

---

METHODS AND STANDARDS FO RESTABLISHING PAYMENT RATES  
INPATIENT SERVICES

---

I. Cost finding and 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, 2013.
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 request records. These records must be available upon request to representatives,

TN No.: 13-027

Supersedes

TN No.: 13-006

Approval Date: MAR 18 2014 Effective Date: October 1, 2013

---

METHODS AND STANDARDS FO RESTABLISHING PAYMENT RATES  
INPATIENT SERVICES

---

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, 2013. 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.
- 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

TN No.: 13-027

Supersedes

TN No.: 13-006

Approval Date: MAR 18 2014 Effective Date: October 1, 2013

---

METHODS AND STANDARDS FO RESTABLISHING PAYMENT RATES  
INPATIENT SERVICES

---

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;

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

---

METHODS AND STANDARDS FO RESTABLISHING PAYMENT RATES  
INPATIENT SERVICES

---

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.

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.

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;

TN No.: 13-027

Supersedes

TN No.: 13-006

Approval Date: MAR 18 2014 Effective Date: October 1, 2013

---

METHODS AND STANDARDS FO RESTABLISHING PAYMENT RATES  
INPATIENT SERVICES

---

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.

TN No.: 13-027

Supersedes

TN No.: 13-006

Approval Date: MAR 18 2014 Effective Date: October 1, 2013

---

METHODS AND STANDARDS FO RESTABLISHING PAYMENT RATES  
INPATIENT SERVICES

---

II. Rate Setting

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

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

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

For admissions on and after January 1, 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.

For admissions on and after April 1, 2014:

The cost data is derived from SFY 2013 Disproportionate Share Hospital (DSH) data and cost reports for the fiscal year ending in CY 2011. For the capital add-on calculations, the 2013 supplemental survey data was used to supplement the DSH and cost report data. 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). See page 7 for example.

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). See page 7 for example

**METHODS AND STANDARDS FO RESTABLISHING PAYMENT RATES  
INPATIENT SERVICES**

**Example of Non Outlier and Outlier DRG Payment Formulas**

Hospital Data:		DRG Data:	
Base Rate	\$ 4,879.72	DRG #:	134 (Hypertension)
Operating CCR	0.231	DRG weight	0.8078
Capital Add-on per case	\$ 408.02	DRG Outlier Threshold	\$ 33,786.42
GME Add-on per case	\$ 422.07	Outlier Payment Percentage	0.893

**Example 1 for Non-Outlier DRG Payment Per Case = (Hospital-Specific Base Rate x DRG Relative Rate) + Capital Add-on + GME Add-on (if applicable)**

**Non -Outlier DRG Payment per case calculation:**

1 Base Rate	\$ 4,879.72	
2 DRG weight	0.8078	
3 Base rate DRG payment	\$ 3,941.84	(line 1 x line 2) = Hospital Specific Base Rate times DRG Relative Rate
4 Capital Add-on per case	\$ 408.02	
5 GME Add-on per case	\$ 422.07	
6 Non Outlier DRG payment	\$ 4,771.93	(line 3 + line 4 + line 5)

**Example 2 for 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)**

**Outlier DRG Payment per case calculation:**

1 \$	4,879.72	Base Rate
2 \$	0.81	DRG weight
3 \$	3,941.84	(line 1 x line 2) = Hospital Specific Base Rate times DRG Relative Rate
4 \$	200,000.00	Allowable charges
5 \$	0.23	Operating CCR
6 \$	46,200.00	(line 4 x line 5) = Allowable Charges * Hospital Specific Operating Cost to Charge Ratio
7 \$	42,258.16	(line 6 - line 3)
8 \$	0.8930	Outlier Payment Percentage
9 \$	37,736.54	(line 7 x line 8) = Additional outlier payment
10 \$	408.02	Capital Add-on per case
11 \$	422.07	GME Add-on per case
12 \$	42,508.47	(line 3 + line 9 + line 10 + line 11) = Total Outlier Payment

**C. Discussion of Payment Components****1. Base Rates**TN No.: 13-027

Supersedes

Approval Date: MAR 18 2014 Effective Date: October 1, 2013TN No.: 13-006

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

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

The peer group base rate is obtained 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. If a hospital is assigned to the specialty peer group the hospital specific base rate is assigned.

