Table of Contents

State/Territory Name: Georgia

State Plan Amendment (SPA) #:13-007

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

January 10, 2014

Dr. Jerry Dubberly, Chief
Georgia Department of Community Health
Medicaid Division
2 Peachtree Street, NW, 40th Floor
Atlanta, Georgia 30303-3159

RE: Title XIX State Plan Amendment, GA 13-007

Dear Dr. Dubberly:

We have reviewed the proposed Georgia State Plan Amendment 13-007, which was submitted to the Atlanta Regional Office on August 12, 2013. This SPA will increase the minimum prospective payment services (PPS) rate for Federally Qualified Health Centers (FQHC), free standing Rural Health Clinics (RHC) and hospital based RHCs, from the current minimum level mandated by federal law to the current statewide Georgia Medicaid average.

Based on the information provided, the Medicaid State Plan Amendment GA 13-007 was approved on January 10, 2014. The effective date of this amendment is July 1, 2013. We are enclosing the approved HCFA-179 and the plan pages.

If you have any questions, please contact Amr Ali at (404) 562-7338.

Sincerely,

//s//

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: **13-007**	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. § 447.371, Section 1902(bb)	**FFY 2013 $ 0.00** **FFY 2014 $ 755,469**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B: Page 1B **Attachment 4:19-B: Page 5Q**	**Attachment 4.19-B: Page 1B** **Attachment 4:19-B: Page 5Q**

10. SUBJECT OF AMENDMENT: **This State Plan Amendment will result in an increase in the minimum Prospective Payment Services (PPS) rate for Federally Qualified Health Centers (FQHC), free standing Rural Health Clinics (RHC), and hospital based RHCs from the current minimum level mandated by federal law to the current statewide Georgia Medicaid average.**

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:	16. RETURN TO:
13. TYPED NAME: Jerry Dubberly	**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: 08/12/13	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 08/12/13	18. DATE APPROVED: 01/10/14
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/13	20. SIGNATURE OF REGIONAL OFFICIAL: *//s//*
21. TYPED NAME: Jackie Glaze	22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns

23. REMARKS:

Approved with the following changes to item 7, 8 and 9 as authorized by State Agency e-mail dated 01/09/14 and RAI response dated 11/05/13.

Block #7 Changed to read: FFY 2014 $501,119

Block # 8 Changed to read: Attachment 3.1-A pages 1e and 1e(i); Attachment 4.19-B page 1b and 5q; Block # 9 Changed to read: Attachment 3.1-A pages 1e and 1e(i); Attachment 4.19-B page 1b and 5q

FORM HCFA-179 (07-92)

2b. RURAL HEALTH CLINIC SERVICES AND OTHER AMBULATORY SERVICES

Rural Health Clinic (RHC) Services are defined in section 1905(a)(2)(B) of the Social Security Act (the Act). RHC services include services provided by physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, clinical social workers and visiting nurses and other ambulatory services included in the state plan. RHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife, and, for visiting nurse care, related medical supplies and other than drugs and biologicals.

EPSDT limitations may be exceeded if medically necessary. Medical Necessity must be properly documented.

LIMITATIONS

Services are subject to retrospective reduction or denial if adequate medical justification is not provided in medical records. Limitations on other ambulatory services furnished in the RHC are those that are listed in the state plan for those services. RHC visits are limited to twelve (12) visits per year per member. This limitation may be exceeded based upon medical necessity. Medical necessity must be properly documented.

NON-COVERED SERVICES

1. Ancillary services unrelated to the establishment of a diagnosis or treatment of the patient.
2. Routine physical examination or immunization unless in conjunction with the EPSDT Program.
3. Experimental services or procedures or those not recognized by the profession or the U.S. Public Health Service as universally accepted treatment.
4. Additional non-covered services are listed in the *Part II, Policies and Procedures for Rural Health Clinic Services* manual.

2c. FEDERALLY QUALIFIED HEALTH CENTER SERVICES

Federally Qualified Health Center (FQHC) Services are defined in section 1905(a)(2)(C) of the Social Security Act (the Act). FQHC services include services provided by physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, clinical social workers and visiting nurses and other ambulatory services included in the state plan. FQHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife, and, for visiting nurse care, related medical supplies and other than drugs and biologicals.

