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

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

Financial Management Group

OCT 21 2015

Ms. Linda Wiant
Directory of Medicaid Assistance Plans
Medicaid Division
Georgia Department of Community Health
9 Peachtree Street, NW, Suite 36-450
Atlanta, GA 30303-3159

RE: Georgia 15-005

Dear Ms. Wiant:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 15-005. The purpose of this amendment is to change Medicaid inpatient prospective system methodology and payment rates. Specifically, the amendment proposes to update operating cost to charge ratios (CCR) on July 1st each year based on most recent available DSH survey data, to include adjustments to the hospital specific rate for each hospitals Medicaid inpatient utilization rate (MIUR), to include adjustments for indirect Medical Education (IME) to the hospital specific rate, add a stop-loss/stop gain adjustment, incorporate the capital cost into the base rate, and eliminate the capital add on rate and revise the outlier payment methodology.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. As part of the review process the State was asked to provide information regarding funding of the State share of expenditures under Attachment 4.19-A.

Based upon your assurances, Medicaid State plan amendment 15-005 is approved effective July 1, 2015. We are enclosing the HCFA-179 and the amended plan page.

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

Sincerely,

Timothy Hill
Director

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 15-005	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, 2015**	

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. § 447.205	FFY 2015 $0 FFY 2016 $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, pages 6-14	Attachment 4.19-A pages 6-14

10. SUBJECT OF AMENDMENT:

Effective July 1, 2015, DCH proposes a cost neutral change to the Medicaid Inpatient Prospective Payment System methodology and 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: Lynnette R Rhuck on behalf of Linda Wiant	16. RETURN TO:
13. TYPED NAME: LINDA WIANT	Department of Community Health Division of Medicaid 2 Peachtree Street, NW, 36th Floor Atlanta, Georgia 30303-3159
14. TITLE: CHIEF, DIVISION OF MEDICAID	
15. DATE SUBMITTED:	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: OCT 21 2015
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2015	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Kristin Fan	22. TITLE: Deputy Director, FMG

23. REMARKS:

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT SERVICES

II. Rate Setting

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

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

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

For admissions on and after January 1, 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.

For admissions on and after July 1, 2015:

All hospital operating cost to charge ratios (CCR) will be updated annually on July 1 based on the most recent available DSH survey data (Section II, part H) and in order to maintain budget neutrality in lieu of a prospective payment update based on more recent financial data.

B. Payment Formulas

For admissions before July 1, 2015:

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 DRG Payment Formulas for Admissions prior to July 1, 2015

Hospital Data:			**DRG Data:**		
Base Rate	$	4,879.72	DRG #:	134	(Hypertension)
Operating CC		0.231	DRG weight	0.8078	
Capital Add-o	$	408.02	DRG Outlier Threshold	$33,786.42	
GME Add-on p	$	422.07	Outlier Payment %	0.893	

Example 1 for Non-Outlier DRG Payment Per Care = (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	$	3,941.84	(line 1 x line 2) = Hospital Specific Base Rate times DRG Relative Rate
4	Capital Add-o	$	408.02	
5	GME Add-on p	$	422.07	
6	Non Outlier D	$	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		0.8078	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		0.231	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)
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)

For Admissions on and after July 1, 2015:

The Hospital Specific Base Rate will include adjustments for each hospital's Medicaid Inpatient Utilization Rate (MIUR), Indirect Medical Education (IME) if applicable and a stop-loss/stop-gain adjustment. The Hospital Specific Base Rate is calculated as (Base Rate x (1 +MIUR factor) x (1 + IME factor) x (1 + Stop-Loss/Stop Gain Adjustment). Refer to page 11 and 12 "Admissions on and after July 1, 2015" for detail on the specific MIUR and IME calculations. Refer to page 13 #2 for detail on the Stop-Loss/Stop-Gain calculation.

Non-Outlier DRG Payment Per Case = (Hospital Specific Base Rate x DRG Relative Rate). See page 6b for example.

Outlier DRG Payment Per Case = [{(Allowable Charges x hospital specific cost to charge ratio) – (Adjusted Base Rate x DRG Relative Rate)} x (Outlier Payment Percentage] + (Hospital Specific Base Rate x DRG Relative Rate).

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For Admissions on and after July 1, 2015

Example of Non-Outlier and Outlier DRG Payment Per Case

Hospital Data:			**DRG Data:**		
Base Payment Rate	$	5,462.45	DRG Number	313	(Chest Pain)
Operating CCR		0.231	DRG Relative Weight	0.9069	
MIUR Factor		6.00%	DRG Outlier Threshold	$ 44,299.82	
IME Factor		1.48%			

Example 1 for Non-Outlier DRG Payment Per Case = {Hospital-Specific Payment Rate x DRG Relative Rate}. Hospital-Specific Payment Rate is calculated as {[(Base Payment Rate x (1+MIUR factor) x (1+IME factor)}x (1+Stop Loss Adjustment)}.

