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State/Territory Name: South Georgia

State Plan Amendment (SPA) #:15-0006

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

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 4, 2016

Dr. Linda Wiant, Chief
Medical Assistance Plans
Georgia Department of Community Health
2 Peachtree Street, NW, 40th Floor
Atlanta, Georgia 30303

RE: Title XIX State Plan Amendment (SPA), Transmittal # GA 15-006

Dear Dr. Wiant:

We have reviewed the proposed Georgia State Plan Amendment 15-006, which was submitted to the Atlanta Regional Office on July 17, 2015. The SPA allows primary care physicians and physician extenders that practice in family medicine, general internal medicine and pediatric medicine to receive increase payment for certain primary care services effective July 1, 2015. These eligible payment increases for physician services will be billed under the Healthcare Common Procedure Coding System (HCPCS) Evaluation and Management codes 99213 and 99391 through 99395.

Based on the information provided, the Medicaid State Plan Amendment 15-006 was approved on February 4, 2016. The effective date of this amendment is July 1, 2015. We are enclosing the approved HCFA-179 and the plan pages.

If you have any additional questions or need further assistance, please contact Yvette Moore at (404) 562-7327or Yvette.Moore@cms.hhs.gov.

Sincerely,

//s//

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

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 15-006	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, 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 $8,829,190 FFY 2016 $35,638,589
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19B page 4.007 and 4.008	Attachment 4.19B page 4.007 and 4.008

10. SUBJECT OF AMENDMENT:

To allow primary care physicians and physician extenders that practice in family medicine, general internal medicine, and pediatric medicine to receive increase payment for certain primary care services effective July 1, 2015. The services eligible for the payment increase are billed under the Healthcare Common Procedure Coding System (HCPCS) Evaluation and Management codes 99213 and 99391 through 99395.

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: LINDA WIANT	
14. TITLE: CHIEF, DIVISION OF MEDICAID	
15. DATE SUBMITTED:	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 07-17-15	18. DATE APPROVED: 02-04-16
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07-01-15	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 as authorized by state agency email dated: 11/24/15:

Block # 7 changed to read: FFY15 $9,244,081; FFY16 $37,797,795.

Block # 8 changed to read: Attachment 4.19-B, pages 3g, 4, 4.007, 4.008.

Block # 9 changed to read: Attachment 4.19-B, pages 3g, 4, 4.007, 4.008.

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

H. INDEPENDENT LABORATORY AND XRAY SERVICES

Payments are made for specific authorized procedures on a statewide basis and are limited to the lower of:

(a) The actual charge for the procedure, or

(b) The statewide rate in effect on the date of service.
Reimbursement for laboratory services performed by an independent laboratory will not exceed the upper limit of payment established by Medicare for the same clinical laboratory test**.**

I. ORTHODICS AND PROSTHETICS SERVICES

The maximum reimbursement amount for items and services will not exceed rates established by the State Agency based upon the usual and customary charge for the items and services.

Effective for dates of service July 1, 1994 and after, a $3.00 recipient co-payment is required on Orthotics and Prosthetics services.

Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice services are not required to pay a co-payment. Emergency services and family planning are also exempt from a co-payment.

J. PHYSICIAN SERVICES – Office Visit (Includes Physicians, Podiatrists, Optometrists and Psychologists)

Payments are made for specific authorized procedures on a statewide basis and are limited to the lower of:

(a) The actual charge for the services; or
(b) The statewide rate in effect on the date of services.
(c) If the recipient is referred in writing by the surgeon to an optometrist for post-cataract surgery follow-up care, the surgeon's fee will be reduced by an amount equal to the maximum allowable reimbursement for the post-cataract surgery follow-up care.

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

J. PHYSICIAN SERVICES Non-Office Settings (Includes Physicians, Podiatrists, Optometrists and Psychologists)

Professional Services:

Payments for certain professional services rendered in a hospital, outpatient, or Ambulatory Surgical Center setting which are normally performed in a physician's private office or clinic, are made on a statewide basis and are limited to the lower of:

(a) The actual charge for the service; or

(b) The statewide rate in effect with the appropriate site of service differential on the date of service.

Services that are primarily performed in office settings will be subject to a reimbursement reduction when performed in an inpatient, outpatient, emergency, or ambulatory surgical setting. The reduced reimbursement is calculated at 90% of the Resource Based Relative Value Scale (RBRVS) facility-setting rate as specified by the current Medicare Fee Schedule.

Injectable Drugs:

Effective for dates of services on or after September 1, 2009, the maximum allowable reimbursement for physician's injectable drugs administered by a provider or appropriate designee, in an office or outpatient setting, to the lower of:

(a) Usual and customary charge, or

(b) Average Sales Price (ASP) plus 6% as defined January 1st of each year or upon the drug's initial availability in the marketplace which ever is later; or

(c) Average Wholesale Price (AWP) minus 11%, for drugs that do not have a published ASP price until such time ASP pricing becomes available and ASP plus 6% pricing can be utilized.

All agency rates for injectable drugs are published on the Physician's Injectable Drug List (PIDL), which is published on the agency's website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Increased Primary Care Service Payment 42 CFR 447.00

Physician Services – Primary Care Payment

The state will continue to reimburse for services provided by physicians with a primary specialty designation of family medicine, pediatric medicine or internal medicine as if the requirements of 42 C.F.R. §447.00 remain in effect. The rates will be 90 percent of those in effect for these services and providers during CY 2014. A provider must meet one of the following requirements listed below to qualify for the enhanced payment.

a. A provider must be Board certified with a specialty or subspecialty designation in family medicine, general internal medicine or pediatrics that is recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA), and must actually practice their specialty.
b. A non-board certified provider who practices in the field of family medicine, general internal medicine, or pediatrics or a subspecialty under one of the these specialties, is eligible if he/she can attest that 60 percent of their paid Medicaid procedures billed are for certain specified procedure codes for evaluation and management services and certain vaccines for children administration codes.
c. Physician extenders (physician assistants, nurse practitioners and nurse midwives) are also eligible for increased payment for designated services as long as they practice under the supervision of an eligible physician with professional responsibility for the provision of care.

Physicians and physician extenders who are reimbursed through Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), public health departments, nursing homes or a facility's encounter (visit or per diem rate) or who are not practicing in one of the designated primary care specialties are not eligible for increased rates. Primary care physicians who receive supplemental reimbursement via the Physician Upper Payment Limit (UPL) Program are excluded from the provider rate increase.

Method of Payment

The state has adjusted its fee schedule to make payment at the higher rate for each E&M code.

Primary Care Services Affected by this Payment Methodology

This payment applies to all Evaluation and Management (E&M) billing codes 99213 and 99391 through 99395.

Effective Date of Payment

E&M Services

This reimbursement methodology applies to services delivered on and after July 1, 2015. All rates are published at: https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Fee%20Schedules/tabId/56/Default.aspx .