

**Department of Law****State of Georgia**

THURBERT E BAKER  
ATTORNEY GENERAL

40 CAPITOL SQUARE SW  
ATLANTA GA 30334 1300

**CERTIFICATION**

The Attorney General hereby certifies that the agency, Georgia Department of Community Health, has been established as the single State agency with authority to administer the State of Georgia Plan for Medical Assistance under Title XIX of the Social Security Act. It is further certified that the Georgia Department of Community Health administers the plan on a statewide basis and has authority to make rules and regulations governing the administration of the Plan. The legal source of this authority to administer the Plan and to make such rules and regulations is Act 268 of the General Assembly of Georgia known as the Department of Community Health, Board of Community Health, and commissioner of Community Health, approved on July 1, 1999 (Ga. Laws 1999 Vol. 1 Pgs. 296-317). The Georgia Department of Community Health succeeds the Georgia Department of Medical Assistance as the single State agency authorized to administer the Plan.

A handwritten signature in black ink that reads "Thurbert E. Baker".

THURBERT E. BAKER  
Attorney General

DATE

Revision: HCFA-AT-80-38(BPP)  
May 22, 1980

State Georgia

Citation 1.1(b) The State agency that administered or supervised the administration of the plan approved under title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.

Sec. 1902 (a)  
of the Act

Yes. The state agency so designated is

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This agency has a separate plan covering that portion of the State plan under title XIX for which it is responsible.

Not applicable. The entire plan under title XIX is administered or supervised by the State agency named in paragraph 1.1(a).

TN #78-5  
Supersedes  
TN # \_\_\_\_\_

Approval Date 8/28/78

Effective Date 7/1/77

Revision: HCFA-AT-80-38(BPP)  
May 22, 1980

State Georgia

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Citation  
Intergovernmental  
Cooperation Act  
of 1968

1.1(c) Waivers of the single State agency  
requirement which are currently  
operative have been granted under  
authority of the Intergovernmental  
Cooperation Act of 1968.

Yes. ATTACHMENT 1.1-B describes  
these waivers and the approved  
alternative organizational  
arrangements.

Not applicable. Waivers are no  
longer in effect.

Not applicable. No waivers have  
ever been granted.

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TN #78-5

Supersedes

TN # \_\_\_\_\_

Approval Date 8/28/78

Effective Date 7/1/77

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State Georgia

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Citation

42 CFR 431.10  
AT-79-29

1.1(d)

The agency named in paragraph 1.1 (a) has responsibility for all determinations of eligibility for Medicaid under this plan.

Determinations of eligibility for Medicaid under this plan are made by the agency (ies) specified in ATTACHMENT 2.2-A. There is a written agreement between the agency named in paragraph..1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.

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TN # 78-5  
Supersedes  
TN # \_\_\_\_\_

Approval Date: 8/28/78

Effective Date: 7/1/77

Revision: HCFA-AT-80-38(BPP)  
May 22, 1980

w/o

State Georgia

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Citation 1.1(e) All other provisions of this plan are  
42 CFR 431.10 administered by the Medicaid agency  
AT-79-29 except for those functions for which  
final authority has been granted to a  
Professional Standards Review  
Organization under title XI of the Act.

(f) All other requirements of 42 CFR.431.10  
are met.

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TN #78-5  
Supersedes  
TN # \_\_\_\_\_

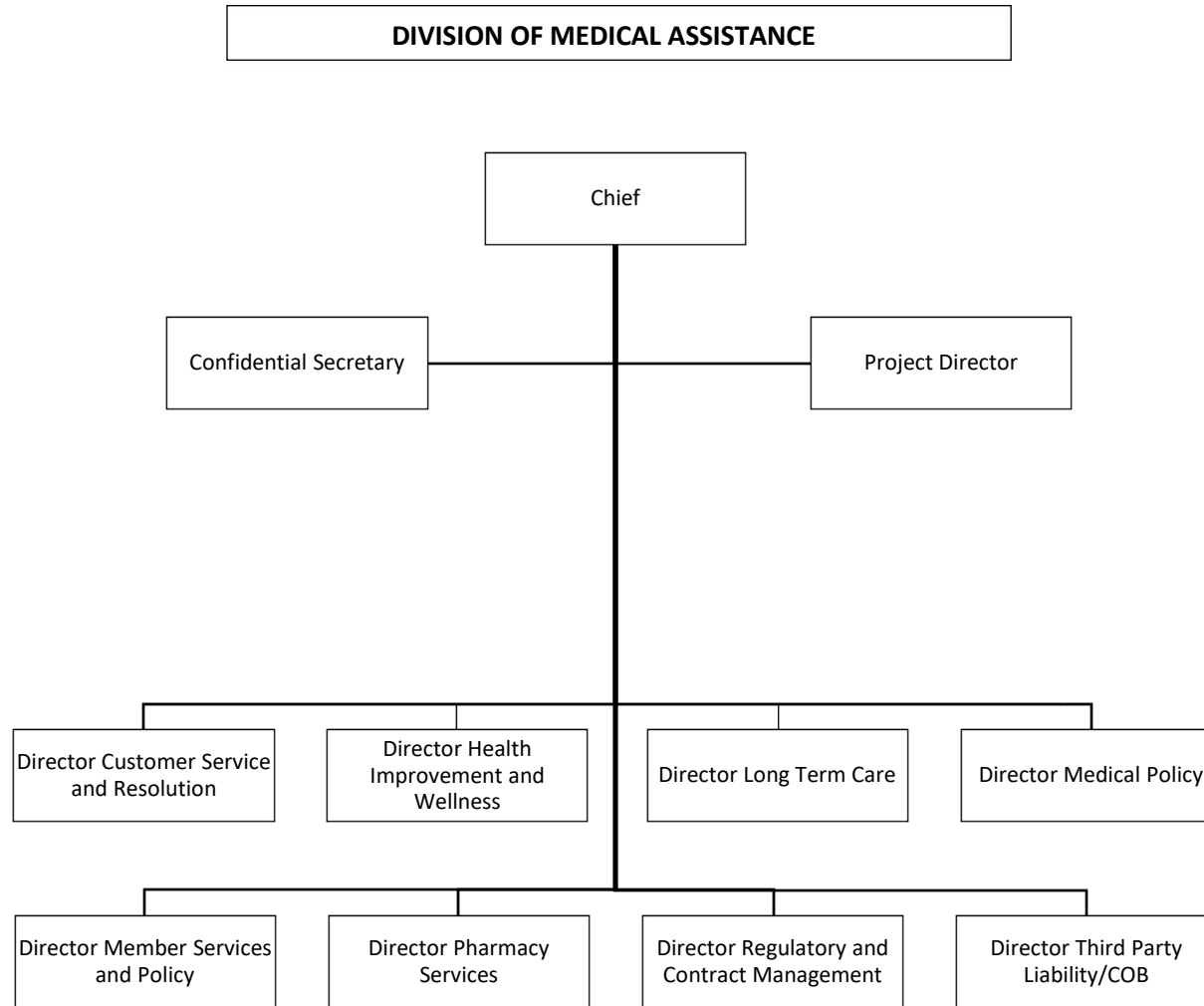
Approval Date 8/28/78 Effective Date 7/1/77

State GEORGIA

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Citation 1.2 Organization for Administration  
42 CFR 432.11  
AT-79-29

- (a) ATTACHMENT 1.2-A contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.
- (b) Within the State agency, the Division of Medical Assistance has been designated as the medical assistance unit. ATTACHMENT 1.2-B contains a description of the organization and functions of the medical assistance unit and an organization chart of the unit and a description of the kinds and numbers of professional and medical personnel and supporting staff used in the administration of the plan and their responsibilities.
- (c) Eligibility determinations are made by State or local staff of an agency other than the agency named in paragraph 1.1(a). ATTACHMENT 1.2-D contains a description of the staff designated to make such determinations and the functions they will perform.
- Not applicable. Only staff of the agency named in paragraph 1.1(a) make such determination.

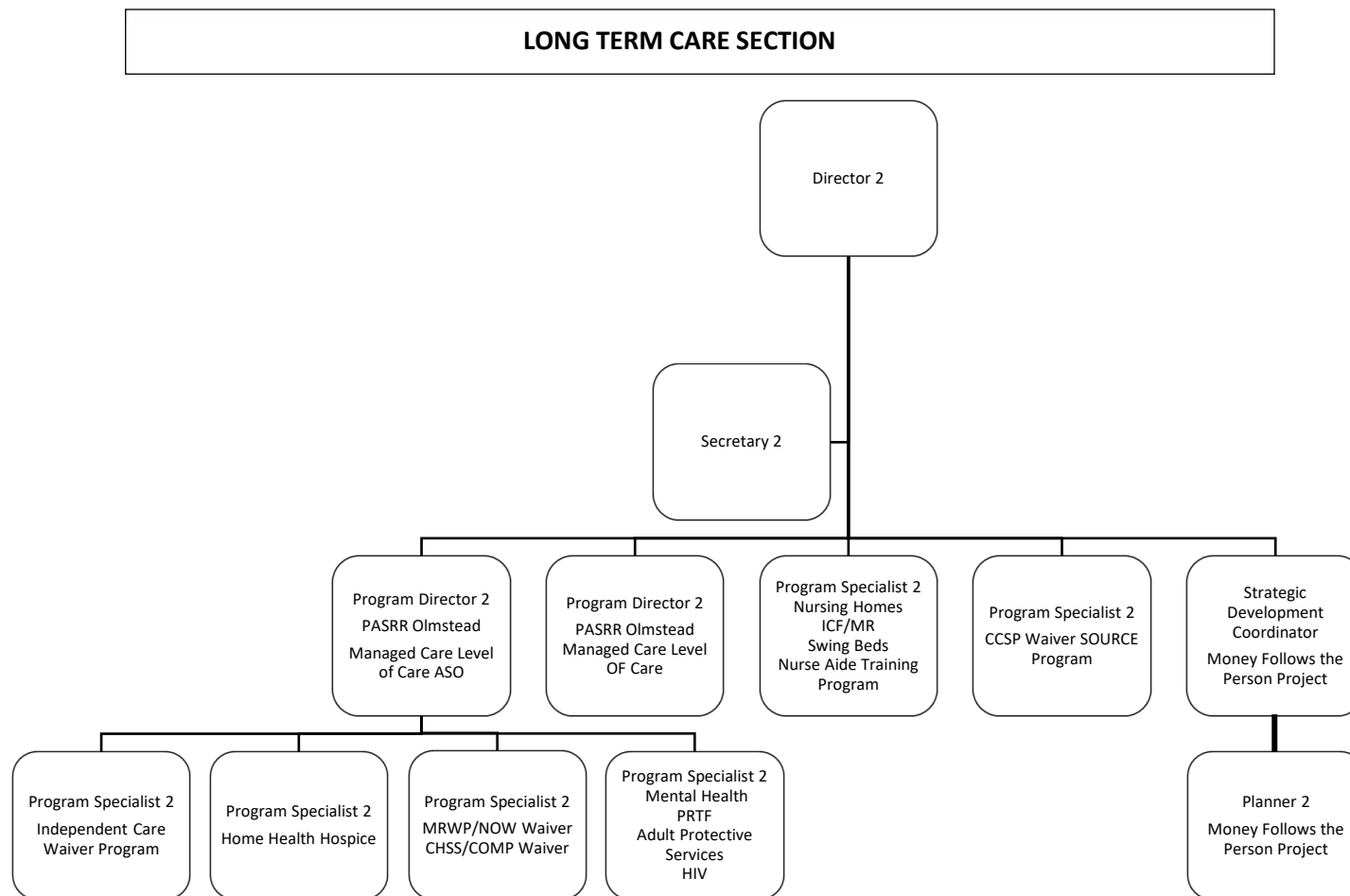


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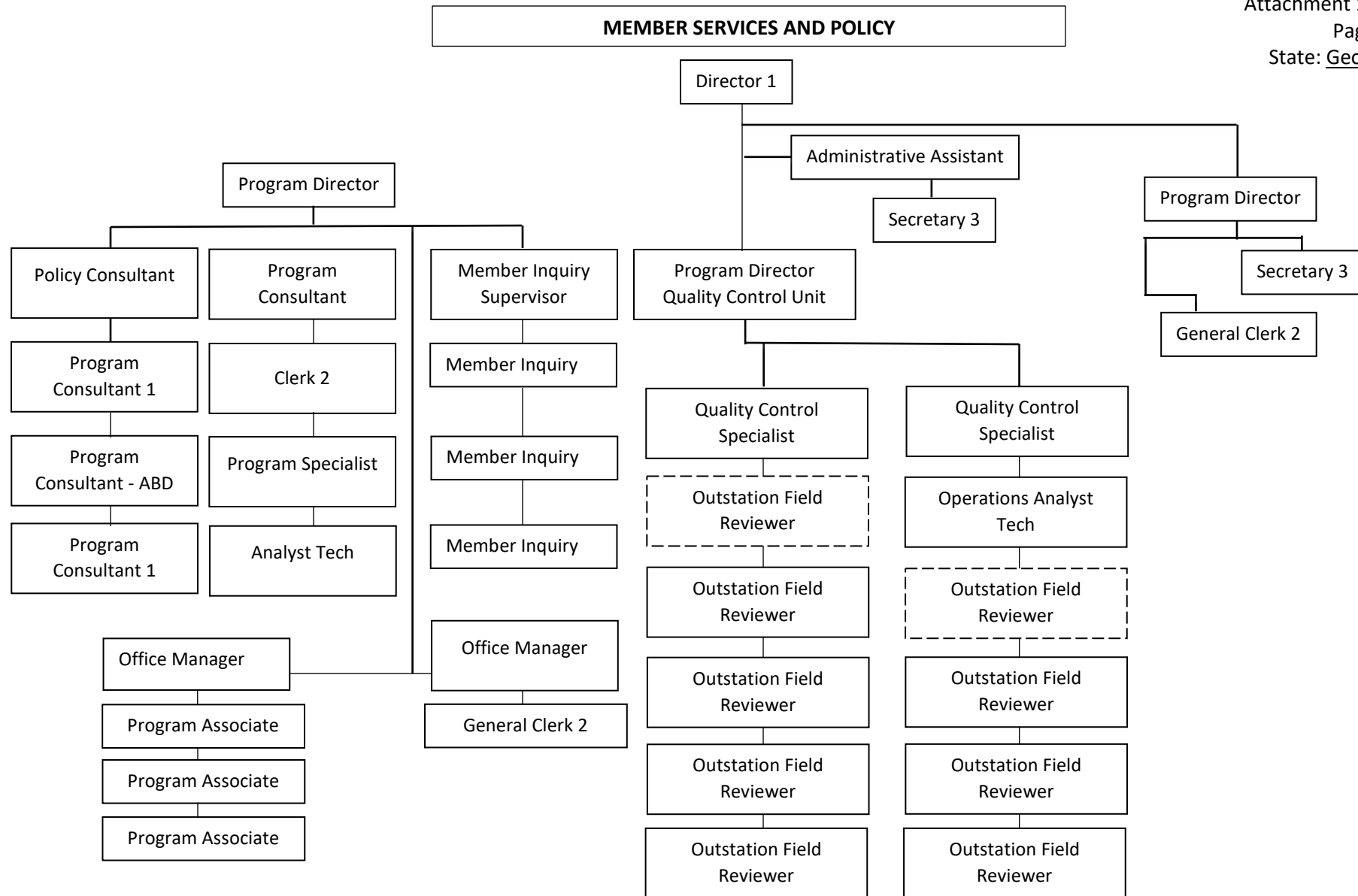
TN No: 07-013  
Supersedes  
TN No: 95-012