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, 2013 through June 30, 2017:

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

Provider Type	Provider Fee Percent	Rate Increase Percent
---------------	----------------------	-----------------------

---

---

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

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

The new base rate change will be a multiplier, which will be expressed as a constant percentage of the DRG Payment Per Case. There will be three different values for this Base Rate Change. 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. Three new system parameters will be created to store these percentages.

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

**2. Calculation of the Capital Add-on Amount**

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

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

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

**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)

---

---

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

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

**Part 1 - Calculation of the Capital Add-On Amount**

- (a) A Medicaid allocation ratio is used to apportion the Medicaid portion of the hospital's total capital. The allocation ratio is the hospital's Medicaid inpatient costs divided by total hospital costs.
- (b) Sum the hospital's reimbursable capital costs (total building and fixtures) and capital costs (total major movable) from the cost report.
- (c) Determine the Medicaid allocation of capital costs from the cost report by multiplying the Medicaid allocation ratio (Item 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).

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

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

- (a) A Medicaid allocation ratio is used to apportion the Medicaid portion of the hospital's GME. The allocation ratio is the hospital's Medicaid inpatient costs divided by total hospital costs.
- (b) Use the hospital's reimbursable GME costs from the cost report.
- (c) Determine the Medicaid allocation of GME costs from the cost report by multiplying the Medicaid allocation ratio (Item 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.

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

- (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.

**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 on and after January 1, 2008, the grouper used to classify cases into DRG categories will be TRICARE Grouper version 24.0. For admissions on and after April 1, 2014, the grouper used to classify cases into DRG categories will be TRICARE Grouper version 30.0. The grouper used to assign claims to DRG categories, as well as the corresponding DRG weights and threshold amounts, may be updated periodically.

---

---

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

For dates of service from April 1, 2014 through March 31, 2016, and for hospitals whose net TriCare DRG Version 30 payment change results in a gain or a loss of greater than \$10 million, the Department shall apply a stop-loss/gain corridor. The stop-loss/gain amount will be stated in a per case value, and solely for payment administration purposes, it will be combined with the hospital's per case capital add-on payment.

- For Dates of Service from April 1, 2014 through March 31, 2015, the stop-loss/gain corridor shall result in a \$17 million transfer from the hospital with the largest gain to the hospital with the largest loss.
- For Dates of Service from April 1, 2015 through March 31, 2016, the stop-loss/gain corridor shall result in a \$10 million transfer from the hospital with the largest gain to the hospital with the largest loss.
- No stop-loss corridor will be applied for any hospital for dates of service on or after April 1, 2016.

**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.

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

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 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

---

---

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

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.

- 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.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

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.

---

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

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.

---

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

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.

---

---

---

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

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 total per diem costs to Medicaid covered inpatient days and total ratios of cost to charges to Medicaid inpatient and outpatient

---

---

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

- charges grouped by cost center. The patient day and charge amounts will be determined by Medicaid 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 actual claim payments, outpatient settlement estimates and non-DSH rate adjustments. Uninsured costs will be determined by applying the uninsured days and charges reported on the DSH data survey to the same per diems and cost to charge ratios used to calculate Medicaid costs. 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:

---

---

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

- 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, effective January 1, 2013 is limited to 50% 75% of the calculated amount.
  - Final DSH payment amounts for all other hospitals reflects 100% of the allocation calculation based on the methodology specified in section (III)(B)(6).
  - Effective July 1, 2013 the maximum DSH allotment for all hospital are set at 75% as calculated 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 2010, eligibility and DSH limit calculations will be based on the most recent year for which comparable data would be available.

