favorable reconsideration of imposition of civil monetary penalties.

Authority Ga. L. 1977, p. 384, et seq.; O.C.G.A. Sec. 49-4-142(a). **Administrative History.** Original Rule entitled "Promulgation of Rules" was filed on April 11, 1978; effective May 1, 1978. **Repealed:** ER. 350-3-0.3-.08 adopted. F. Oct. 5, 1989; eff. Sept. 29, 1989, the date of adoption, to remain in effect for 120 days or until adoption of a permanent Rule superseding said Emergency Rule, as specified by the Agency. **Repealed:** Permanent Rule entitled "Administrative Review" adopted. F. Oct. 4, 1989; eff. Nov. 1, 1989, as specified by the Agency.

350-3-.09 Administrative Hearing.

(1) Should the facility wish to appeal the Administrative Review decision for remedies described in Subsections .02(a), (b), (c), (g), and (h), and for Subsection (d) where no determination of immediate jeopardy has been made, it may request an administrative hearing. Subsequent correction of a deficiency or deficiencies shall not constitute a defense to the imposition of a remedy or remedies. The hearing request shall state specifically which portion(s) of the Administrative Review decision the facility contests. A hearing shall be granted only if Administrative Review was timely requested, and a written request for a hearing has been received by the State Survey Agency within ten (10) business days of the facility's receipt of the Administrative Review decision. Failure to file a timely request shall result in the Administrative Review decision becoming final, and no further administrative or judicial review or hearing shall be available.

(2) If the Department has imposed temporary management pursuant to the provisions of Subsection .05(c), or imposed either of the remedies specified in Subsection .02(e), the facility shall be entitled to a hearing which shall commence not less than five (5) nor more than ten (10) days after the facility's receipt of notice of imposition of said remedy or remedies. No Administrative Review shall be conducted in such cases and no request for hearing shall be required. The date, time, and location of the hearing shall be included in the Notice of imposition of the remedy or remedies. A facility may waive its right to a hearing by written notice to the State Survey Agency.

(3) Except for appointment of a temporary manager (unless the

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Department has determined that immediate jeopardy to the health or safety of a facility's residents exists), termination of a facility's participation, closure of a facility, or payment of civil monetary penalties, the imposition of remedies shall not be stayed during the pendency of any hearing.

Authority Ga. L. 1977, p. 384, et seq.; O.C.G.A. Sec. 49-4-142(a). **Administrative History.** Original Rule entitled "Public Notice" was filed on April 29, 1982; effective May 19, 1982. **Repealed:** ER. 350-3-0.3-.09 adopted. F. Oct. 5, 1989; eff. Sept. 29, 1989, the date of adoption, to remain in effect for 120 days or until adoption of a permanent Rule superseding said Emergency Rule, as specified by the Agency. **Repealed:** Permanent Rule entitled "Administrative Hearing" adopted. F. Oct. 4, 1989; eff. Nov. 1, 1989, as specified by the Agency.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

The name of the nurse aide training and competency evaluation program or competency evaluation program certifying competency is collected for administrative purposes only.

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STATE PLAN UNDER TITLE XXIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

DEFINITION OF SPECIALIZED SERVICES

I. Specialized Services Definition

A. For Mental Illness

Specialized services are services that are specified by the State which, in combination with services provided by the nursing facilities, results in the continuous and aggressive implementation of an individualized plan of care that—

(i) Is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professional and, as appropriate, other professionals.

(ii) Prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness, which necessitates supervision by trained mental health personnel; and

(iii) Treatment is directed toward stabilization and restoration of the level of functioning that preceded the acute episode.

B. For Mental Retardation or Related Conditions

Specialized services are services that are specified by the State which, in combination with services provided by the nursing facilities or others service providers, results in treatment which includes aggressive, consistent implementation of specialized and generic training and related services by qualified mental health or mental retardation personnel that are directed toward—the acquisition of behaviors necessary for the client to function with as much self determination and independence as possible and to prevent deceleration of regression or loss of current optimal functional status.