Approval Date: 12/18/07

Effective Date: 10/01/07



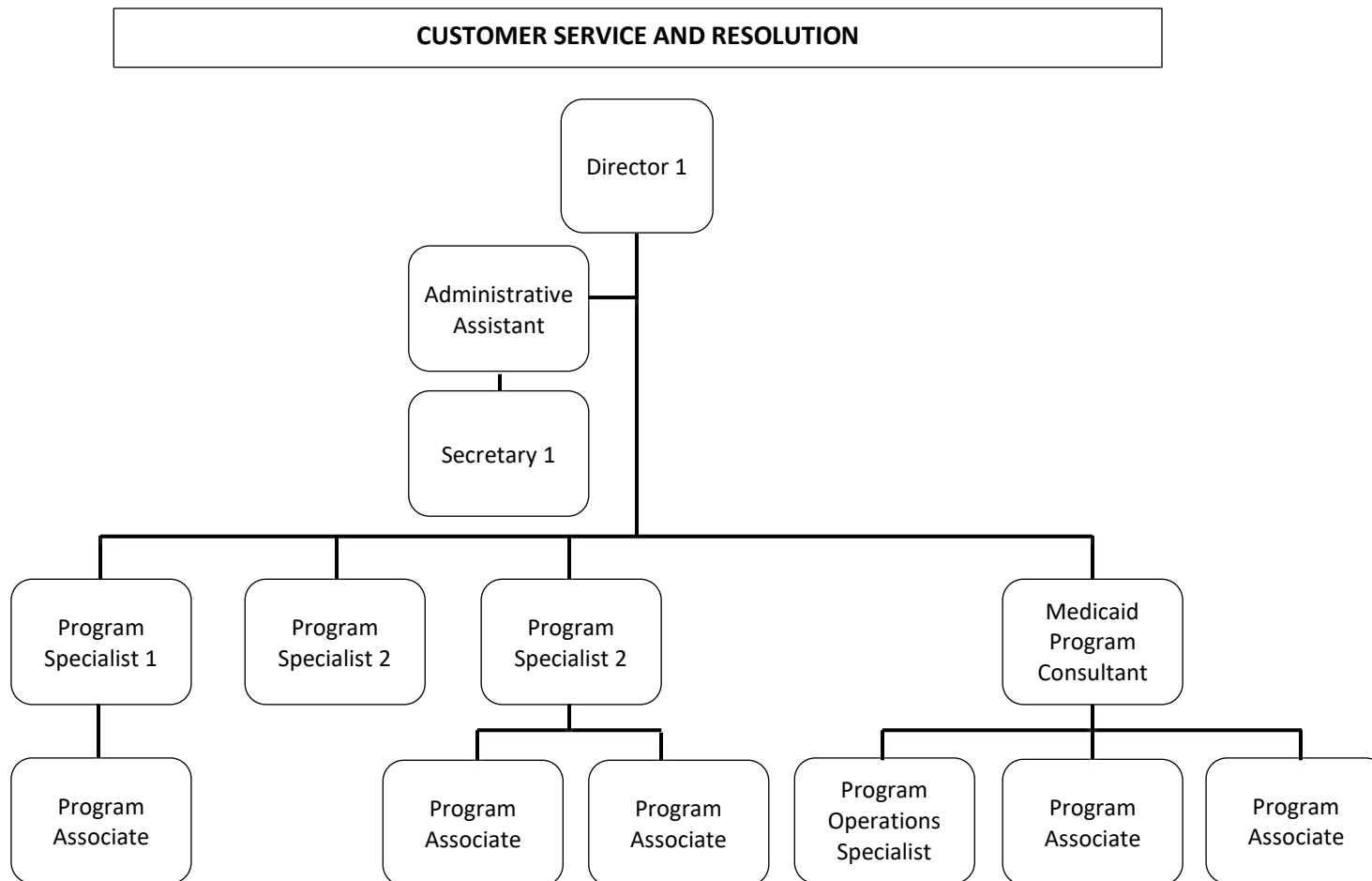


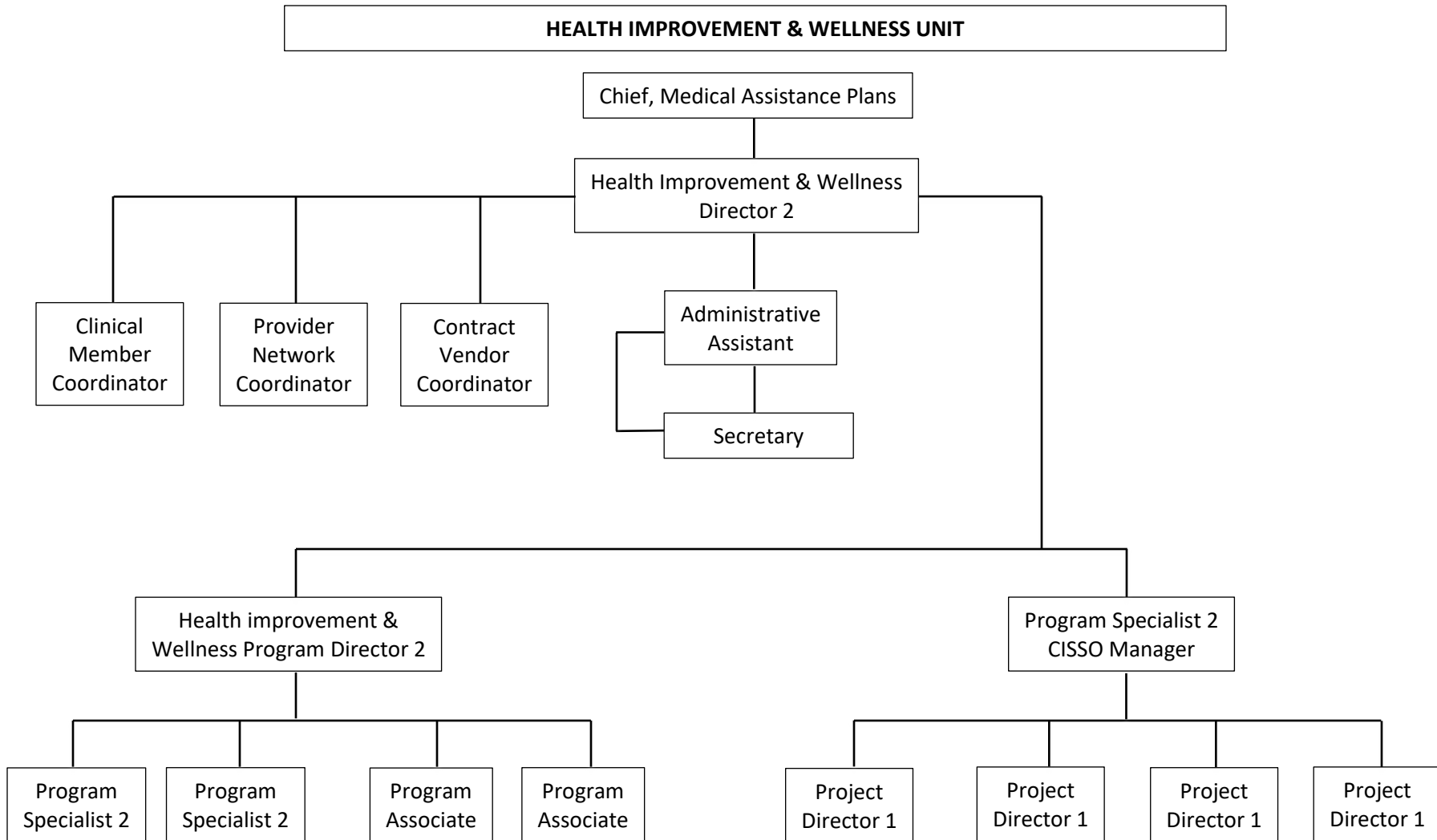


TN No: 07-013  
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TN No: 07-013  
Supersedes  
TN No: 95-012

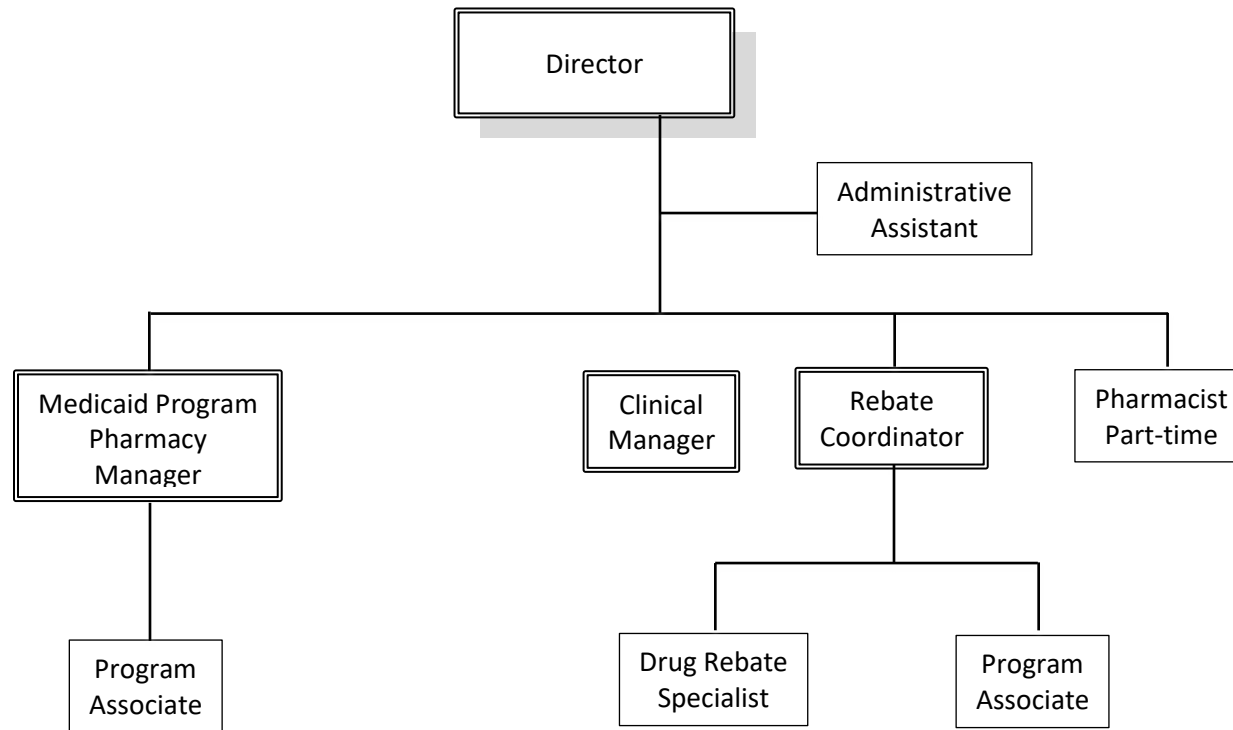
Approval Date: 12/18/07

Effective Date: 10/01/07

# PHARMACY UNIT

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Wednesday, August 08, 2007



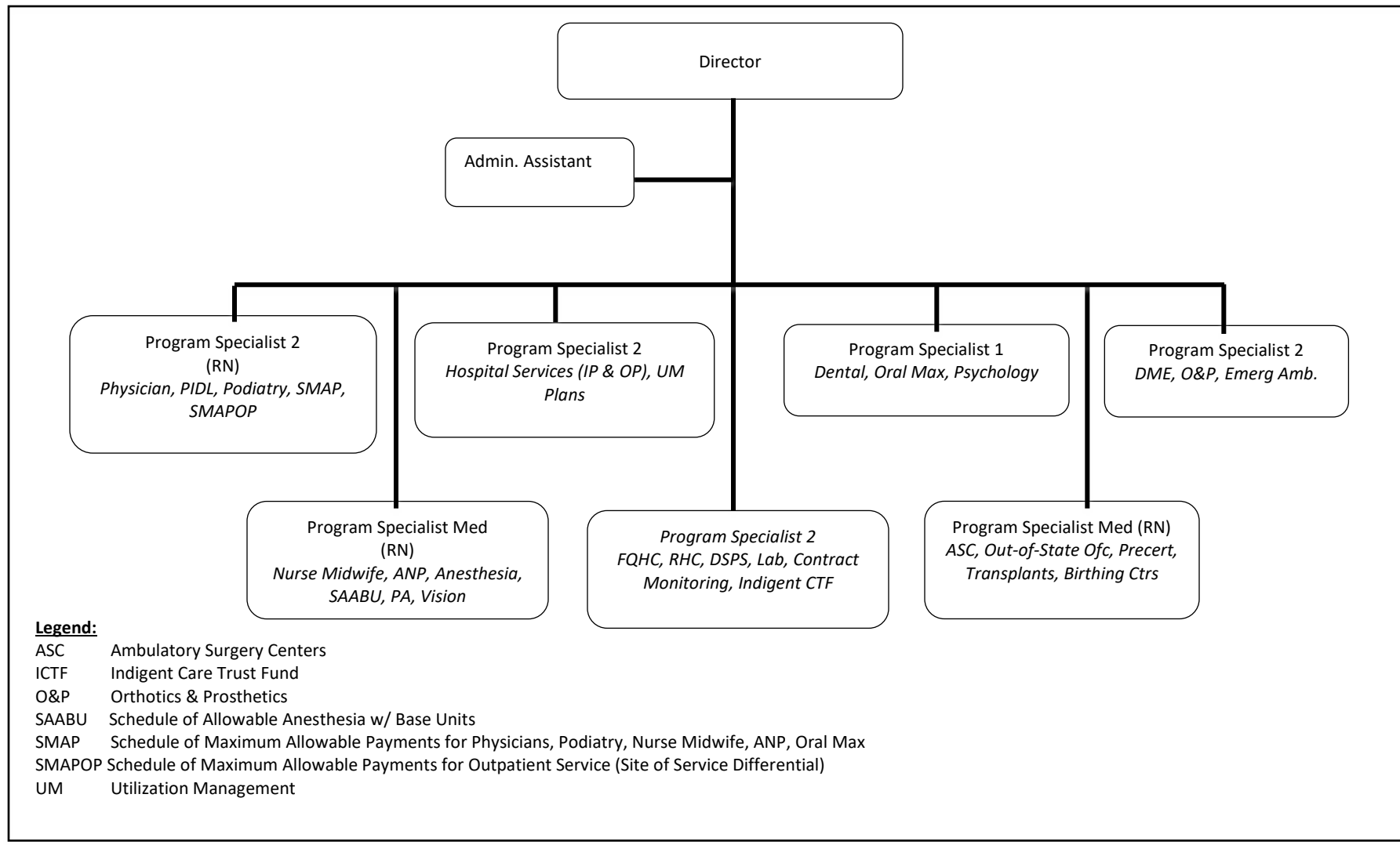
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TN No: 07-013  
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**MEDICAL POLICY**



**Legend:**

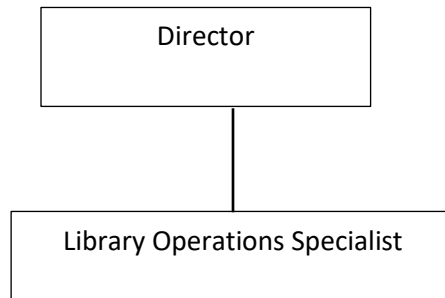
- ASC Ambulatory Surgery Centers
- ICTF Indigent Care Trust Fund
- O&P Orthotics & Prosthetics
- SAABU Schedule of Allowable Anesthesia w/ Base Units
- SMAP Schedule of Maximum Allowable Payments for Physicians, Podiatry, Nurse Midwife, ANP, Oral Max
- SMAPOP Schedule of Maximum Allowable Payments for Outpatient Service (Site of Service Differential)
- UM Utilization Management