Audit of Disproportionate Share Payments:

As required by Section 1923(j) of the Social Security Act related to auditing and reporting of disproportionate share hospital payments, the Division of Medical Assistance will implement procedures to comply with the Disproportionate Share Hospital Payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009, to ensure that the hospital specific DSH limits have not been exceeded.

Any funds recouped as a result of audits or other corrections shall be redistributed to other eligible hospitals within the state, provided each hospital remains below their hospital specific DSH limit. Funds shall be redistributed to hospitals within the pools, as identified in (III)(B)(4) above, for which funds were recouped. The recouped funds within each pool shall be redistributed to the governmental facilities that are still below their hospital specific DSH limit. The funds shall be allocated to those hospitals based on their allocation factor that was derived in (III)(B)(6)(b) above. If the redistribution causes a hospital to exceed their hospital specific DSH limit those excess funds will be redistributed using the same methodology until all funds are expended.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
INPATIENT SERVICES

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

---



---

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
INPATIENT SERVICES

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 Description	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	<u>Medicaid inpatient claims paid at amount &gt; 0:</u>		
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

19

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
INPATIENT SERVICES

13	annual cost of services	Line 4 X Line 6 X Line 12	1,761,990
15			
16	<u>adjustment factors</u>		
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

---

---

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
INPATIENT SERVICES

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
INPATIENT SERVICES

Facility Name	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)	1.00000
5	
6 <u>Medicaid inpatient claims paid at amount &gt;0:</u>	
7 covered charges	3,949,268
8 payments	1,828,506
9 annual covered charges	3,949,268
10 annual payments	1,828,506
11	
12 inpatient CCR	0.446156
13	
14 annual cost of services	1,761,990
15	
16 <u>adjustment factors</u>	
17 claim completion	1.029799
18 inflation	1.073852
19 volume allowance	1.212883
20 combined adjustment factors	1.341269
21	
22 adjusted annual charges	5,297,031
23 adjusted cost of services	2,363,303
24 adjusted Medicaid payments	2,452,518
25 supplemental inpatient rate adjustments	0
26 total Medicaid payments	2,452,518
27	
28 DRG differential	1.176249
29 adjusted Medicare-based annual payments	2,884,772
30 UPL estimate	432,254

---

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
INPATIENT SERVICES

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 of 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 1c-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 TYPES 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

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

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

<b>Program Name:</b>	XYZ - Residential Care Facility
<b>Program Vendor Number</b>	XXXXXX
<b>Program Cost Totals</b>	<b>Cost Report</b>
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
<b>Total Program Cost per Cost Report</b>	<b>\$17,938,792</b>
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
<b>Program Revenue Totals</b>	<b>Cost Report</b>
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
<b>Total Program Revenue per Cost Report</b>	<b>\$20,639,626</b>
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 waived 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 waived 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 waived 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 dividing 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 will 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:
- o Add 50% for each DSH provider.
  - o Add 0-50% proportionally for DSH providers whose percentage of Medicaid days is greater than the statewide mean percentage of Medicaid days.
  - o Add 12.5% for each additional DSH criterion that a hospital meets.
  - o Add 0-50% proportionally based on the percentage of Medicaid births for each hospital.
  - o Add 25% if the hospital is the only Medicaid-enrolled hospital in its county.
  - o Add 0-100% proportionally for hospitals admissions greater than 1000.

- o 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.
  - o 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 be 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 & BURSTITIS	\$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 MALIGNANCY	\$20,184.06	1.3392
345 OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	\$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 VULVECTOMY	\$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 DIAGNOSIS	\$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 SIGNIFICANT TRAUMA	\$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 EXTREMITY	\$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 ANTERIOR/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.

---

TN No.: 06-015

Supersedes

Approval Date: 02/28/07

Effective Date: 01/01/07

TN No.: New