Non-Outlier DRG Payment per case calculation:

1	Base Payment Rate	$	5,462.45	
2	MIUR Factor+1		106.00%	
3	IME Factor+1		101.48%	
4	Adjusted Base Rate	$	5,875.89	(Line 1 X Line 2 X Line 3)
5	Stop-Loss/Stop-Gain Adjustment		101.35%	
6	Hospital-Specific Payment Rate	$	5,955.22	(Line 4 X [1 + Line 7])
7	DRG Relative Weight		0.9069	
8	Non-Outlier DRG Payment (for DRG 313)	$	5,400.79	(Line 8 X Line 9)

Example 2 for Qualifying Outlier DRG Payment Per Case = {Non-Outlier DRG Payment + [(Estimated Cost of Claim – DRG Outlier Threshold) x Outlier Payment Percentage]}. Estimated Cost of Claim is determined as {Allowable Charges x Hospital-Specific Operating Cost-to-Charge Ratio} and must be a greater than DRG Outlier Threshold to be a Qualifying Outlier Case.

Outlier DRG Payment per case calculation:

1	Non-Outlier DRG Payment	$	5,400.79	
2	Allowable Charges	$	225,000.00	
3	Operating CCR		0.231	
4	Estimated Cost of Claim	$	51,975.00	(Line 2 x Line 3)
5	DRG Outlier Threshold	$	44,299.82	
6	Estimated Cost Above Threshold	$	7,675.18	(Line 4 - Line 5)
	Qualifies for Outlier Payment only if Estimated Cost Above Threshold > 0			
7	Cost Above DRG Payment	$	46,574.21	(Line 4 - Line 1)
8	Outlier Payment Percentage		0.893	
9	Eligible Outlier Payment	$	41,590.77	(Line 7 x Line 8)
10	**Total DRG Payment with Outlier**	**$**	**46,991.56**	**(Line 1 + Line 9)**

C. Discussion of Payment Components

1. Base Rates

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.

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

For admissions on and after January 1, 2008:

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

For admissions on and after January 1, 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.

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

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

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

For Admissions before July 1, 2015:

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

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

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)

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

Part 1 - Calculation of the Capital Add-On Amount

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

For Admissions on and after July 1, 2015:

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

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

Determine IME cost factor for the claims used in the fiscal period using Medicare cost report factors concurrent with the claims period. For admissions on or after July 1, 2015, IME calculations will be based on cost reports for the fiscal year ending in 2011.

(a) Find total interns & residents full time equivalents for hospital and subproviders from the cost report, Worksheet S-3, Column 9, Line 27.
(b) Sum the number of beds at the hospital and subproviders from the cost report, Worksheet S-3, Column 2, Line 14 plus Line 16 plus Line 17.
(c) Determine total number of inpatient beds by subtracting nursery beds from total beds on the cost report (Item 1 (b) minus Worksheet S-3, Colum 2, Line 13).
(d) Calculate ratio of interns & residents to beds by dividing the total interns & residents - full time equivalents (Item 1(a)) by the total number of inpatient beds (Item 1(c)).
(e) Use the CMS Medicare formula in place on July 1 2015 to determine Indirect Medical Education Factor: $1.35 * ([1 + \text{ratio of interns \& residents to bed (Item 1(d))}]^{0.405} - 1)$.

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

(a) For facilities completing DSH surveys, use As-Adjusted MIUR reported on DSH Survey, Part II, Eligibility Data, Line 17.
(b) For facilities without DSH surveys, determine total inpatient days from cost report Worksheet S-3, Part I, Column 8, Line 14.
(c) For facilities without DSH surveys, determine total Medicaid fee for service and managed care days from cost report Worksheet S-3, Part I, Column 7, Line 14 plus Line 2.
(d) For facilities without DSH surveys, calculate MIUR from Medicaid days (Item 2(c)) divided by total inpatient days (Item 2(b)).

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

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

D. Special Payment Provisions

1. Graduate Medical Education Supplemental Payments

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

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

2. New Facilities

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

3. Out-of-State Facilities

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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. For dates of admission on or after July 1, 2015, capital costs will be reimbursed as part of the statewide average base rate instead of via the capital add-on payment.

4. New Medicaid Providers

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

1. For dates of service from April 1, 2014 through June 30, 2015 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 June 30, 2015, 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.

2. For dates of service from July 1, 2015 through June 30, 2017 and for hospitals whose net payment change due to the July 1, 2015 update to the inpatient services rate results in a gain in or loss exceeding a certain percentage, the Department shall apply a stop-loss corridor as follows:

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- For dates of service from July 1, 2015 through June 30, 2016, the Department will apply a stop-loss/gain adjustment to the operating base rate that limits losses to 5.5% and gains to 10%. Refer to page 6a and 6b for detail on the payment formula.
- For dates of service from July 1, 2016 through June 30, 2017, the Department will apply a stop-loss/gain adjustment to the operating base rate that limits losses and gains to a maximum percentage as determined by the Department.
- Stop-loss adjustments will be offset by stop-gain adjustments so there is no net change to inpatient services payments.

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.

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 administrative days greater than three that a recipient remains in the acute care setting awaiting placement in a nursing facility are non-covered days.

I. Hospital Crossover Claims

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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.

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.