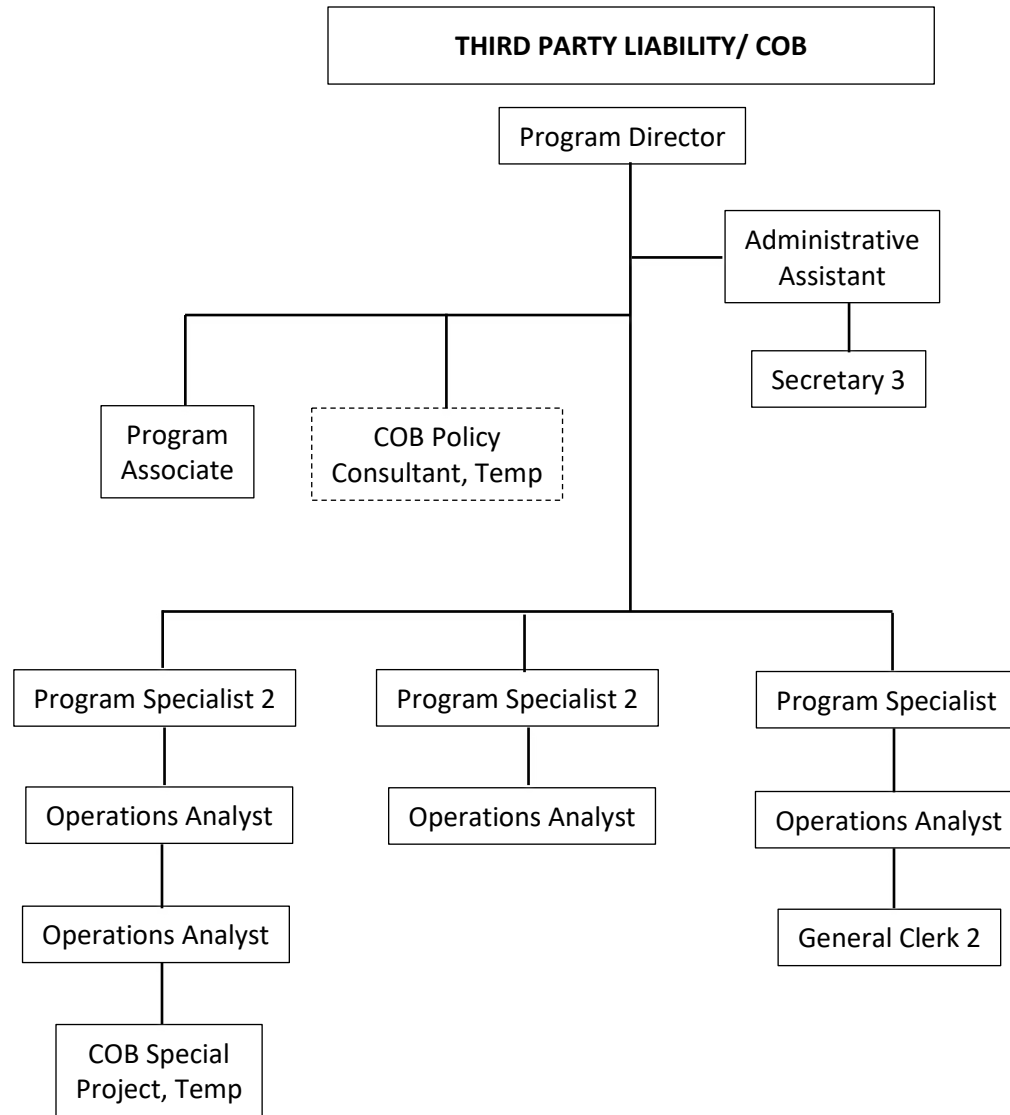
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**REGULATORY AND CONTRACT MANAGEMENT**





**Long Term Care Section**

The Long Term Care unit is responsible for policy development and management of programs and services that are provided primarily to persons who have chronic needs whether they reside in institutions or in the community with the assistance of home and community based services.

The unit covers the following programs:

- ICWP Waiver
- MRWP/NOW Waiver
- CHSS/COMP Waiver
- CCSP Waiver
- SOURCE
- Hospice
- Home Health
- Mental Health Community Services
- PASRR
- HIV Case Management
- Adult Protective Services
- At Risk of Incarceration Case Management
- Psychiatric Residential Treatment Facilities (PRTF)
- PRTF Demonstration Grant
- Nursing Homes
- Swing Beds
- Nurse Aide Training Program
- PACE
- Olmstead/Nursing Home Transition
- Money Follows the Person Grant
- Level of Care ASO
- LTC Initiatives

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TN No: 07-013

Supersedes

TN No: 87-10

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Long Term Care Section

Director 2

Section Director. Oversees operation of all service programs.

Secretary 2 - One year of general office work or one year of business school or college.

Serves as secretary and assistant to the Section Director and Section staff in the daily management of the program.

Program Director 2

Provides supervision to Program Specialists that are assigned to one or more programs.

Program Specialist 2- Bachelor's degree or licensure as a registered nurse or other health care professional and 4 years of professional experience in a health care venue.

Independent Care Waiver Program - Oversees the operation of the program, monitoring and interpreting changes in Federal guidelines and regulations, analyzes impact on Medicaid programs, utilization costs of services and makes recommends new or revised policies and procedures. Interprets program policies and serves as a resource and DMA representative to assist providers in resolving complex problems. Analyzes the nature and scope of policy related problems; develops appropriate corrective measures. Develops implements and evaluates utilization review results to ensure quality services.

Program Specialist 2- Bachelor's degree or licensure as a registered nurse or other health care professional and 4 years of professional experience in a health care venue.

Home Health and Hospice - Oversees the operation of the program, monitoring and interpreting changes in Federal guidelines and regulations, analyzes impact on Medicaid programs, utilization costs of services and recommends new or revised policies and procedures. Interprets program policies and serves as a resource and DMA representative to assist providers in resolving complex problems. Analyzes the nature and scope of policy related problems; develops appropriate corrective measures. Develops, implements and evaluates utilization review results to ensure quality services.

Program Specialist 2- Bachelor's degree or licensure as a registered nurse or other healthcare professional and 4 years of professional experience in a health care venue.

MRWP/NOW and CHSS/COMP Waivers -Oversees the operation of the program, monitoring and interpreting changes in Federal guidelines and regulations, analyzes impact on Medicaid programs, utilization costs of services and makes recommends new or revised policies and procedures. Interprets program policies and serves as a resource and DMA representative to assist providers in resolving complex problems. Analyzes the nature and scope of policy related problems; develops appropriate corrective measures. Develops, implements and evaluates utilization review results to ensure quality services.

Program Specialist 2- Bachelor's degree or licensure as a registered nurse or other health care professional and 4 years of professional experience in a health care venue.

Mental Health, PRTF, Adult Protective Services, and HIV Case Management - Oversees the operation of the program, monitoring and interpreting changes in Federal guidelines and regulations, analyzes impact on Medicaid programs, utilization costs of services and makes recommends new or revised policies and procedures. Interprets program policies and serves as a resource and DMA representative to assist providers in resolving complex problems. Analyzes the nature and scope of policy related problems; develops appropriate corrective measures. Develops, implements and evaluates utilization review results to ensure quality services.

Program Specialist 2- Bachelor's degree or licensure as a registered nurse or other health care professional and 4 years of professional experience in a health care venue.

Nursing Homes, ICF/MR, Swing Beds, Nurse Aide Training Program - Oversees the operation of the program, monitoring and interpreting changes in Federal guidelines and regulations, analyzes impact on Medicaid programs, utilization costs of services and makes recommends new or revised policies and procedures. Interprets program policies and serves as a resource and DMA representative to assist providers in resolving complex problems. Analyzes the nature and scope of policy related problems; develops appropriate corrective measures. Develops, implements and evaluates utilization review results to ensure quality services.

Program Specialist 2 - Bachelor's degree or licensure as a registered nurse or other health care professional and 4 years of professional experience in a health care venue.

Community Care Services Waiver and SOURCE Programs - Oversees the operation of the program, monitoring and interpreting changes in Federal guidelines and regulations, analyzes impact on Medicaid programs, utilization costs of services and makes recommends new or revised policies and procedures. Interprets program policies and serves as a resource and DMA representative to assist providers in resolving complex problems. Analyzes the nature and scope of policy related problems; develops appropriate corrective measures. Develops, implements and evaluates utilization review results to ensure quality services.

Program Director 2

Manages the PASRR, Olmstead/Nursing Home Transition, Managed Care, and Level of Care ASO programs.

Strategic Development Coordinator – Bachelor's degree and four years of experience in long-term care or health related services.

Administers the Money Follows the Person grant project and reporting requirements.

Planner 2 – Bachelor's degree and three years of experience in long-term care or health related services.

Serves as the lead planner/ researcher for the Money Follows the Person project, performing complex and comprehensive research; analyzing and evaluating the effectiveness of the project.

**MEMBER SERVICES AND POLICY**

## PeachCare for Kids Unit

The PeachCare for Kids unit has overall responsibility for the eligibility and enrollment process as well as federal SCHIP State Plan compliance. This unit sets policy for eligibility, premium payment and member services. This unit manages the contract of our Third Party Administrator (TPA). Services provided by the TPA include development and operation of enrollment/eligibility determination system, development and maintenance of web-based application system, premium collection and processing and Member Support Center.

## Quality Control Unit

The Quality Control Unit has the overall responsibility for management of the federal Payment Error Rate Measurement (PERM) process associated with both Medicaid and SCHIP. The unit also oversees the ASO accuracy reviews of 850 Medicaid eligibility reviews monthly. The unit manages the contract of our Third Party Administrator (TPA). The TPA reads Medicaid cases monthly to determine if eligibility was determined correctly.

## The Quality Control Unit:

- Gathers records for PERM/ASO accuracy reviews
- Gathers and reports data on results associated with accuracy reviews
- Provide a second level review for case accuracy
- Responds to rebuttals and questions related to error findings
- Monitors the PERM sample and results for both Medicaid and SCHIP
- Composes Quality Control Communicators for DFCS corrective action

## The Policy unit

The Policy unit is responsible for Federal and State family and adult legislation/policy interpretation, clarification and dissemination to State DFCS. This unit is responsible for updating the State Plan in accordance with policy. The Program Consultants also provide guidance to various organizations regarding Medicaid policy including presentations and other speaking engagements.

**CUSTOMER SERVICE & RESOLUTION**

This Unit is responsible for support services for all Medicaid programs. These support services includes but or not limited to Administrative Reviews, Appeals, claims resolution of a complex nature, provider enrollment assistance, prepayment reviews for various programs, all System Related requirements, i.e., ticket development requirement document, ticket testing for implementation and reference files updates.

Staff: Director 1 (75/25) SPMP  
 Administrative Secretary (75/25) SPMP  
 Secretary 1 (75/25) SPMP  
 1 - Program Specialist 1 (75/25)  
 2 - Program Specialist 2 (75/25)  
 1 - Medicaid Program Consultant  
 5 - Program Associate (75/25)  
 1 - Program Operations Specialist (75/25)

Director 1	Responsible for day to day operations of the Customer Service & Resolution Unit as well as:
Support:	Administrative Secretary - Serves as secretary and assistant to the Director 1 in the daily technical management of the Customer Services & Resolution Unit. Organize and coordinates the clerical operation of the Unit.
2 – Program Specialists 2	Provides technical assistance to Medicaid Program areas regarding policy revisions and development. Utilizes professional judgment when making determinations related to Administrative Reviews and Appeals outcome; supervises two Program Associates responsible for claims research and provider inquiry support responds.
1 - Program Specialist 1	Establishes policy, monitors compliance, train providers for the Dialysis program and; responds in writing regarding Providers Administrative Reviews and Appeals for the hospital and Ambulatory Surgical Center programs. Supervises one Program Associate responsible for prepayment review for various programs

- 1 - Medicaid Program Consultant Provides technical assistance to all Medicaid Programs areas regarding policy revisions and development. Utilizes professional judgment when making determinations related to Administrative Reviews and appeals outcome; responds in writing to Provider's Administrative Review and/or Appeal requests. Supervise one Program Operations Specialist and two Program Associates for claims research and provider inquiry support.
- Support: Secretary 1- Prepares memoranda, types correspondence and perform other related office tasks.
- 5 - Program Associates Accesses information from MMIS and conducts other research to provide information as needed by the Program Specialist 1 and 2, and the Medicaid Program Consultant; responds verbally to a large volume of provider inquiries regarding billing procedures, claims, and reimbursement inquiries.
- 1 - Program Operations Specialist Provides technical assistance to program areas. Prepares basic to moderately complex reports and correspondence that requires researching information from a variety of sources. Responds verbally and/or in writing to provider inquires regarding problems with billing procedures, claim's issues and reimbursement.

**HEALTH IMPROVEMENT & WELLNESS UNIT**

This unit is responsible for establishing and publishing Title XIX policies and procedures and reimbursement methodologies for certain provider services.

Staff: Director 2 (75/25) SPMP  
 Administrative Secretary (75/25) SPMP  
 Secretary 1 (75/25) SPMP

UNIT: Manages service programs (including fee schedules) for EPSDT, Family Planning, Pregnancy-Related Services, Early Intervention Case Management, Child Birth Education, Health Check Children at Risk Targeted Case Management, Pediatric Waiver(GAPP), Children's Intervention School Services(CISS), Children's Intervention Services(CIS), and Wellness initiatives(contracts).

Staff: R.N. Program Director 2 (75/25) SPMP  
 2 R.N. Program Specialist (75/25) SPMP  
 Program Specialist (50/50)  
 2 R.N. Strategic Coordinator (75/25/) SPMP  
 1 NON- R.N. Strategic Coordinator (50/50)  
 4 Project Director's 1 (50/50)

**Health Improvement and Wellness Unit**

R.N. Medicaid Director 2 oversees Operation of EPSDT for Federal CMS Coordination and Compliance, VFC, Targeted Case Management for Children-at-Risk Specialist 2 and Strategic Coordinators.

2 R.N.- Program Specialists 2 2 Program Specialists 2. Establishes Policy monitor compliance, recruit And train providers. Programs are: ESPDT, Perinatal Case Management. Family planning, GAPP (Pediatric Waiver) Pregnancy-related Services, Early Intervention, and Child Birth Education

Support: Administrative Clerk

R.N.- Program Director:	Programs: EPSDT, Early Intervention Case Management, Family Planning, Children Intervention Services (CIS) And supervises 2 Program Specialist 2.
R.N.- Program Specialist 2	Medicaid Program Specialist 2. Establishes policy and monitors compliance of the children's Pediatric waiver (GAPP). Serves on Appropriate interdepartmental and Interdivisional committees as the department's representative for the Administration of this programs.
Program Specialist 2	Medicaid Program Specialist. Establishes policy and monitors Compliance of the Children's Intervention School Services (CISS) Serves on appropriate Inter-Departmental and interdivisional Committees as the Department's Representative for the administration of the CISS program. Supervises 4 Project Directors who are Responsible for auditing school based services
Program Associate	2 administrative Clerks. Accesses Information from computer terminals And microfiche/film and conducts Other research to provide Information as needed by Specialists other Department staff. Responds verbally and/or in writing to a large volume of provider Inquires regarding problems with Program policies, billing procedures and reimbursement.



