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State/Territory Name: Georgia

State Plan Amendment (SPA) #:13-006

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

AUG 27 2013

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

RE: State Plan Amendment (SPA) GA 13-006

Dear Mr. Dubberly:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number 13-006. Effective July 1, 2013 this amendment proposes to extend the state's reimbursement methodology for setting payment rates for inpatient hospital services at the current level past the original end date of June 30, 2013 to a revised end date of June 30, 2017.

As part of our review of this amendment we reviewed the state's upper payment limit demonstration and approved the state using a Medicare cost to charge ratio versus a total cost to charge ratio methodology. However, we do want to put you on notice that we will be reviewing this method again in the near future and may require that you adopt a more precise method to determine a reasonable estimate of what Medicare would pay for these services.

We conducted our review of your submittal according to the statutory requirements of sections 1902(a)(13),1902(a)(30),1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of July 1, 2013. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Dicky Sanford at (334) 241-0044.

Sincerely,

//s//

Cindy Mann
Director

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 13-006	2. STATE GEORGIA
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2013	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 C.F.R. §433.68 ; 42 C.F.R. § 447.250	FFY 2013 ~~$27,820,874~~ $0 mw FFY 2014 ~~$111,283,495~~ $0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A: Page 1	Attachment 4.19-A: Page 1

10. SUBJECT OF AMENDMENT: **The Georgia Hospital Medicaid Financing Program Act ("Act"), which authorizes the Department to assess one or more provider payments on hospitals based upon a percentage of net patient revenue, takes effect on July 1, 2013. The provider payment assessed under the Act will result in increased hospital inpatient rates.**

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Single State Agency Comments Attached

12. SIGNATURE OF STATE AGENCY OFFICIAL: //s//	16. RETURN TO: Department of Community Health Division of Medicaid 2 Peachtree Street, NW, 36th Floor Atlanta, Georgia 30303-3159
13. TYPED NAME: Jerry Dubberly	
14. TITLE: Chief, Division of Medicaid	
15. DATE SUBMITTED:04/03/13	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 04/03/13	18. DATE APPROVED: 08/27/13
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:07/01/13	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Cindy Mann	22. TITLE: Director

23. REMARKS:

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

I. Cost Finding and Cost Reporting

A. Cost Reporting

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

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

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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

METHODS AND STANDARDS FOR ESTABLISHING 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

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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;

METHODS AND STANDARDS FOR ESTABLISHING 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.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

II. Rate Setting

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

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

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

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

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

For admissions on and after January 1, 2008:

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

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

B. Payment Formulas

Non-Outlier DRG Payment Per Case = (Hospital-Specific Base Rate x DRG Relative Rate) + Capital Add-on + GME Add-on (if applicable). See page 6a 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 6a for example.

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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**

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C. Discussion of Payment Components

1. Base Rates

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

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

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

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

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

In order to partially offset the 1.45% and 1.40% hospital fee rates, a new Base Rate Change will be created. This new base rate change will be a multiplier, which will be expressed as a constant percentage of the Allowed Charge. There will be 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 Allowed Charge, the addition of this new Base Rate Change will be the final step before any cutbacks are considered. The dollar amount will be calculated as a percentage (stored in the new System Parameter) of the Allowed Charge at that point in adjudication.

2. Calculation of the Capital Add-on Amount

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

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

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

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

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

(a) the hospital's cost report (for capital and GME add-on amounts)

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

Part 1 - Calculation of the Capital Add-On Amount

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

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

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

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

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F. Reviews and Appeals

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

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

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

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

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

G. Co-Payment

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

H. Administrative Days

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

- 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

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claims will be the average hospital-specific inpatient per case rate for enrolled non-Georgia hospitals.

J. Payment In Full

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

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

K. Expanded Newborn Screening Program

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