C. Specialized Services Under GA's PASRR Program are:

Crisis Intervention Services – Immediate response and thorough assessment of an individual's (in an active state of crisis) risk factors, mental status, and medical stability and if necessary immediately intervene to de-escalate the crisis.

Individual, Group, Family Training/Counseling – Therapeutic intervention or counseling by a credentialed person that addresses behavior management, development or enhancement of specific skills.

Physician Assessment and Care Services – Specialized medical and/or psychiatric services that include, but not limited to, evaluation and assessment of physiological phenomena, psychiatric diagnostic evaluation, medical or psychiatric therapeutic services.

In-Service Training Services – Training for NF staff and assistance with skill development training classes for staff that will aid in the day-to-day provision of services recommended in individual's treatment plan.

Skills Training Services (Rehab Supports/Therapy) – Comprehensive rehabilitative services that aid in developing daily living skills, including interpersonal skills and behavior management skills.

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State/Territory: Georgia

DEFINITION OF SPECIALIZED SERVICES

Day Support for Adults (Community Support) – Environmental and targeted case management aimed at assisting the person in gaining access to necessary services with the intention of developing/restoring interpersonal and community coping skills, including adaptation to home, school and work environments that allow the individual to maintain stability and independence in their daily community living.

Case Management (Assertive Community Treatment) – Intensive case management service that assist individuals in identifying and gaining access to all specialized services. Included in the list of services are; medication administration and monitoring, crisis assessment and social rehabilitation and skill development, personal, social and interpersonal skill training, etc., designed to assist the individual in transitioning into a community based program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

CATEGORICAL DETERMINATION

The State mental health or mental retardation authority makes determinations as to whether nursing facility level of services and specialized services are needed, based on an evaluation of data concerning the individual (42 CFR 483.130). The State mental health or mental retardation authority may make determinations either through an advance group (categorical) determination or an individualized determination. A categorical determination may be made in the circumstances listed below, when sufficient and current patient information is available to clearly indicate that admission to, or residence in, a NF is needed or that the provision of specialized services is not needed. An individualized determination is performed in all other circumstances in which a Level II evaluation is needed.

Categories that the State mental health or mental retardation authority will utilize to determine that nursing facility services are needed:

1. Convalescent care from an acute physical illness which requires hospitalization and does not meet all the criteria for an exempt hospital discharge (which is not subject to preadmission screening);
2. Terminal Illness, as defined for hospice purposes in 42 CFR Sec. 418.3 and Section 483.106(b)(2);
3. Severe physical illnesses such as coma, ventilator dependence, functioning at the brain stem level, or diagnoses such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis (ALS), and congestive heart failure which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services;
4. Provisional admissions pending further assessment in cases of delirium where an accurate diagnosis cannot be made until the delirium clears, not to exceed 7 days;
5. Provisional admissions pending further assessment in emergency situations requiring protective services, with placement in a nursing facility not to exceed 7 days; and
6. Very brief and finite stays of up to 7 days to provide respite to in-home caregivers to whom the individual with MI or MR is expected to return following the brief NF stay.

Categories that the State mental health or mental retardation authority will utilize to determine that specialized services are not needed:

1. When admission is for situations 4., 5., and 6. above.
2. When dementia exists in combination with mental retardation or a related condition.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

The state survey agency has, and will continue to have, surveyors and supervisory staff participate in and conduct training sessions sponsored by various provider groups, facility staff, disciplinary associations, consumer groups and ombudsman to provide education and training on federal regulatory requirements, guidelines, survey procedures.

During the survey process, surveyors routinely provide information about the regulations and policies to staff, residents and their representatives. In order to expand current educational opportunities, the survey agency is exploring distribution of selected videos to facilities for use with staff, residents and their representatives.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

The survey agency has a centralized intake and referral unit to receive all complaints including allegations of abuse, neglect or misappropriations of resident property. The intake unit has a toll-free number which is required to be posted in all nursing facilities.