HEALTH IMPROVEMENT & WELLNESS UNIT

The Health Improvement & Wellness Unit of the Division of Medical Assistance Plans is responsible for the Medicaid programs and policies for certain providers of maternal and child health services. The Division of Medical Assistance Plans is a sub-unit of the Department of Community Health, the State's health care purchasing agency. The State's Medicaid Chief appoints the Director of the Health Improvement & Wellness Unit formerly called Maternal and Child Health Section.

Staff:	Director 2	75/25 SPMP
	Administrative Assistant	75/25 SPMP

Director 2 Oversees operation of all the programs.

Support: Administrative Assistant: Serves as secretary and Assistant to the Director in the daily technical management of the section.

Secretary 1: Serves as secretary to the unit staff and under the supervision of the Administrative Assistant.

Health Improvement & Wellness

The Health Improvement & Wellness Unit is responsible for the Pregnancy Related Services (PRS), Perinatal Case Management (PCM), Childbirth Education (CBE), Family Planning, Health Check, Children At Risk Targeted Case Management, Pediatric Waiver (GAPP), Children's Intervention Services (CIS), Children's Intervention School Services (CISS) and Early Intervention Case Management programs. In addition to these programs, the unit manages several wellness contracts, including Georgia Enhanced Care (disease management contractors) and Georgia Medicaid Management Program (GAMMP). The Unit develops and modifies policy to ensure compliance with federal standards, state practice acts, and with advice from a variety of professional and advocacy groups. Policy staff works with IT system staff to develop computer system edits to administer the program's policies.

The Program Specialist establishes policies, monitors program compliance, and trains providers.

Staff:	Program Director 2	75/25 SPMP
	(2) Program Specialist 2	75/25 SPMP
	(2) Program Associate	50/50

Program Director 2      Directs the Community Service programs including Pregnancy Related Services (PRS), Perinatal Case Management (PCM), Childbirth Education (CBE), Family Planning programs.

Wellness Staff- under direct supervision of the Director 2

(1) Clinical Member Enrollment Coordinator	75/25 SPMP
(1) Provider Network Coordinator	50/50
(1) Contract Vendor Coordinator	75/25 SPMP

Program Specialist 2      Directly oversees Children Intervention School  
(CISSO Manager)      Services (CISS) program and 4 Project Directors I staff.

(4) Project Director I	50/50
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**DIVISION OF PHARMACY SERVICES**

This division is responsible for establishing and publishing Title XIX policies, procedures, and reimbursement methodologies for certain provider services.

Staff: Director (75/25 Pharmacist)  
Administrative Assistant (50/50)  
Medicaid Program Pharmacy Manager (75/25 Pharmacist)  
Pharmacist (part-time) (75/25 Pharmacist)  
Clinical Manager (75/25 Pharmacist)  
2 Program Associates (50/50)  
Medicaid Rebate Coordinator (75/25 Pharmacist)  
Drug Rebate Specialist (50/50)

**DIRECTOR**

Responsible for the overall direction of the pharmacy unit and all operational, fiscal, and policy components

**ADMINISTRATIVE ASSISTANT**

Provides administrative support to the Director of Pharmacy Services

**MEDICAID PROGRAM PHARMACY MANAGER**

Communications, Banner, Web Portal  
MMIS Issue – PBM-MMIS/ IS interface point person  
Out of State Enrollment  
Policy Issues  
Reimbursement Issues; GMAC

**PHARMACIST (PART-TIME)**

Supplemental Rebate Contracting  
Special Projects  
Prior Authorization/Clinical Support

**CLINICAL MANAGER**

Prior Authorization Appeals  
Prior Authorization vendor management  
Clinical protocol development  
Clinical Projects

**PROGRAM ASSOCIATE**

Eligibility Updates  
Pharmacy Claims Resolution  
Support Pharmacy Operations

**MEDICAL POLICY UNIT POSITION DESCRIPTIONS****Director (1-FTE)**

Directs the activity of the Hospital and Physician's Services Unit. Ensure that goals of the organizations are reflected and accomplished. Works with subordinate staff, community and advocate groups, trade organizations, and other branches of government to define objectives and goals in the area of long term care.

Defines and develops work plan to accomplish organizational goals. Arranges unit resources to accomplish objectives and goals. Monitors and ensures completion of tasks within defined timeframes. Serves on and/or chairs committees and task forces as requested, to represent the Department while accomplishing Department objectives. *Develop Unit's organization in such areas as personnel, budget, purchasing, organizational structure procedures and use of resources.*

Prepares and/or manages assigned budgets through sound analytical, reporting and financial management practices as directed. Works with Section Director and other Department staff to develop unit budget. Coordinates human resource activities for unit, including recruiting, orienting, monitoring and otherwise supervising staff of unit.

**Administrative Assistant (1)**

Under general to limited supervision, provides professional-level administrative support to management which requires exercise of independent judgment and initiative. Assists in the operation, management and planning of the organization, coordinates meetings and agendas; represents supervisor in both internal and external settings. May supervise administrative staff.

**Program Specialist 1 (1)**

Under general supervision reviews, monitors and ensures compliance with Medicaid policies and procedures. Provides technical and customer support, conducts training and participates in meetings for assigned program areas. May supervise clerical and/or support staff.

**Program Specialist Medical ( 2 RN)**

Under general supervision, reviews, monitors and ensures compliance with Medicaid policies and procedures. Provides technical and customer support, conducts training and participates in meetings for assigned program areas. This position requires a skilled medical professional, i.e., registered nurse.

**Program Specialist 2 (-1 RN and 2 non-RN's)**

Under limited supervision monitors and interprets changes in Federal guidelines and regulations, analyzes the impact on Medicaid programs, utilization costs of services and makes recommendations for new or revised policies and procedures. Interprets program policies in the areas of responsibilities; serves as a resource and DMA representative to assist providers in resolving complex problems. May function as staff advisor to analysts in areas of responsibility and as primary point of communication with professionals and groups related to programs in area of assignment. Analyzes the nature and scope of policy related problems; develops or assists with the development of appropriate corrective measures. Develops implements and evaluates the surveillance of utilization review process to ensure quality services.

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TN No: 87-10

**REGULATORY REVIEW AND CONTRACT MANAGEMENT**

The Regulatory Review Unit function is to ensure that State Plan amendments are filed appropriately. The unit serves as a resource to other departments by researching and interpreting regulatory requirements and assisting departments to respond to new and revised State requirements. The unit is responsible for ensuring that all Medicaid policy is produced accurately and on time. The contract management function monitors the work flow of contract initiation and execution with Medicaid third party vendors. The functions of this unit are accomplished by the Director and an operations specialist.

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TN No: 87-10

**THIRD PARTY LIABILITY/ COB**

Responsible for the identification, maintenance and recovery of third party resources liable for the medical cost of the Medicaid member. Assures that Medicaid members and providers are in compliance with existing federal and state regulations involving Medicaid and third-party resources.

Staff: Program Director 2 (50/50)  
 3- Program Specialist II (50/50)  
 4 - Operations Analyst 1 (50/50)  
 Program Associate (50/50)  
 Clerk 2 General (50/50)  
 2 – Temporary staff

**Program Director 2:** Oversees the development and on-going management of programs with statewide impact in health, education, social services and human resources management. Establishes program plans, budget and staffing requirements; and ensures programs are completed and meet stated objectives.

**Program Specialist II:** Monitors and interprets changes in Federal guidelines and regulations, analyzes the impact on Medicaid programs. Makes recommendations for new and revised policies and procedures.  
 Interprets program policies in the areas of responsibilities; serves as a resource and Division of Medical Assistance representative to assist providers in resolving complex problems.  
 Serves as primary point of communication with professionals and group related programs in areas of assignment.  
 Analyzes the nature and scope of policy related problems.  
 Develops or assists with the development of appropriate corrective Measures

**Operations Analyst 1:** Gathers, compiles and analyzes data in relation to program area(s).  
 Participates in the assessment of program operations.  
 Prepares statistical and narrative reports.  
 Monitors and ensures program compliance.  
 Provides technical assistance to staff.

- Program Associate:** Serves as liaison between the program/administrative/technical operation, program management and customer.  
Researches and analyzes program/operation data.  
Maintains financial related records of the program/operation.  
Establishes and maintains filing and record-keeping systems in support of program/operation.
- Clerk 2 General:** Performs administrative and advanced clerical duties in support of unit or program area.  
Interprets, explains and applies pertinent laws, rules, regulations, policies, procedures, standards, and guidelines.
- Temporary Staff:** Performs administrative and clerical duties

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TN No: 87-10

The state agency is the medical assistance unit. A description of the organization and functions of the agency is in Attachment 1.2-A.

TRANSMITTAL 87-10  
APPROVED 7-21-87  
EFFECTIVE 7-1-87



**GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE  
SKILLED PROFESSIONAL MEDICAL PERSONNEL**

July 1, 1991

OPERATIONS

PLANNING & COORDINATION

R.N. Medicaid Policy Coordinator.  
Responsible for assuring that the policy used in any of the program areas reflects current medical and health standards and conforms to the Department's total quality management plan.

DIVISION OF PROFESSIONAL SERVICES

PHARMACY UNIT

R. Ph. Medicaid Policy Coordinator.  
Oversees operation of pharmacy, drug formulary, drug utilization review program, drug rebate program and pharmacy investigative functions.

R. Ph. Pharmacist. Reviews complex pharmacy billing, reviews medical records documentation and assesses medical necessity and quality of care of services provided in all Medicaid program areas related to pharmacy.

R. Ph. Pharmacist. Maintains drug formulary. Issues approval/denial for drugs not on formulary.

Physician Consultant. Reviews administration of Clozapine.

Support: 2 Administrative Clerks  
Senior Secretary

TRANSMITTAL 91-28  
APPROVED 10-3-91  
EFFECTIVE 7-1-91  
SUPERSEDES 90-2

INDIVIDUAL PRACTITIONER'S SECTION

R.N.	Medicaid Program Analyst III. Establishes policy and medical coverage determinations for physician, podiatry, nurse practitioner, and vision care programs. Determines computer modifications necessary to implement changes in policies and assure compliance with federal regulations. Supervises MPA II's in physician services unit.
R.N.	Medicaid Program Analyst II. Monitors compliance for physician, podiatry and nurse practitioner programs. Monitors precertification for individual practitioners and reviews the appeals using medical judgement. Performs provider relations, medical liaison and review functions for physician services.
R.N.	Medicaid Program Analyst II. Monitors compliance for vision care services. Performs medical liaison and reviews functions for physician services programs. Reviews and determines Maximum Allowable Payment Schedules and Allowances for Injectable Drug List. Performs prior approval for office surgery, office visits, nursing home visits, and vision care services. Performs prepayment review for multiple surgeries, mandatory outpatient surgery abortions, sterilizations and for providers on prepayment review.
Dentists	5 Consultants. Issues prior approval for dental services.
Physician	Consultant.

TRANSMITTAL 91-32  
APPROVED 11-20-91  
EFFECTIVE 11-1-91  
SUPERSEDES 91-28

Podiatrist Consultant.  
Optometrist Consultant.  
Support: 2 Administrative clerks  
Principal clerk

DIVISION OF MATERNAL AND CHILD HEALTH

DIRECTOR'S OFFICE

R.N. Division Director. Oversees operation of all service programs.  
Support: Administrative Secretary.

MATERNAL AND CHILD HEALTH SECTION:

R.N. Medicaid Policy Coordinator. Oversees operation of EPSDT, Family Planning, Perinatal Case Management, Pregnancy-Related Services, Early Intervention Case Management Program, Educational Initiative, Day Treatment for Pregnant Women.  
R.N. 2 Medicaid Program Analysts II. Establish policy, monitor compliance, recruit and train providers for EPSDT, Perinatal Case Management, Family Planning, Pregnancy-Related Services, Day Treatment for Substance Abusing Pregnant women.  
Support: Administrative Clerk

DIVISION OF COMMUNITY SERVICES

DIRECTOR'S OFFICE

R.N. Division Director. Oversees operation of all service programs.  
Support: Administrative Secretary. Serves as secretary and assistant to the Division Director in the daily technical management of the Division.

COMMUNITY SERVICES SECTION

R.N.		Medicaid Policy Coordinator. Oversees the operation of home health, durable medical equipment, orthotics & prosthetics, emergency and non-emergency transportation and mental health clinic programs.
R.N.		Medicaid Program Analyst III. Establishes policy, monitors compliance, and provides liaison for home health services. Also, supervises the Utilization Review staff who have responsibility for performing on-site reviews for the Home Health Services Program.
R.N.		Medicaid Program Analyst II. Establishes policy, issues prior approvals and monitors compliance for Durable Medical Equipment and Orthotics & Prosthetics services.
R.N.	(UR)	Medicaid Program Analyst II. Performs utilization review for Home Health services. Reviews patient records and performs in-home assessments for compliance with state and federal regulations as well as for quality assurance.
R.N.		Medicaid Program Analyst I. Establishes policy, issues prior approvals and monitors compliance for Durable Medical Equipment and Orthotics & Prosthetics services.
Support:		Administrative Clerk. Prepares prior authorizations for review by the Program Analysts. Accesses information from computer terminals and researches microfiche/film to provide information as needed by Program Analysts or other Department staff. Responds both verbally and/or in writing to a large volume of provider inquiries regarding problems with program policies, billing procedures, claims and reimbursement.

TRANSMITTAL 91-32  
APPROVED 11-20-91  
EFFECTIVE 11-1-91  
SUPERSEDES 91-28

2 Senior Secretaries. Prepares memoranda, types correspondence, reports, forms, narratives and performs other related office tasks. Organizes and coordinates the clerical operation of the unit.

WAIVERED SERVICES SECTION

R.N.

Medicaid Program Analyst III. Establishes policy and monitors compliance of the Model Waiver Program Also, supervises the Utilization Review staff who have responsibility for performing on-site reviews for all programs in the Waivered Services Unit.

R.N. (UR)

5 Medicaid Program Analysts II. Utilizing professional judgement and appropriate criteria, conducts on-site utilization reviews for Model Waiver and Community Care Services Programs to determine compliance with state and federal regulations, medical necessity and quality of client services.

Support:

Senior Secretary. Prepares memoranda, types correspondence, reports, forms, narratives and performs other related office tasks. Organizes and coordinates the clerical operation of the unit.

DIVISION OF PROGRAM COMPLIANCE

UTILIZATION REVIEW SECTION

R.N.

Medicaid Policy Coordinator. Oversees all utilization review programs; serves as departmental liaison and expert on UR protocols for physicians and hospitals.

R.N.

Medicaid Program Analyst III. Supports technical development and enhancements on issues involving medical necessity and quality of care.

TRANSMITTAL 91-28  
APPROVED 10-3-91  
EFFECTIVE 7-1-91  
SUPERSEDES (NEW)

R.N. Medicaid Program Analysts II.  
Reviews complex hospital and physician  
billing, reviews medical records  
documentation and assesses medical  
necessity and quality of care  
of services provided in all Medicaid  
program areas.

Support: Principal Secretary  
Senior Secretary  
Administrative Clerk

DIVISION OF INSTITUTIONAL POLICY AND REIMBURSEMENT

HOSPITAL POLICY SECTION

R.N. Medicaid Program Analyst III.  
Establishes policy, monitors compliance,  
provides liaison for hospital  
services.

