GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Provider Request for Extended Repayment Schedule

Provider Name: _____

Rendering Provider ID:_____

Office of Inspector General (OIG) Case Number (if applicable):_____

Medicaid Payee ID:_____ EIN: _____

Critical Access Hospital: Yes _____ No _____

If not a Hospital, please indicate type of provider:_____

Request:
The above named Medicaid Provider requests a repayment plan for the amount due to the Georgia Department of Community Health in the amount of $_____.

Please include a description of what the debt is related to (NH provider fee, hospital cost settlement, etc) along with a copy of the document from DCH requesting the refund._____

Repayment Plan Requested: (Check One) Three Months____ Six Months (Critical Access Only)___
Twelve Months (Includes Fee)____

I hereby certify that I am authorized to submit this form and that the information is true and accurate. I understand that the Department may recover any supplemental UPL or DSH payment or any other settlement or judgment due to the provider to accelerate repayment of debts owed to the Department.

NOTE: All applications received after Wednesday of each week will be processed in the following week.

Authorized Official:

_____ _____
Printed Name Signature

_____ _____
Title Date

_____ _____
Phone Number Email Address (Required)

Completed form, **with a signature**, must be sent to the following email address: AR-inquiry@dch.ga.gov

Reserved for use by the Georgia Department of Community Health

Recoupment Amount $_____Fee Amount $_____Total Recoupment Amount $_____

Recoupment Start Date _____ Recoupment End Date _____

Reviewed by _____ Date of review _____

Denial Signature _____ Date Denied _____

Approval Signature _____ Date Approved _____

1. Rationale or background to policy:

For a variety of reasons, a Provider will be in a position of owing the Department of Community Health some amount of money. Typically, the Department will seek to recoup the outstanding balance through weekly payment cycle recoupments. On occasion and for some providers, the balance owed the Department is significant and the impact of full recoupment of weekly payments may impose, in the view of the Provider, a crippling financial burden. Consequently, the Provider may seek some extended term for repayment of the debt that better accommodates the Provider's needs.

2. Policy Statement:

To establish a formal process and specific guidelines for providing an extended repayment schedule for Providers to repay monies owed to the Department of Community Health.

3. Procedures:

Medicaid Providers may request an extended repayment schedule if (1) the balance owed is in excess of $5,000 and (2) the balance owed exceeds two (2) times the Provider's average weekly claims. A Provider's average weekly claims shall be calculated utilizing the sum of the Provider's claims over the most recent twenty-six (26) weeks divided by twenty-six (26).

Providers seeking to obtain an extended repayment schedule shall first complete the "Provider Request for Extended Repayment Schedule" form available on the DCH website. Completed forms should be forwarded to the email address indicated on the form. Providers will be notified via email within three business days after submission of the form if their request has been approved.

In the event that the Provider does not qualify for an extended repayment plan, the Department will recoup weekly amounts up to 100% of the weekly payment until the debt is satisfied.

All extended repayment plan payments must be made through recoupments from the Provider's weekly Medicaid claims payments. A hard copy check is an acceptable form of payment only if the Provider is attempting to pay the debt off in full or make a lump sum payment for an amount owed in excess of the amount to be paid through a repayment plan..

Providers may request one of the repayment schedule options offered. If approved, equal weekly amounts will be deducted from the Provider's Medicaid and/or PeachCare benefit payments until the obligation is paid in full. The Department will accept an initial partial payment from the Provider at the outset of the repayment schedule but thereafter recoupment against weekly payments is the accepted means of repayment. The Department will also accept a terminal payment from a provider at any point in the repayment term.

If a Provider enters into a repayment plan and the Department does not receive a payment under that repayment plan by the payment deadline plus five (5) business days, the Department shall initiate recoupment of 100% of the Provider's reimbursement until the total balance of funds owed on the repayment plan, plus any applicable fees, has been paid. A Provider that fails to make one or more payments may reenter its original repayment plan by bringing its payments to current and paying any applicable fees. The Department shall assess a six (6) percent penalty fee on all payments made after the payment due date plus five (5) business days.

Providers may not have more than 3 extended repayment plans at any one time. Providers that have more than 3 repayment plans as of March 2015 may continue to make payments under those repayment plans until the debt is paid. Providers may not enter into an additional repayment plan unless the Provider is current on its other repayment plan(s). Providers' total weekly repayment plan payments may not exceed 25% of the Provider's average weekly claims.

Repayment plans ordered by a court will be followed accordingly and are not subject to this policy.

This Provider Extended Repayment Plan Policy is effective 9/1/2013. In those instances where existing informal or nonconforming repayment arrangements have been in effect, the Department will consider those specific situations but in all cases the Department retains the sole discretion to amend or adjust those arrangements to be consistent with this policy.

Provider repayment guidelines and options are as follows:

1. Providers may request a repayment term of three months with equal weekly recoupment. No fee shall be charged for this three month repayment term. Critical access hospitals are provided a six month repayment term with no fee assessed.

2. Alternatively, Providers may request a repayment term of up to one year. For repayment terms in excess of the repayment term defined in #1, a 6% fee shall be applied to the outstanding balance and added to the total recoupment amount. The fee is non-refundable and becomes part of the total balance owed once the established date of the Account Receivable is determined. The beginning date of the repayment term will be the established date of the Account Receivable. If the Provider decides to pay the balance of the debt early, the balance and the fee must be remitted to the Department.

3. For any debt not satisfied within the 12 month repayment period, the Department may forward the unsatisfied debt to the Department of Law for collection.

4. If a Provider requests and is approved for a repayment term as outlined in #1 and subsequently requests that the repayment be extended up to one year, the one year term shall be considered to have begun on the date of the original repayment term and the 6% fee shall be calculated on the original beginning balance. No repayment term shall be for a period of longer than twelve months.

5. Every approved Provider Extended Repayment Plan shall be separate and apart from any other approved Provider Repayment Plan for a particular Provider. For example, if a hospital settlement for a hospital results in a balance due to the Department and the Provider is approved for an extended repayment plan and then a subsequent mass adjustment to a certain claim type results in another balance owed the Department any extended repayment plan related to the new balance will apply irrespective of the first repayment plan.

6. The Department may, at its sole discretion, disallow an extended repayment schedule. Reasons for this would include, but are not limited to, the following:
   a. The Department is aware or becomes aware that the Provider is likely to become financially insolvent within the requested repayment term.
   b. There is indication that the amount due the Department may have been the result of fraud or other inappropriate actions by the Provider.

   The preceding policy does not supplant, but may be in addition to, any statutory or court imposed interest and/or penalties.

Completed form, **with a signature**, must be sent to the following email address: AR-inquiry@dch.ga.gov

Any questions about completing the form should be directed to Lea Lee at (404) 656-4468.