Each complaint/allegation is reviewed by survey agency staff. Investigations are initiated and conducted based on the seriousness of the allegation, the information available from the facility and the potential for further harm to residents.

Allegations which are confirmed are referred to the appropriate licensing boards, law enforcement or the nurse aide registry after an opportunity for an administrative hearing, as provided in OBRA.

A detailed description of the investigative process is described in Policy and Procedure memorandums kept on file at the Office of Regulatory Services, Department of Human Resources.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

The policy of conducting unannounced surveys is stressed with each new surveyor during orientation, and the survey agency has implemented various means of protecting the confidentiality of its survey schedules. These procedures include:

-not telling anyone outside of the office of scheduled survey activities or allowing such unauthorized persons to see survey schedules or related information;

-exercising caution, especially during telephone calls, in answering questions from providers or others which might lead to sharing schedule related information;

-not taking schedules or related information into facilities while surveying;

-keeping schedules filed or stored out of sight. This includes not leaving schedules or related information exposed on desk tops, in boxes or stored in labelled folders on desk tops, work tables in bookcases;

-putting schedules out of sight when not working with them.

-removing schedules and related information from view when visitors are nearby;

-delivering schedules to appropriate staff in person or in a protected manner when placed in mailboxes (i.e. placed upside down, in envelopes, or underneath other materials); and

-developing any other means of safeguarding such information which individual situations might require. In addition, it is the practice of the survey agency to vigorously pursue any allegation that a facility was informed in advance of a survey visit.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

The survey agency has a Quality Assurance program which is designed to prevent inconsistencies from one surveyor to another, from one region to another and from one program to another. All deficiencies cited during surveys are screened for consistency at two or more levels, and training programs are developed to address identified problems.

A detailed description of the Quality Assessment program is described in Policy and Procedure memorandums kept on file at the Office of Regulatory Services, Department of Human Resources.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

Complaints

All complaints are received by a centralized intake and referral unit and referred to the Long Term Care Section for investigations as appropriate.

Complaints alleging a serious threat to patient/resident health and safety will be investigated onsite. Using complaint procedures established in the Medicare/Medicaid State Operations Manual (SOM), allegations are investigated based on priority and, whenever feasible, are investigated in conjunction with the next scheduled survey visit.

A copy of the survey agency's complaint process can be found in the internal policy and procedure memorandums kept on file in the Department of Human Resources' Office of Regulatory Services.

Monitoring

Consistent with the criteria in (i), (ii), and (iii) above, the section 350-3-.06 of the Department's Rules and Regulations specifies the process by which the Department monitors facilities, as needed. (See Attachment 4.35-A, Pages 1m and 1n.)

In addition, the survey agency will, upon request or independently, monitor a facility on-site when there is reason to question continued compliance.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERIES

The Georgia Department of Community Health will ensure compliance with 1902(a)(68) of the act by making compliance with the provision a condition of participation in the Medicaid and SCHIP programs. To make the provision a condition of participation, the Department will incorporate it within the Part One Policy and Procedures Manual for Medicaid/PeachCare for Kids (PeachCare is the SCHIP program in Georgia). The specific wording from 1902(a)(68) will be included in the policy so as to clearly demonstrate to entities if it is applicable to them. Notification will be forwarded to all entities through an electronic message, or *banner message*. . Policy is updated on a quarterly basis and entities that participate in the Medicaid/PeachCare program are expected to review these updates. When changes in policy occur, entities are expected to comply fully at the time the policy is issued.

Initially, entities that the policy applies to will be required submit a written attestation that they have complied with Section 1902(a)(68). The Department will determine if Section 1902(a)(68) is applicable to the entity. These are entities that meet the specifications during the Federal Fiscal Year 2006 (October 1, 2005 – September 30, 2006). Entities that substantially change their policy or new entities entering the program that meet the threshold, must submit their policy to the Department's Program Integrity Unit for approval.