R.N. Medicaid Program Analysts II.  
Responsible for hospital utilization  
review.

Support: Senior Secretary

NURSING FACILITY POLICY SECTION

R.N. Medicaid Program Analyst III.  
Establishes policy, monitors compliance,  
provides liaison for nursing facility  
services.

R.N. Medicaid Program Analyst II.  
Responsible for nursing facility  
quality assurance and standards.

Support: Senior Secretary

SWING-BED, HOSPICE POLICY SECTION

R.N. Medicaid Program Analyst III.  
Establishes policy for hospice  
and swing-bed programs. Responsible  
for precertification program and  
out-of-state services.

Support: Administrative Clerk

TRANSMITTAL 91-32  
APPROVED 11-20-91  
EFFECTIVE 11-1-91  
SUPERSEDES 91-28

HEALTH CENTERS AND CLINICS

R.M.T.

Medicaid Program Analyst III.  
Establishes policy and determines  
rates for independent labs, rural  
health clinics, community health  
centers, dialysis centers and  
ambulatory surgical centers.  
Also, resolves provider and claims  
payment problems.

Support:

Senior Secretary

TRANSMITTAL 91-32  
APPROVED 11-20-91  
EFFECTIVE 11-1-91  
SUPERSEDES NEW

ELIGIBILITY DETERMINATION MADE BY STATE OR LOCAL STAFF OF AN AGENCY  
OTHER THAN DEPARTMENT OF MEDICAL ASSISTANCE

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The eligibility policy is developed by the Department of Medical Assistance and issued to the Department of Human Resources (DHR). Policy decisions are made based on Federal and state laws and Federal regulations. Eligibility determination is made through contract with the DHR. Local County Departments of Family and Children Services determine medical assistance eligibility for all non-SSI payment recipients. Determination for medical assistance eligibility is completed by eligibility caseworker staff in the local county Departments of Family and Children Services. These individuals involved in eligibility determinations also notify clients of initial eligibility and termination of medical assistance.

TRANSMITTAL 91-31  
APPROVED 12-18-91  
EFFECTIVE 10-1-91  
SUPERSEDES 78-5



Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: Georgia

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Citation  
42 CFR  
431.50 (b)  
AT-79-29

1.3 Statewide Operation

The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50.

- The plan is State administered.
- The plan is administered by the political subdivisions of the State and is mandatory on them.

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TN #78-5  
Supersedes  
TN #    

Approval Date 8/28/78

Effective Date 7/1/77

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: Georgia

<u>Citation</u> 42 CFR 431.12(b) AT-78-90	1.4	<u>State Medical Care Advisory Committee</u>  There is an advisory Committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.
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TN #75-7  
Supersedes  
TN # \_\_\_\_\_

Approval Date 12/30/75      Effective Date 9/29/75

Revision: HCFA-PM-94-3 MB  
 APRIL 1994  
 State/Territory: Georgia

Citation

1.5 Pediatric Immunization Program

1928 of  
 the Act

1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.
  - a. The State will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.
  - b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.
  - c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.
  - d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.
  - e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.
  - f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

Revision: HCFA-PM-94-3  
APRIL 1994  
State/Territory: Georgia

MB

Citation

- 1928 of the Act
2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.
  3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.
  4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:  
  
\_\_\_\_\_ State Medicaid Agency  
  
 X  State Public Health Agency

1.6 State Option for Managed Care

1932 of the Act  
(BBA 1997)

Georgia Better Health Care (GBHC) is the Primary Care Case Management (PCCM) program for the State of Georgia. This program matches Medicaid recipients to a primary care provider (PCP) who, through an on-going provider/patient relationship, will provide and coordinate all health care services, including referrals for necessary specialty services, and maintain 24-hour availability to members. Enrollment with a PCP in GBHC is mandatory for all Medicaid recipients with the exception of those recipients listed in 1.B. below. The objectives of this program are to improve access to medical care - particularly primary care services, enhance continuity of care through creation of a "medical home", and decrease cost through reduction of unnecessary medical services. Georgia Better Health Care operates as a statewide program. This proposed SPA will replace the current 1915(b) waiver program.

1. Assurances

- A. The State of Georgia assures that all requirements under 1932 and 1905(t), and 42 CFR part 438, as applicable, will be met for the Primary Care Case Management (PCCM) program, Georgia Better Health Care (GBHC).
- B. The State assures that the following populations will be exempt from enrollment in Georgia Better Health Care:
- (1) Individuals who meet the eligibility requirements for receipt of both Medicare and Medicaid ("dual eligibles")
  - (2) American Indians who are members of a Federally-recognized tribe, and
  - (3) Children under 19 years of age who:
    - (a) are eligible for SSI under Title XVI;
    - (b) are described in section 1902(e)(3) of Title XIX of the Social Security Act;
    - (c) are in foster care or other out-of-home placement;
    - (d) are receiving foster care or adoption assistance under part E of Title IV; or
    - (e) have, or at increased risk for, a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that generally required by children;
    - (f) are receiving services through a family-centered, community-based, coordinated care system receiving grant funds under section 501(a)(1)(D) of Title V (**Children's Medical Services**).

**Children's Medical Services**, administered by the Georgia Division of Public Health, provides comprehensive, coordinated, community-based, Title V services for children birth to 21 with chronic medical conditions. Medical eligibility includes, but is not limited to:

- |                      |                     |
|----------------------|---------------------|
| - burns              | - spina bifida      |
| - cardiac conditions | - cerebral palsy    |
| - cystic fibrosis    | - diabetes mellitus |
| - hearing disorders  | - vision disorders  |

TN No. 11-008  
Supersedes  
TN No. 02-006

Approval Date: 12-23-11

Effective Date: 11/18/11

## 9d

- craniofacial anomalies (including cleft lip/palate)
- gastrointestinal disorders
- neurological and neurosurgical conditions including epilepsy and hydrocephalus
- orthopedic and/or neuromuscular disorders (scoliosis)
- congenital or traumatic amputations of limbs

Identification for purposes of exemption will be accomplished by encounter and pharmacy claims analysis (high cost, high utilization, chronic disease diagnosis), recipient self-referral to Member Services or via referral by any provider or state agency on behalf of the recipient, new recipient questionnaire, and eligibility category. Upon confirmation of the child's exemption status, exclusion will be noted so the child will not be enrolled in Georgia Better Health Care. Upon notification that a GBHC enrolled child is in one of the excluded groups outlined above, that child will be disenrolled from GBHC with the appropriate exclusion code. Services for these children will not require prior authorization and emergency authorizations (EAs) will be provided for services rendered prior to the disenrollment date.

- (4) In addition to those listed in B. (1), (2), (3) above, the State of Georgia will exempt the following populations from enrollment in GBHC:
- (a) Residents of nursing homes, personal care homes or mental health hospitals or other domiciliary facilities;
  - (b) Right from the Start Medicaid mothers;
  - (c) Other recipients with short-term Medicaid enrollment; or
  - (d) Recipients who have other Third Party Liability (TPL) coverage

C. Enrollment in Georgia Better Health Care is mandatory for the following Medicaid recipients:

- (1) Low income Medicaid adults
- (2) Low income Medicaid-related adults
- (3) SOBRA children

SSI recipients age nineteen (19) and above

- D. Georgia Better Health Care is operational statewide. Individuals in every county have a choice of two (2) Georgia Better Health Care providers offering primary care case management services within their county of residence or adjacent counties. Potential enrollees and members will be required to select a PCP from a list or providers meeting this criterion. In rural areas, if only one PCCM group exists within the member service area, members will be given a choice between two providers within the PCCM group. If a selection is not made by the 15th of the month, the member will be assigned a primary care provider using the process outlined in section G below.
- E. Georgia Better Health Care members are permitted to disenroll with a PCP at any time with cause. (Cause may be, but is not limited to: members who need covered Medicaid services that are not provided by the PCP on moral or religious grounds, poor quality care, lack of access to covered services, lack of access to experienced providers, the enrollee moves out of the PCPs service area.) Members will be allowed to request a change in PCP during the first 90 days of enrollment and at least every 12 months thereafter without cause.
- F. Any GBHC member who is disenrolled from a PCP for any reason other than ineligibility for Medicaid will be immediately assigned to a different PCP using the process outlined in G below.

- G. Georgia Better Health Care uses a default enrollment in the event the member does not choose a provider. The State assures that default enrollment will be based on maintaining existing as well as historical provider/member relationships to the extent possible. Members are given the opportunity to choose a primary care provider. If a selection is not made, a provider is auto-assigned to the member using an algorithm that ensures historical usage, family history, sex, age and geographic proximity. Historical usage is defined as one paid claim within the last 18 months from a provider. If the claims history shows the member has prior history with a PCP, the member is assigned to that provider. If no history with a PCP exists, a search is done for a family member's history with a PCP for assignment. Lacking any historical or family history, members are assigned to PCPs using an algorithm based on age, sex, geographic proximity, and in a manner that equitably distributes members among qualified PCCMs available. Members are notified of the auto-assignment and provided with a list of providers within the member's service area. If unhappy with an auto-assigned provider, a member may contact Member Services within the first 90-day period to request a change.
- H. Potential enrollees and members are provided information for their service area, in an easily understood, comparative, chart-like format. The information explains: eligibility requirements and exclusions; provider and member rights and responsibilities; grievance, fair hearing and appeal procedures and timeframes; covered items and services; benefits that are not covered by Georgia Better Health Care; Primary Care Case Management benefits; cost sharing (if applicable); non-English languages of service area providers; how to obtain services not provided by the PCP (including referrals to specialists); and to the extent available, quality and performance indicators and member satisfaction information. This information will be available at enrollment, annually and on request. Member written materials will be available in English and Spanish and other prevalent languages identified within a service area. Primary language will be asked of members at the time of enrollment. Primary language and other languages spoken will be requested at the time of provider enrollment. Oral interpretive services for information in all languages can be obtained by calling the Customer Interaction Center. Providers will likewise be required to make written information available in the prevalent non-English language in its service area. Notification of how to access this information (regardless of format) will be available at enrollment locations, PCP offices, the State web site and other contacts as they are identified.
- I. Access to medically necessary emergency services shall not be restricted. Emergency care means covered inpatient and outpatient services furnished by a qualified provider that are necessary to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard. Treatment in emergency situations does not require prior authorization from the PCP or Georgia Better Health Care.
- J. Georgia Better Health Care began on a limited basis in 1993. Prior to expansion to a statewide program in 1998, and through subsequent changes, public comment, from both providers and recipients, has been considered in the program design and implementation. Because this SPA will not constitute a change in the program, public notice to members did not occur. This conversion to Managed Care under the Georgia State Plan will be seamless to our members. Comments and feedback were solicited from the GBHC Advisory Committee members whose representation includes practicing providers from throughout the state. We also on an ongoing basis collect member feedback from the GBHC member services unit. Public notice of fee changes are done pursuant to policy as mandated by O.C.G.A. 350-2-.08. In the future, GBHC will continue to utilize providers from the various physician advisory committees, recipients currently involved in NET advisory committees, staff liaisons to advocacy groups that include both providers and recipients, and member satisfaction surveys in the ongoing development of the GBHC program.

II. Methodology and Process

Georgia Better Health Care operates a statewide network of providers with sufficient capacity available to ensure convenient geographic access, choice, and minimum travel times. Once eligibility is determined, beneficiaries are mailed informational materials regarding Georgia Better Health Care. Included is a list of two or more primary care providers located geographically convenient to the recipient. Recipients have until the 15th of a month to make a PCP selection. If no choice is made, PCP assignment is completed through the auto-assignment process described in 1.G. above. Members have the opportunity to change their PCP within the first 90 days of enrollment or reenrollment and at least annually thereafter. Members may change PCP at any time with cause. Members have access to a toll-free number for Member Services to assist with PCP selection, PCP changes and access issues that may occur. Periodic surveys are done to assess member satisfaction including travel time to the primary care provider office and wait times for scheduled appointments.

III. Contracts With Primary Care Providers

The State assures that contracts with Primary Care Providers are in compliance with the terms required under section 1905(t)(3) and 42 CFR part 438. These are non-risk contracts. Georgia Better Health Care PCCM providers are reimbursed on a fee-for-service basis, according to the regular Medicaid fee schedule when they render care to a member. In addition, they are paid a monthly case management fee for each assigned Georgia Better Health Care member for the purpose of coordinating members' health care services.

- A. The following provider types may contract with the Georgia Better Health Care PCCM Program:
1. Physicians (doctors of medicine or osteopathy) practicing the following specialties: Family Practice, General Practice, Pediatrics, Internal Medicine and Gynecology
  2. Licensed and Certified Advance Nurse Practitioners (ARNPs) specializing in Family Practice, Pediatrics or Gynecology. Nurse Practitioners in independent practice must also have a current collaborative agreement with a licensed physician who has hospital admitting privileges
  3. Other entities including Rural Health Centers, Community Health Centers, Primary Care Public Health Department Clinics and Primary Care Hospital Outpatient Clinics.
  4. Physician specialists, public health departments, clinics and hospital outpatient clinics may enroll if they agree to meet the obligations of the PCP role, including the following conditions:
    1. Practice must routinely provide primary care services to a majority of its patients. Any exceptions to this requirement will be considered on a case-by-case basis for business need
    2. Any referrals for specialty care to other members of the same practice may be reviewed for appropriateness
    3. It is preferable that any specialist provider acting in a PCP capacity is willing to accept a minimum of fifty members to case manage.

In addition to the standard Medicaid provider agreement, all participating PCPs are required to complete an Application, Statement of Participation and an After-Hours Telephone Coverage & Provider Accessibility Agreement and successfully complete an on-site visit.



## B. By contractual agreement the PCP agrees to the following PCCM Scope of Services:

1. The PCP is ultimately responsible for managing the total care provided to GBHC members, serving as the linkage between members and the various services along the health care continuum.
2. The PCP must provide or arrange PCP coverage for services - including treatment for emergency medical conditions, consultation, or approval of referrals 24 hours a day, 7 days a week through access by telephone to a live voice.
3. The PCP must be available in the office to provide primary care services a minimum number of hours each week as specified in the current Part II. Policies and Procedures for Georgia Better Health Care Services.
4. The PCP may not refuse an assignment or disenroll a member or otherwise discriminate against a member on the basis of age, sex, race, color, national origin or an adverse change in the enrollee's health status or due to an enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs except when his or her continued enrollment seriously impairs the PCP's ability to furnish services to either that enrollee or other enrollees or when that illness or condition can be better treated by another provider type. The PCP may not use any policy or practice that has the effect of discriminating on the basis of age, sex, race, color, national origin or an adverse change in the enrollee's health status or due to an enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs except when his or her continued enrollment seriously impairs the PCP's ability to furnish services to either that enrollee or other enrollees or when that illness or condition can be better treated by another provider type.
5. The PCP must be able to manage elective hospitalizations for members in a manner that combines access to care with continuity. Therefore, a PCP must have hospital admitting privileges, or must have a formal arrangement with a physician who does have hospital admitting privileges and who agrees to abide by the established Georgia Better Health Care hospital authorization requirements.
6. Each PCP is required to specify the number of recipients the provider is willing to serve as primary care provider. Unless circumstances exist that require authorization of a greater number to ensure adequate coverage in an underserved area, the upper limit for a physician, NP, or PA will be as designated in Part II. Policies and Procedures for Georgia Better Health Care Services. There is no minimum requirement except as listed in III.A.4.3. above.
7. PCPs must restrict enrollment to recipients who reside sufficiently near one of the PCP's delivery sites to reach that site within a reasonable time using available and affordable modes of transportation.
8. The PCP must provide for arrangements with, or referrals to, sufficient numbers of physicians and other practitioners to ensure that services under the contract can be furnished to members promptly and without compromise to quality of care.