EPSDT limitations may be exceeded if medically necessary. Medical Necessity must be properly documented.

LIMITATIONS

Services are subject to retrospective reduction or denial if adequate medical justification is not provided in medical records. Limitations on other ambulatory services furnished in the FQHC are those that are listed in the state plan for those services. FQHC visits are limited to twelve (12) visits per year per member. This limitation may be exceeded based upon medical necessity. Medical necessity must be properly documented.

NON-COVERED SERVICES

1. Ancillary services unrelated to the establishment of a diagnosis or treatment of the patient.
2. Routine physical examination or immunization unless in conjunction with the EPSDT Program.
3. Experimental services or procedures or those not recognized by the profession or the U.S. Public Health Service as universally accepted treatment.
4. Additional non-covered services are listed in the *Part II, Policies and Procedures for Rural Health Clinic Services* manual.

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

2b. Rural Health Clinic Services (RHC) and Other Ambulatory Services

In accordance with Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, effective January 1, 2001, reimbursement is provided for all RHC services ("core services") that are referenced in item 2b and 2c on page 1e of Attachment 3.1-A, and other ambulatory services (excluding in-house pharmacy services) at a prospective payment rate (PPS) per encounter. The rates will be calculated on a per visit basis and will reflect 100 percent of the average of the RHC's reasonable cost of providing Medicaid-covered services including other ambulatory services cost during FY 1999 and FY2000., Those costs will be adjusted to take into account any increase (or decrease) in the scope of services furnished by the RHC during FY2001for services that only occurred in calendar year 2000. Cost reports for the RHC's FY 1999 and FY 2000 periods will be used to establish the baseline rate for each RHC effective January I, 2001. The baseline rate will be calculated by dividing the sum of the total reasonable cost of providing Medicaid covered services during FY 1999 and FY 2000 by the total Medicaid visits during the two fiscal years. Until the baseline rates are established, RHCs will be paid their interim rate effective December 31, 2000. When the baseline rates are established, they will be paid retroactive to January 1, 2001.

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

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

Effective July 1, 2013, RHCs that have a PPS rate less than the statewide average will have their PPS rate increased to be equal to the statewide average. This is an alternate payment methodology.

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

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

An alternative payment methodology is established for services furnished in Rural Health Clinics located at Critical Access Hospitals. The reimbursement methodology will follow the provisions established in Attachment 4.19-B, Page 8.1 (Outpatient Hospital). All clinics affected by this methodology have agreed and their payments will at least equal the amount they would have received under the PPS methodology. .

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

2c. Federally Qualified Health Center (FQHC) Services

In accordance with Section 702 of the Medicare, Medicaid and SCRIP Benefits Improvement and Protection Act (BIPA) of 2000, effective January 1, 2001, reimbursement is provided for all FQHC services ("core services") referenced in items 2b and 2c on page 1e of Attachment 3.1-A, and other ambulatory services (excluding in- house pharmacy services) at a prospective payment rate (PPS) per encounter. The rates will be calculated on a per visit basis and will reflect 100 percent of the average FQHC's reasonable cost of providing Medicaid-covered services including other ambulatory services cost during FY 1999 and FY 2000. Those costs will be adjusted to take into account any increase (or decrease) in the scope of services furnished by the FQHC during FY 2001 for services that only occurred in calendar year 2000. Cost reports for the FQHC's FY 1999 and FY 2000 periods will be used to establish the baseline rate for each FQHC effective January 1, 2001. The baseline rate will be calculated by dividing the sum of the total reasonable cost of providing Medicaid covered services during FY 1999 and FY 2000 by the total Medicaid visits during the two fiscal years. Until the baseline rates are established, FQHCs will be paid their interim rate effective December 31, 2000. When the baseline rates and are established, they will be paid retroactive to January 1, 2001.

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

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

Effective July 1, 2013, FQHCs that have a PPS rate less than the statewide average will have their PPS rate increased to be equal to the statewide average PPS rate .

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

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