Compliance and oversight of this policy will be accomplished by incorporating reviews for the specific requirements of 1902(a)(68) as standard operating procedure for Utilization Reviews. These reviews are both random and selected and are conducted on an ongoing basis. This method allows for the potential review of any entity participation in the program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: GEORGIA

Provider Screening and Enrollment

Citation	The State Medicaid agency gives the following assurances:
1902(a)(77) 1902(a)(39) 1902(kk); P.L. 111-148 and P.L. 111-152	
42 CFR 455 Subpart E	PROVIDER SCREENING ___X__ Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.
42 CFR 455.410	ENROLLMENT AND SCREENING OF PROVIDERS __X___ Assures enrolled providers will be screened in accordance with 42 CFR 455.400 *et seq.* ___X__ Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.
42 CFR 455.412	VERIFICATION OF PROVIDER LICENSES ___X__ Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.
42 CFR 455.414	REVALIDATION OF ENROLLMENT ___X__ Assures that providers will be revalidated regardless of provider type at least every 5 years.
42 CFR 455.416	TERMINATION OR DENIAL OF ENROLLMENT ___X__ Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.
42 CFR 455.420	REACTIVATION OF PROVIDER ENROLLMENT __X___ Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

42 CFR 455.422 APPEAL RIGHTS

__X___ Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

42 CFR 455.432 SITE VISITS

__X___ Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will occur.

42 CFR 455.434 CRIMINAL BACKGROUND CHECKS

__X__ Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.

42 CFR 455.436 FEDERAL DATABASE CHECKS

__X___ Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

42 CFR 455.440 NATIONAL PROVIDER IDENTIFIER

__X___ Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

42 CFR 455.450 SCREENING LEVELS FOR MEDICAID PROVIDERS

__X___ Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

42 CFR 455.460 APPLICATION FEE

__X___ Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.

42 CFR 455.470 TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS

__X___ Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.

State of Georgia

CITATION OF STATE LAWS, RULES, REGULATIONS AND POLICY STATEMENTS PROVIDING ASSURANCE OF CONFORMITY TO FEDERAL MERIT SYSTEM STANDARDS

GEORGIA CITATION LISTING - Grant Aided Agencies

I. Constitutional Provisions

A. Article XIV, Section I, Paragraph I, The Georgia Constitution (1945) , Establishes the State Personnel Board.

B. Article III, Section VII, Paragraph XXIV, The Georgia Constitution (1945), Ammendment (1967) Establish preference for Veterans.

II. Georgia Laws

A. Act 81 (1975), Establishes the State Merit System to oversee activities in covered agencies.

B. Act 1398 (1976), Amends Act 81 (1975).

C. Act 1383 (1976), Amends Act 81 (1975).

III. Rules and Regulations of the State Personnel Board (as amended to date).

IV. Interpretive Memorandum issued by the Commissioner of Personnel Administrative (as released to date).

V. Certain memorandum and letters of Authorization or understanding from the United States Civil Service Commission to the Georgia State Merit System.

NONDISCRIMINATION

In accordance with the Assistance Payments Manual, Policies and Procedures, Section VII-190; Part I of the Policies and Procedures Applicable to All Medicaid Providers, General Conditions of Participation, Sections 106.3 and 106.4; and Rules of the Department of Medical Assistance, Chapter 350-1-.05, all assistance programs and services of the Department are to be administered in conformity with Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973. Services will be administered in such a manner that no person in this State will on the grounds of race, color, sex, age, religion, national origin or handicap be excluded from participation in, be denied any aid, care, services or other benefits of, or be otherwise subjected to discrimination in the granting of assistance.

This policy covers not only the administrative procedures and practices within the Department but extends to individuals, agencies, institutions and organizations to whom referrals are made by the Department and who participate in the programs of the Department through purchase of service. Therefore, payments can only be made to vendors who comply with these Acts.