State: GEORGIA

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## SECTION 2 - COVERAGE AND ELIGIBILITY

Citation42 CFR  
435.10 and  
Subpart J2.1 Application, Determination of Eligibility and  
Furnishing Medicaid

- (a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

42 CFR  
435.930  
1902(e) (4)

Before a child loses eligibility as a newborn, an ex parte determination is made to determine continued eligibility under another Medicaid coverage. A new application is not required.

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 TN No. 91-31  
 Supersedes  
 TN No. 89-23

Approval Date 12-18-91

Effective Date 10-1-91

HCFA ID: 7982E

Revision: HCFA-PM-93-2 (MB)  
MARCH, 1993

State: GEORGIA

Citation

- |  |          |     |   |
|--|----------|-----|---|
| 42 CFR 435.914<br>1902(a) (34)<br>of the Act | 2.1(b)   | (1) | Except as provided in items 2.1(b) (2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in <u>ATTACHMENT 2.6-A</u> .   |
| 1902(e) (8) and<br>1905(a) of the Act        |          | (2) | For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under Section 1902(a)(a) (E) (i) of the Act, coverage is available for services furnished after the end of the month in which the individual is first: determined to be a qualified Medicare beneficiary. <u>ATTACHMENT 2.6-A</u> specifies the requirements for determination of eligibility for this group.           |
| 1902 (a) (47) and<br>1920 of the Act         | <u>X</u> | (3) | Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with Section 1920 of the Act. <u>ATTACHMENT 2.6-A</u> specifies the requirements for determination of eligibility for this group.  |
| 42 CFR 434.20                                |          | (c) | The Medicaid agency elects to enter into a risk contract with an HMO that is --<br><br><u>X</u> Qualified under Title XIII of the Public Health Service Act or is provisionally qualified as an HMO pursuant to Section 1903 (m) (3) of the Social Security Act.<br><br><u>X</u> Not Federally qualified, but meets the requirements of 42 CFR 434.20(c) and is defined in <u>ATTACHMENT 2.1-A</u> .<br><br>___ Not applicable. |

TN No. 94-027  
Supersedes  
TN. No. 93-10

Approval Date 8-24-94

Effective Date 7-01-94

Revision: HCFA-PM-91-6 (MB)  
September 1991

OMB No.

State/Territory: GEORGIA

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Citation

1902(a)(55) of the Act      2.1(d) The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in §1902(a) (10)(A) (i) (IV), (a)(10)(A) (i) (VI), (a) (10)(A)(i) (VII), and (a)(10)(A)(ii)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the ADFC form except as permitted by HCFA instructions.

Georgia has implemented Section 1902(a)(55) of the Act by outstationing workers or developing procedures to assure that applications are taken and clients assisted in completion of same at sites other than the county locations:

- In low usage areas, hospital staff have been trained to take applications and assist clients in completion of same. Additionally, posters have been placed in prominent places in these facilities and pamphlets have been placed in waiting areas. Local county eligibility workers are available on request by the facility;
- For areas in which health centers or hospitals and county welfare departments are located in adjacent buildings (or other close proximity), eligibility workers are on call on a daily basis. Additionally, facility staff have been trained in application procedures and will assist clients in the application process when county staff are not available (at night or weekends);
- Facility and local county department, by joint agreement, have scheduled county staff on-site at facility according to facility's identification of need and allocation of space.

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TN No. 91-30  
Supersedes  
TN No.: NEW

Approval Date: OCT 22 1992

Effective Date: JUL 1 1991  
HCFA ID: 7985E

State: Georgia

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Citation  
42 CFR  
435.102.2 Coverage and conditions of EligibilityMedicaid is available to the groups specified in  
ATTACHMENT 2.2-A.

- \_\_\_ Mandatory categorically needy and other required special groups only.
- \_\_\_ Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.
- \_\_\_ Mandatory categorically needy, other required special groups, and specified optional groups.
- X Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

\*All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A) (i) (IV), (V), and (VI), 1902(a) (10)(A)(ii)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.

\*Cite should include 1902(a)(10)(A)(i)(VII).

Georgia does not cover individuals described at 1902(a)(10)(A)(ii)(XI) and 1902(m).

Revision: HCFA-PM-87-4 (BERC)  
MARCH 1987

OMB No.: 0938-0193

State: Georgia

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Citation

435.10 and  
435.403, and  
1902(b) of the  
Act, P.L. 99-272  
(Section 9529)  
and P.L. 99-509  
(Section 9405)

2.3 Residence

Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.

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TN No. 87-6  
Supersedes  
TN No. 86-27

Approval Date: AUG 06 1987

Effective Date: APR 1 1987  
HCFA ID: 1006P/0010P

Revision: HCFA-PM-87-4 (BERC)  
MARCH 1987

OMB No.: 0938-0193

State: Georgia

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Citation

42 CFR 435.530(b)  
42 CFR 435.531  
AT-78-90  
AT-79-29

2.4 Blindness

All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.

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TN No. 87-6  
Supersedes  
TN No. 75-8

Approval Date: AUG 05 1987

Effective Date: APR 1 1987  
HCFA ID: 1006P/0010P

State: GeorgiaCitation42 CFR  
435.121,  
435.540(b)  
435.5412.5 Disability

All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.13.b. of Attachment 2.2-A of this plan.

The determination of disability completed by the Social Security Administration for Supplemental Security Income (SSI) individuals is accepted as establishing disability for Medicaid purposes for twelve (12) months following the month of termination from the SSI program when the termination is for other than disability reasons.



Revision: HCFA-PM-92-1 (MB)  
FEBRUARY 1992

State: Georgia

<u>Citation(s)</u>	2.6	<u>Financial Eligibility</u>
42 CFR 435.10 and Subparts G & H 1902(a) (10)(A)(i) (III), (IV), (V), (VI), and (VII), 1902(a) (10) (A)(ii) (IX), 1902 (a) (10) (A)(ii)(X), 1902 (a) (10) (C), 1902 (f), 1902 (l) and (m), 1905 (p) and (s), 1902(r)(2), and 1920		(a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in <u>ATTACHMENT 2.6-A</u> .

Georgia covers individuals and utilizes financial eligibility criteria described at 42 CFR 435 Subparts G and I; 1902(a)(10)(E); 1924 and 1925.

State/Territory: GeorgiaCitation      2.7      Medicaid Furnished Out of State431.52 and  
1902(b) of the  
Act, P.L. 99-272  
(Section 9529)Medicaid is furnished under the conditions  
specified in 42 CFR 431.52 to an eligible  
individual who is a resident of the State  
while the individual is in another State, to the  
same extent that Medicaid is furnished to residents  
in the State.

State/Territory: GEORGIA

## SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation3.1 Amount, Duration, and Scope of Services42 CFR  
Part 440,  
Subpart B  
1902(a), 1902(e),  
1905(a), 1905(p),  
1915, 1920, and  
1925 of the Act

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(1) Categorically needy.Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:1902(a) (10)(A) and  
1905 (a) of the Act

(i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905(a) (17) of the Act, as defined in 42 CFR 440.165 are provided to the extent that nurse-midwives are authorized to practice under State law or regulation. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

Not applicable. Nurse-midwives are not authorized to practice in this state.

State/Territory: GEORGIACitation3.1(a)(1) Amount Duration, and Scope of Services: Categorically  
Needy (Continued)1902(e) (5) of  
the Act

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

 (iv) Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.1902(a)(10),  
clause (VII)  
of the matter  
following (F) (VII)  
of the Act

(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a) (10)(A)(i)(IV) .and 1902(a)(10)(A)(ii) (IX) of the Act.

State/Territory: GEORGIACitation3.1(a)(1) Amount Duration and Scope of Services:  
Categorically Needy (Continued)1902 (a)(10)(D) of  
the Act

(vi) Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.

1902(e)(7) of  
the Act

(vii) Inpatient services that are being furnished to infants and children described in section 1902(1)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved state plan will continue until the end of the stay for which the inpatient services are furnished.

1902(e)(9) of the  
Act

(viii) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

1902(a)(52)  
and 1925 of the  
Act

(ix) Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifics all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

State/Territory: GEORGIA

Citation                      3.1 Amount, Duration, and Scope of Services (continued)

42 CFR Part 440,  
Subpart B

(a) (2) Medically needy.

This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

1902(a) (10)(C)(iv)  
of the Act  
42 CFR 440.220

(i) If services in an institution for mental diseases (42 CFR 440.140 and 440.160) or intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1) through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.

Not applicable with respect to nurse-midwife services under section 1902(a) (17). Nurse-midwives are not authorized to practice in this state.

1902(e) (5) of  
the Act

(ii) Prenatal care and delivery services for pregnant women.

State/Territory: GEORGIA

Citation

3.1(a)(2) **AMOUNT, DURATION AND SCOPE OF SERVICES  
MEDICALLY NEEDY (CONT'D)**

1902(A)(10)(C) of  
the Act

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

(iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.

Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

42 CFR 440.140,  
440.150, 440.160  
Subpart B,  
442.441,  
Subpart C  
1902(a)(20)  
and (21) of  
the Act

(vii) Services in an institution for mental diseases for individuals over age 65.

(viii) Services in an intermediate care facility for the mentally retarded.

(ix) Inpatient psychiatric services (Psychiatric Residential Treatment Facility) for individuals under age 21.

State/Territory: GEORGIA

Citation

3.1(a)(2)

Amount, Duration, and Scope of Services:  
Medically Needy (Continued)

1902(e) (9) of  
the Act

- (ix) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the1 additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.



Revision: HCFA-PM-97-3  
December 1997

(CMBO)

State Georgia

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Citation

3.1 Amount, Duration, and Cost of Services (continued)

<p>1902(a)(10)(E)(i) and clause (VIII) of the matter following (F), and 1905 (p)(3) of the Act</p>	(a)(3)	<p><u>Other Required Special Groups: Qualified Medicare Beneficiaries</u></p>	<p>Medicare cost sharing for qualified Medicare beneficiaries described in section 1905(p) of the Act is provided only as indicated in item 3.2 of this plan.</p>
<p>1902 (a)(10) (E)(ii) and 1905 (e) of the Act</p>	(a)(4)(i)	<p><u>Other Required Special Groups: Qualified Disabled and Working Individuals</u></p>	<p>Medicare Part A premiums for qualified disabled and working individuals described in section 1902 (a)(10) (E)(ii) of the Act are provided as indicated in item 3.2 of this plan.</p>
<p>1902(a)(10) (E) (iii) and 1905 (p) (3) (A) (ii) of the Act</p>	(ii)	<p><u>Other Required Special Groups: Specified Low-Income Medicare Beneficiaries</u></p>	<p>Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the Act are provided as indicated in item 3.2 of this plan.</p>
<p>1902(a)(10) (E)(iv)(I)1905(p)(3) (A)(ii), and 1933 of the Act</p>	(iii)	<p><u>Other Required Special Groups: Qualifying Individuals - 1</u></p>	<p>Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.</p>

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Supersedes  
TN NO. 93-010

Approval Date 6/16/98

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HCFA ID: 7982E

Revision: HCFA-PM-97-3  
December 1997

State Georgia

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1902(a)(10)  
(E)(iv)(II), 1905(p)(3)  
(A)(iv)(II), 1905(p)(3)  
the Act

(iv) Other Required Special Groups: Qualifying  
Individuals - 2

The portion of the amount of increase to the Medicare Part B premium attributable to the Home Health provisions for qualifying individuals described in 1902(A)(10)(E)(iv) (II) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

1925 of the  
Act

(a)(5) Other Required Special Groups: Families  
Receiving Extended Medicaid Benefits

Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

State/Territory: GEORGIACitation 3.1 Amount, Duration, and Scope of Services (Continued)Sec. 245A(h) (a)(6) Limited Coverage for Certain Aliens  
of theImmigration and  
Nationality Act

- (i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they--
  - (A) Are aged, blind, or disabled individuals as defined in section 1614(a)(1) of the Act;
  - (B) Are children under 18 years of age; or
  - (C) Are Cuban or Haitian entrants as defined In section 501(e) (1) and (2) (A) of P.L. 96-422 in effect on April 1, 1983.
- (ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3:1(a)(6)(i)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved state plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

State/Territory: GEORGIA

Citation

3.1 (a)(6) Amount, Duration, and scope of Services: Limited Coverage for Certain Aliens (continued)

1902(a) and 1903(v)  
of the Act

(iii) Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v) (3) of the Act.

1905(a)(9) of  
the Act

(a)(7) Homeless Individuals.

Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.

Presumptively Eligible Pregnant Women

1902(a) (47)  
and 1920 of  
the Act

(a)(8) Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.

42 CFR 441.55  
50 FR 43654  
1902(a) (43),  
1905(a)(4)(B).  
and 1905 (r) of  
the Act

(a)(9) EPSDT Services.

The Medicaid agency meets the requirements of sections 1902(a) (43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

State/Territory: GEORGIA

Citation 3.1(a)(9) Amount, Duration, and Scope of Services: EPSDT Services  
(continued)

42 CFR 441.60

The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.

42 CFR 440.240  
and 440.250

(a)(10) Comparability of Services

1902(a) and 1902  
(a) (10), 1902(a) (52),  
1903(v), 1915(g), and  
1925(b)(4) of the Act

Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915 and 1925 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:

- (i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.
- (ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those, made available to the medically needy.
- (iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group
- (iv) Additional coverage for pregnancy-related services and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

Revision: HCFA-AT-80-38  
May 22, 1980

(BPP)

State: GEORGIA

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Citation

42 CFR Part  
440, Subpart B  
42 CFR 441.15  
AT-78-90  
AT-80-34

3.1(b) Home health services are provided in accordance with the requirements of 42CFR 441.15.

(1) Home health services are provided to all categorically needy individuals 21 years of age or over.

(2) Home health services are provided to all categorically needy individuals under 21 years of age,

Yes

Not applicable. The state plan does not provide for skilled nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

Yes, to all

Yes, to individuals age 21 or over; SNF services are provided

Yes, to individuals under age 21; SNF services are provided

NO, SNF services are not provided

Not applicable; the medically needy are not included under this plan.

State/Territory: GEORGIA

Citation      3.1      Amount, Duration, and Scope of Services (continued)

42 CFR 431.53      (c) (1) Assurance of Transportation  
Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-D.

42 CFR 483.10      (c) (2) Payment for Nursing Facility Services  
The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8) (i).

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State Georgia

Citation  
42 CFR 440.260  
AT-78-90

3.1(d) Methods and Standards to Assure  
Quality of Services

The standards established and the  
methods used to assure high quality  
care are described in ATTACHMENT 3.1-C.



Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State Georgia

Citation  
42 CFR 441.20  
AT-78-90

3.1(e) Family Planning Services

The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

State/Territory: Georgia

Citation  
42 CFR 441.30  
AT-78-90

3.1 (f) (1) Optometric Services

Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

Yes.

No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

Not applicable. The conditions in the first sentence do not apply.

1903(i) (1)  
of the Act,  
P.L. 99-272  
(Section 9507)

(2) Organ Transplant Procedures

Organ transplant procedures are provided.

No.

Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.

State/Territory: Georgia

Citation  
42 CFR 431.110(b)  
AT-78-90

3.1(g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

1902 (e)(9) of  
the Act,  
P.L. 99-509  
(Section 9408)

(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902(e) (9)(C) of the Act, are provided under the plan to individuals who—

- (1) Are medically dependent on a ventilator for life support at least six hours per day;
- (2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of--
  - 30 consecutive days;
  - \_\_\_\_ days (the maximum number of inpatient days allowed under the State plan);
- (3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;
- (4) Have adequate social support services to be cared for at home; and
- (5) wish to be cared for at home.

Yes. The requirements of section 1902(e)(9) of the Act are met.

Not applicable. These services are not included in the plan.

Revision: HCFA-PM-93-2  
MARCH 1993

State Georgia

Citation 3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902(a) (10) (E) (i) and  
1905(p)(1) of the Act

(i) Qualified Medicare Beneficiary  
(QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, by the following method:

Group premium payment arrangement for Part A

Buy-In agreement for

Part A  Part B

The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

Revision: HCFA-PM-97-3  
December 1997

State: GEORGIA

Citation

- 1902(a)(10)(E)(ii)  
And 1905 (s) of the Act
- (ii) Qualified Disabled and Working Individual (QDWI)
- The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in Attachment 4.18-E, for individuals in the QDWI group defined in item A.26 of Attachment 2.2-A of this plan.
- 1902(a)(10)(E)(iii)  
And 1905(p)(3)(A)(ii)  
of the Act
- (iii) Specified Low-Income Medicare Beneficiary (SLMB)
- The Medicaid agency pays Medicare part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of Attachment 2.2-A of this plan.
- 1902(a)(10)(E)(iv)(I),  
1905(p)(3)(A)(ii), and  
1933 of the Act
- (iv) Qualifying Individual-1 (Q1-1)
- The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902 (a) (10) (E) (iv) (I) and subject to 1933 of the Act.

State GeorgiaCitation

1843(b) and 1905 (a)  
of the Act and  
42 CFR 431.025

(vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI), b) receiving state supplements under title XVI; or c) withing a group listed at 42 CFR 431.625(d)(2).

Individuals receiving title II or Railroad Retirement benefits.

Medically needy individuals (FFP is not available for this group).

1902(a)(30)  
and 1905(a)  
of the Act

## (2) Other Health Insurance

The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B),

Revision: HCFA-PM-93-2 (MB)  
MARCH 1993

State Georgia

Citation

(b) Deductibles/Coinsurance

(1) Medicare Part A and B

1902 (a) (30), 1902 (n),  
1905(a), and 1916 of the  
Act

Supplement 1 to ATTACHMENT 4.19-B  
describes the methods and standards for establishing  
payment rates for services covered under Medicare,  
and/or the methodology for payment of Medicare  
deductible and coinsurance amounts, to the extent  
available for each of the following groups.

Sections 1902  
(a)(10)(E)(i) and  
1905(p)(3) of the Act

(i) Qualified Medicare Beneficiaries (QMBS)  
The Medicaid agency pays Medicare Part A and Part  
B deductible and coinsurance amounts for QMBS  
(subject to any nominal Medicaid copayment) for  
all services available under Medicare.

1902(a)(10), 1902(a)(30),  
and 1905(a) of the Act

(ii) Other Medicaid Recipients  
The Medicaid agency pays for Medicaid services  
also covered under Medicare and furnished to  
recipients entitled to Medicare (subject to any  
nominal Medicaid copayment): For services  
furnished to individuals who are described in  
section 3.2(a)(1)(iv), payment is made as follows:

\_\_\_ For the entire range of available under  
Medicare Part B.

X Only for the amount, duration, and scope of  
services otherwise available under this plan.

42 CFR 431.625

(iii) Dual Eligible--QMB plus

1902(a)(10), 1902(a)(30),  
1905(a), and 1905(p)  
of the Act

The Medicaid agency pays Medicare Part A and  
Part B deductible and coinsurance amounts for  
all services available under Medicare and pays  
for all Medicaid services furnished to individuals  
eligible both as QMBs and categorically or  
medically needy (subject to any nominal  
Medicaid copayment).

TN. No: 93-010

Supersedes

TN. No: 92-34

Approval Date MAY 7 1993

Effective Date JAN 1 1993

**Additional State Plan Option for Providing Premium Assistance  
CHIP Medicaid**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

**Medical Assistance Program**

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Condition	Citation Condition or Requirement
1906 of the Act	<p><u>(c) Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations</u></p> <p>The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans.</p> <p>When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h).</p>
1906A of the Act	<p><u>(c)-1 <input checked="" type="checkbox"/> Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations</u></p> <p>The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan, as specified in the qualified employer-sponsored coverage, without regard to limitations specified in section 1916 or section 1916A of the Act, for eligible individuals under age 19 who have access to and elect to enroll in such coverage. The eligible individual is entitled to services covered by the State plan which are not included in the employer-sponsored coverage. For qualified employer-sponsored coverage, the employer must contribute at least 40 percent of the premium cost.</p>

TN. No: 10-017

Supersedes

TN. No: 94-009

Approval Date 3-11-11

Effective Date 11-1-10



**Additional State Plan Option for Providing Premium Assistance  
CHIP Medicaid**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

**Medical Assistance Program**

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Condition	Citation Condition or Requirement
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When coverage for eligible family members under age 19 is not possible unless an ineligible parent enrolls, the Medicaid agency pays premiums for enrollment of the ineligible parent, and, at the parent's option, other ineligible family members. The agency also pays deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan for the ineligible parent.

1902(a)(10)(F) of

(d) \_\_\_\_ The Medicaid agency pays premiums for individuals the Act described in item 19 of Attachment 2.2-A.

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TN No.: 10-017

Supersedes  
TN No. NEW

Approval Date 3-11-11

Effective Date 11-1-10

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State Georgia

Citation  
42 CFR 441.101,  
42 CFR 431.620 (c)  
and (d)  
AT-79-29

3.3 Medicaid for Individuals Age 65 or over in Institutions for  
Mental Diseases

Medicaid is provided for individuals 65 years of age or older  
who are patients in institutions for mental diseases.

Yes. The requirements of 42 CFR Part 441,  
Subpart C, and 42 CFR 431.620(c) and (d) are  
met.

Not applicable. Medicaid is not provided to aged  
individuals in such institutions under this plan.

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State Georgia

Citation  
42 CFR 441.252  
AT-78-99

3.4 Special Requirements Applicable to Sterilization Procedures

All requirements of 42 CFR Part 441, Subpart F are met.

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TN. # 79-1  
Supersedes  
TN # \_\_\_\_\_

Approval Date 5/1/79

Effective Date 3/8/79

State GEORGIACitation1902(a) (52)  
and 1925 of  
the Act3.5 Families Receiving Extended Medicaid Benefits

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are--

Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Medical or remedial care provided by licensed practitioners.

Home health services.

State GEORGIACitation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

- Private duty nursing services.
- Physical therapy and related services.
- Other diagnostic, screening, preventive, and rehabilitation services.
- Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.
- Intermediate care facility services for the mentally retarded.
- Inpatient psychiatric services for individuals under age 21.
- Hospice services.
- Respiratory care services.
- Any other medical care and any other type of remedial care recognized under state law and specified by the Secretary.

State GEORGIACitation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

(c)  The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance—

1st 6 months                       2nd 6 months

The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

1st 6 mos.                               2nd 6 mos.

(d)  (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

Enrollment in the family option of an employer's health plan.

Enrollment in the family option of a State employee health plan.

Enrollment in the state health plan for the uninsured.

Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

State GEORGIACitation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).



(ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

Revision: HCFA-PM-87-4 (BERC)  
March 1987

OMB No.: 0938-0193

State/Territory: Georgia

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation  
42 CFR 431.15  
AT-79-29

4.1 Methods of Administration

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

TN No. 87-6  
Supersedes  
TN No. 75-7

Approval Date AUG 06 1987

Effective Date APR 1 1987

HCFA ID: 1010P/0012P



Revision: HCFA-PM-87-4 (BERC)  
March 1987

OMB No.: 0938-0193

State Georgia

Citation            4.2 Hearings for Applicants and Recipients

42 CFR 431.202

AT-79-29

AT-80-34

The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

TN No. 75-7  
Supersedes  
TN No.

Approval Date    12/30/75

Effective Date 1/1/74

State/Territory: Georgia

Citation  
42 CFR 431.301  
AT-79-29

4.3 Safeguarding Information on Applicants and Recipients

Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

52 FR 5967

All other requirements of 42 CFR Part 431, Subpart F are met.

State/Territory: Georgia

<b>Citation</b>	<b>4.4 Medicaid Quality Control</b>
<b>42 CFR .431.800(c) 50 FR 21839 1903(u)(1)(D) of the Act, P.L. 99-509 (Section 9407)</b>	<p>(a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.</p> <p>(b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h), (j), and (k).</p> <p><u>  X  </u> Yes.</p> <p><u>      </u> Not applicable. The state has an approved Medicaid Management Information System (MMIS).</p>

State/Territory: Georgia

Citation 4.5 Medicaid Agency Fraud Detection and Investigation Program

**42 CFR 455.12  
AT-78-90  
48 FR 3742  
52 FR 48817**

**The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.**



New HCFA-PM-99-3 (CMSO)  
JUNE 1999

State GA.

<b>Citation</b>	<b>4.5a Medicaid Agency Fraud Detection and Investigation Program</b>
<b>Section 1902(a)(64) of the Social Security Act PL 105-33</b>	The Medicaid agency has established a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title.

TN No. 99-016  
Supersedes  
TN No. New

Approval Date Nov 17 1999

Effective Date JUL 01 1999

**GENERAL PROGRAM ADMINISTRATION**

## 4.5 Medicaid Recovery Audit Contractor Program

<p>Citation Section 1902(a)(42)(B)(i) of the Social Security Act</p>	<p><u>      </u> The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan.</p> <p><u>XXX</u> The State is seeking an exception to establishing such program for the following reasons: The State will establish on or by April 1, 2012 one or more Medicaid Recovery Audit Contractors.</p>
<p>Section 1902(a)(42)(B)(ii)(I) of the Act</p>	<p><u>      </u> The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute, RACs are consistent with the statute.</p> <p>Place a check mark to provide assurance of the following:</p> <p><u>XXX</u> The State will make payments to the RAC(s) only from amounts recovered.</p> <p><u>  X  </u> The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.</p>

**GENERAL PROGRAM ADMINISTRATION**

**4.5 Medicaid Recovery Audit Contractor Program**

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**Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act**

**The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee):**

**XX The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.**

**\_\_\_ The State attests that the contingency fee paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.**

**\_\_\_ The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.**

**Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act**

**The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):**

**XX The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as**

**GENERAL PROGRAM ADMINISTRATION**

**4.5 Medicaid Recovery Audit Contractor Program**

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**published in the Federal Register.**

**Section 1902  
(a)(42)(B)(ii)(III)  
of the Act**

**XXX The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).**

**Section 1902  
(a)(42)(B)(ii)(IV)(aa)  
of the Act**

**XXX The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.**

**Section 1902(a)(42)(B)(ii)(IV)(bb) of  
the Act**

**XXX The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.**

**Section 1902 (a)(42)(B)(ii)(IV)(cc) Of  
the Act**

**XXX Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.**

**§ 455.508(f), we prescribe a maximum look back period of 3 years from the date of the claim. The state is asking for an exception to this look back period, we would like for it to mirror our state policy of 5 year record retention.**



Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State Georgia

Citation  
42 CFR 431.16  
AT-79-29

4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

TN # 77-11  
Supersedes:  
TN # \_\_\_\_\_

Approval Date: 2/23/78

Effective Date: 10/1/77

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State Georgia

Citation  
42 CFR 431.17  
AT-79-29

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements, All requirements of 42 CFR 431.17 are met.

TN # 77-11  
Supersedes:  
TN # \_\_\_\_\_

Approval Date: 2/23/78

Effective Date: 10/1/77

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State Georgia

Citation  
42 CFR 431.18 (b)  
AT-79-29

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

TN # 75-7  
Supersedes:  
TN # \_\_\_\_\_

Approval Date: 12/30/75

Effective Date: 1/1/74

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State Georgia

Citation  
42 CFR 433.37  
AT-78-90

4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

TN # 75-7  
Supersedes:  
TN # \_\_\_\_\_

Approval Date: 12/30/75

Effective Date: 1/1/74

Revision: HCFA-PM-99-3 (CMSO)  
JUNE 1999

State: Georgia

<u>Citation</u>	<b>4.10 <u>Free Choice of Providers</u></b>
<p><b>42 CFR431 51 AT-78-90 46 FR 48524 48 FR23212 1902 (a) (23) of the Act P.L. 100-93 (section 8(f)) P.L. 100-203 (Section 4113)</b></p>	<p>(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.</p> <p>(b) Paragraph (a) does not apply to services furnished to an Individual—</p> <p>(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or</p> <p>(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or</p> <p>(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act, or</p> <p>(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services.</p> <p>(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1915(b)(1), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency Services or services under section 1905(a)(4)(c).</p>
<p><b>Section 1902(a)(23) of the Social Security Act P.L. 105-33</b></p>	

TN No. 99-016  
Supersedes:  
TN No. 92-09

Approval Date: Nov 17, 1999

Effective Date: July 1, 1999

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: Georgia

<u>Citation</u>	<b>4.11 <u>Relations with Standard-Setting and Survey Agencies</u></b>
<b>42 CFR 431.610 AT-78-90 AT-80-34</b>	<p>(a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is <u>Georgia Department of Human Resources</u></p> <p>(b) The State authority (ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): <u>Georgia Department of Human Resources</u></p> <p>(c) <u>ATTACHMENT 4.11-A</u> describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.</p>

TN # 75-7  
Supersedes:  
TN # \_\_\_\_\_

Approval Date: 12/30/75

Effective Date: 1/1/74

Revision: HCFA-AT-80-38 (BPP)  
 May 22, 1980

State: Georgia

<u>Citation</u>	<b>4.11(d) <u>The Standards and Licensure Unit</u></b>
<b>42 CFR 431.610</b> <b>AT-78-90</b> <b>AT-89-34</b>	<u>Office of Regulatory Services Division of Administrative Services Georgia Department of Human Resources (agency)</u> which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR. 431.610(e), (f) and (g) are met.

TN: 88-3  
 Supersedes TN 75-7  
 Date of receipt 3/11/88

TRANSMITTAL 88-3  
 APPROVED 3-23-88  
 EFFECTIVE 1-1-88

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: Georgia

Citation  
CFR 431. 105 (b)  
AT-78-90

4.12 Consultation to Medical Facilities

- (a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities; home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).
- (b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105 (b).

- Yes, as listed below:
- Not applicable. Similar services are not provided to other types of medical facilities.

TN # 75-7  
Supersedes:  
TN # \_\_\_\_\_

Approval Date: 12/30/75

Effective Date: 1/1/74



State/Territory: GEORGIACitation4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

- |                                       |                                     |  |
|---------------------------------------|-------------------------------------|--|
| 42 CFR 431.107                        | (a)                                 | For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.   |
| 42 CFR Part 483<br>1919 of the<br>Act | (b)                                 | For providers of NF services, the requirements of 42 CFR Part 483., Subpart B, and section 1919 of the Act are also met.   |
| 42 CFR Part 483,<br>Subpart D         | (c)                                 | For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.  |
| 1920 of the Act                       | (d)                                 | For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met. |
|                                       | <input checked="" type="checkbox"/> | Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.  |

State/Territory: GEORGIACitation

1902(a)(58)

1902(w)

4.13

(e)

For each provider receiving funds under the plan, all the requirements for advance directives of section 1902 (w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, health maintenance organizations and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether

State/Territory: GEORGIA

statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Health maintenance organizations at the time of enrollment of the individual with the organization.

(3) Attachment 4.34A describes law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives.

\_\_\_\_\_ Not applicable. No State law or court decision exist regarding advance directives.

Revision: HCFA-PM-91-10 (MB)  
December 1991

State/Territory: GEORGIA

<u>Citation</u>	<u>4.14 Utilization/Quality Control</u>
42 CFR 431.60 42 CFR 456.2 50 FR 15312 <b>1902 (a) (30) (C) and 1902 (d) of the Act, P.L. 99-509 (Section 9431)</b>	<p>(a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:</p> <p><u>  X  </u> Directly</p> <p><u>  X  </u> By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO—</p> <p>(1) Meets the requirements of §434.6(a);</p> <p>(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;</p> <p>(3) Identifies the services and providers subject to PRO review;</p> <p>(4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and</p> <p>(5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.</p> <p><u>      </u> Quality review requirements described in section 1902(a)(30) (C) of the Act relating to services furnished by HMOs under contract are undertaken through contract with the PRO designed under 42 CFR Part 462.</p> <p><u>      </u> By undertaking quality review of services furnished under each contract with an HMO through a private accreditation body.</p>
<b>1902(a) (30) (C) and 1902(d) of the Act, P.L. 99-509 (section 9431)</b>	

TN No. 92-09  
Supersedes:  
TN No. 88-26

Approval Date: 4-7-92

Effective Date: 1-1-92

Revision: HCFA-PM-85-3 (BERC)  
MAY 1985

State: Georgia

OMB NO. 0938-0193

Citation  
42 CFR 456.2  
50 FR 15312

4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

Utilization and medical review are performed by & Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

All hospitals (other than mental hospitals).

Those specified in the waiver.

No waivers have been granted.

TN No. 85-20  
Supersedes:  
TN No. 75-7

Approval Date: 8-15-85

Effective Date: 7-1-85  
HCFA ID: 0048P/0002P

STATE/Territory: GeorgiaCitation42 CFR 456.2  
50 FR 15312

- 4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental health hospitals.
- Utilization and medical review are performed by & Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.
  - Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:
    - All mental hospitals
    - Those specified in the waiver.
  - No waivers have been granted.
  - Not applicable, Inpatient services in mental hospitals are not provided under this plan.

Revision: HCFA-PM-85-3 (BERC)  
May 1985

State: Georgia

OMB No.: 0938-0193

Citation  
42 CFR 456.2  
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

All skilled nursing facilities.

Those specified in the waiver.

No waivers have been granted.

TN No. 85-20  
Supersedes:  
TN No. 75-7

Approval Date: 8-15-85

Effective Date: 7-1-85

Revision: HCFA-PM-85-3 (BERC)  
May 1985

State: Georgia

OMB No.: 0938-0193

Citation  
42 CFR 456.2  
50 FR 15312

4.14

(e)

The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

Facility-based review.

Direct review by personnel of the medical assistance unit of the State agency.

Personnel under contract to the medical assistance unit of the State agency.

Utilization and Quality Control Peer Review Organizations.

Another method as described in ATTACHMENT 4.14-A.

Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

Not applicable. Intermediate care facility services are not provided under this plan.

TN No. 85-20  
Supersedes:  
TN No. 75-7

Approval Date: 8-15-85

Effective Date: 7-1-85  
HCFA ID: 0048P/0002P



Revision: HCFA-PM-91-10 (MB)  
December 1991

State: Georgia

<u>Citation</u>	<b>4.14 Utilization/Quality Control (Continued)</b>
<b>1902(a) (30) and 1902 (d) of the Act, P.L. 99-509 (Section 9431) P.L. 99-203 (section 4113)</b>	<p>(f) The Medicaid agency meets the requirements of section 1902(a) (30) of section 1902(a) (30) of the Act for control of the assurance of quality furnished by each health maintenance organization under contract with the Medicaid agency. Independent, external quality reviews are performed annually by:</p> <p>_____ A Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.</p> <p>_____ A private accreditation body.</p> <p>_____ An entity that meets the requirements of the Act, as determined by the Secretary.</p> <p>The Medicaid agency certifies that the entity in the preceding subcategory under 4.14(f) is not an agency of the State.</p>

Revision: HCFA-PM-92-2 (BERC)  
1992

STATE/Territory: Georgia

<u>Citation</u>	<b>4.15 <u>Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21(Psychiatric Residential Treatment Facilities) and Mental Hospitals</u></b>
<b>42 CFR Part to 456 Subpart 1 and 1902(a)(31) and 1903(g) of the Act</b>	<p><input checked="" type="checkbox"/> The State has contracted with a Peer Review Organization (PRO) perform inspection of care for:</p> <p><input checked="" type="checkbox"/> ICFs/MR;</p> <p><input checked="" type="checkbox"/> Inpatient psychiatric facilities for recipients under age 21(Psychiatric Residential Treatment Facilities); And</p> <p><input type="checkbox"/> Mental Hospitals.</p>
<b>42 CFR Part met 456 Subpart A And 1902(a)(30) Of the Act</b>	<p><input checked="" type="checkbox"/> All applicable requirements of 42 CFR Part 456, Subpart I, are with respect to periodic inspection of care and services.</p> <p><input type="checkbox"/> Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.</p> <p><input checked="" type="checkbox"/> Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.</p> <p><input type="checkbox"/> Not applicable with respect to inpatient psychiatric services for individuals under age 21(Psychiatric Residential Treatment Facilities); such services are not provided under this plan.</p>

TN No. 06-015  
Supersedes:  
TN No. 92-14

Approval Date: 02/28/07

Effective Date: 01/01/07

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: Georgia

Citation  
42 CFR 431.615(c)  
AT-78-90

4.16 Relations with State Health and Vocational  
Rehabilitation Agencies and Title V  
Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

TN # 76-7  
Supersedes:  
TN # \_\_\_\_\_

Approval Date: 11/4/76

Effective Date: 7/29/76

Revision: HCFA-PM-95-3 (MB)  
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **GEORGIA**

Citation

42 CFR 433.36(c)  
1902 (a) (18) and  
1917 (a) and (b) of  
the Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

\_\_\_\_\_ The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36(c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

X The State imposes liens on real property on account of benefits incorrectly paid.

X The State imposes TEFRA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (Note: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedure, and due process requirements.)

X The State imposes liens on both real and personal property of an individual after the individual's death.

TN No. 06-012  
Supersedes:  
TN No. 04-012

Approval Date: 11/08/06

Effective Date: 07/01/06

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **GEORGIA**(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36 (h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

- (1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.
  - Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.
- (2) The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917 (a)(1)(B) (even if it does not impose those liens).
- (3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.
  - In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State Plan as listed below:
  - Recovers for all approved medical assistance, for Medicaid recipients age 55 and over, except for Medicare cost sharing as specified at 4.17(b)(3 - Continued).

Revision: HCFA-PM-95-3 (MB)  
May 1995

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **GEORGIA**

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4.17 (b) Adjustments or Recoveries

(3) (Continued)

## Limitations on Estate Recovery - Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB plus full Medicaid, SLMB plus full Medicaid. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.

TN No. 10-018  
Supersedes:

Approval Date: 03-16-11Effective Date: 10/1/10TN No. NEW

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT****State: Georgia**

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1917(b)1(C)	(4)	<u>X</u>	If an individual covered under a long-term care insurance policy received benefits for which assets or resources were disregarded as provided for in Supplement 8c Attachment 2.6-A, (State Long-Term Care Insurance Partnership), the State does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.
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## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **GEORGIA**(c) **Adjustments or Recoveries: Limitations**

The State complies with the requirements or section 1917(b)(2) of the Act and regulations at 42 CFR §433.36(h)-(i).

- (1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind or disabled.
- (2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:
  - (a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or
  - (b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who established to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.
- (3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.



## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **GEORGIA**(d) Attachment 4.17-A

- (1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).
- (2) Specifies the criteria by which a son or daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).
- (3) Defines the following terms:
  - Estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),
  - Individual's home,
  - Equity interest in the home,
  - Residing in the home for at least 1 or 2 years,
  - On a continuous basis,
  - Discharge from the medical institution and return home, and
  - Lawfully residing.

Revision: HCFA-PM-95-3  
May 1995

(MB)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **GEORGIA**

- (4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.
- (5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and included methodology or thresholds used to determine cost-effectiveness.
- (6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedure, and the time frames involved.

TN No. 04-012  
Supersedes  
TN No. New

Approval Date 07/07/05

Effective Date: 10/01/04

Revision: HCFA-PM-91-4  
AUGUST 1991

(BPD)

OMB NO.: 0938-

State/Territory: GEORGIA

Citation 4.18 Recipient Cost Sharing and similar Charges

42 CFR 447.51  
through 447.58

1916 (a) and (b)  
of the Act

(a) Unless a waiver under 42 CFR 431.55 (g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

(b) Except as specified in items 4.18 (b) (4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905 (p) (1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

\_\_\_ Age 19

\_\_\_ Age 20

X Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

Revision: HCFA-PM-91-4  
AUGUST 1991

(BPD)

OMB NO.: 0938-

State/Territory: GEORGIA

Citation

4.18 (b) (2) (Continued)

42 CFR 447.51  
through  
447.58

- (iii) All services furnished to pregnant women.
- [ ] Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.
- (iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his or her income required for personal needs.
- (v) Emergency services if the services meet the requirements in 42 CFR 447.53 (b) (4).
- (vi) Family planning services and supplies furnished to individuals of childbearing age.
- (vii) Services furnished by a health maintenance organization in which the individual is enrolled.  
1916 of the Act,
- (viii) Services furnished to an P.L. 99-Individual receiving hospice care, as defined in section 1905 (o) of the Act.

P.L. 99-272  
(Section 9505)

Revision: HCFA-PM-91-4  
AUGUST 1991

(BPD)

OMB NO.: 0938-

State/Territory: GEORGIA

Citation

4.18 (b) (Continued)

42 CFR 447.51  
Through  
447.48

(3) Unless a waiver under 42 CFR 431.55 (g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b) (2) above.

Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

18 or older

19 or older

20 or older

21 or older

Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

Revision: HCFA-PM-91-4 (BPD) OMB NO.: 0938-  
AUGUST 1991

State/Territory: GEORGIA

Citation

4.18 (b) (3) (Continued)

42 CFR 447.51  
through 447.58

- (iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:
- (A) Service (s) for which a charge(s) is applied;
  - (B) Nature of the charge imposed on each service;
  - (C) Amount (s) of and basis for determining the charge (s);
  - (D) Method used to collect the charge (s) ;
  - (E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;
  - (F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53 (b); and
  - (G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

Not applicable. There is no maximum.

Revision: HCFA-PM-91-4  
AUGUST 1991

(BPD)

OMB NO.: 0938-

State/Territory: GEORGIACitation


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1916 (c) of the Act	4.18 (b) (4) <input type="checkbox"/>	A monthly premium is imposed on pregnant women and infants who are covered under section 1902 (a) (10) (A) (ii) (IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916 (c) of the Act are met. <u>ATTACHMENT 4.18-D</u> specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.
1902 (a) (52) and 1925 (b) of the Act	4.18 (b) (5) <input type="checkbox"/>	For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925 (b) (4) and (5) of the Act.
1916 (d) of the Act	4.18 (b) (6) <input type="checkbox"/>	A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902 (a) (10) (E) (ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. <u>ATTACHMENT 4.18-E</u> specifies the method and standards the State uses for determining the premium.

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Revision: HCFA-PM-91-4  
AUGUST 1991

(BPD)

OMB NO.: 0938-

State/Territory: GEORGIA

Citation

- 42 CFR 447.51 through 447.58
- 4.18 (c)  Individuals are covered as medically needy under the plan.
- (1)  An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52 (b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.
- 447.51 through 447.58 (2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:
- (i) Services to individuals under age 18, or under--
- Age 19
  - Age 20
  - Age 21
- Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:



State/Territory: GEORGIA

Citation

4.18 (c) (2) (Continued)

42 CFR 447.51  
Through  
447.58

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy

(iii) All services furnished to pregnant women.

Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53 (b) (4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

1916 of the Act,  
P.L. 99-272  
(Section 9505)

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905 (o) of the Act.

447.51 through  
447.58

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

Not applicable. No such charges are imposed.

Revision: HCFA-PM-91-4  
AUGUST 1991

(BPD)

OMB NO.: 0938-

State/Territory: GEORGIA

Citation

4.18 (c) (3) Unless a waiver under 42 CFR 431.55 (g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b) (2) above.

Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

18 or older

19 or older

20 or older

21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable:

Revision: HCFA-PM-91-4 (BPD) OMB NO.: 0938-  
AUGUST 1991

State/Territory: GEORGIA

Citation

4.18 (c) (3) (Continued)

447.51 through  
447.58

- (iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:
- (A) Service (s) for which charge (s) is applied;
  - (B) Nature of the charge imposed on each service;
  - (C) Amount (s) of and basis for determining the charge (s);
  - (D) Method used to collect the charge (s);
  - (E) Basis for determining whether an individual is unable to pay the charge (s) and the means by which such an individual is identified to providers;
  - (F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53 (b); and
  - (G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

Not applicable. There is no maximum.

Revision: HCFA-PM-91-4  
AUGUST 1991

(BPD)

OMB NO.: 0938-

State/Territory: GEORGIA

Citation 4.19 Payment for Services

42 CFR 447.252  
1902(a)(13)  
and 1923 of  
the Act

(a) The Medicaid agency meets the requirements of  
42 CFR Part 447, Subpart C, and sections  
1902(a)(13) and 1923 of the Act with respect to  
payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and  
standards used to determine rates for payment for  
inpatient hospital services.

Inappropriate level of care days are covered and  
are paid under the state plan at lower rates than  
other inpatient hospital services, reflecting the  
level of care actually received, in a manner  
consistent with section 1861 (v) (1) (G) of the Act.

Inappropriate level of care days are not covered.

Revision: HCFA-PM-91-4  
AUGUST 1991

(BPD)

OMB NO.: 0938-

State/Territory: GEORGIA

Citation  
42 CFR 447.201  
42 CFR 447.302  
52 FR 28648  
1902(a)(13)(E)  
1903(a)(l) and  
(n), 1920, and  
1926 of the Act

4.19(b)

In addition the services specified in paragraph 4.19 (a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements:

- (1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905 (a)(2) (c) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).
- (2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.

ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State GEORGIA

Citation  
42 CFR 447.40  
AT-78-90

4.19 (c) Payment is made to reserve a bed during  
a recipient's temporary absence from an  
inpatient facility.

Yes. The state's policy is  
described in ATTACHMENT 4.19-C.

No.

TN # 77-13  
Supersedes  
TN # \_\_\_\_\_

Approval Date 3/28/78

Effective Date: 9/16/77

Revision:  
0193

HCFA-PM-87-9

(BERC)

OMB No.:

0938-

MARCH, 1993

State: GEORGIA

Citation  
42 CFR 447.252  
47 FR 47964  
48 FR 56046  
42 CFR 447.280  
47 FR 31518  
52 FR 28141

4.19 (d)

X (1)

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

(2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

\_\_\_ At the average rate per patient day paid to SNFS for routine services furnished during the previous calendar year.

X At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart c, as applicable.

\_\_\_ Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

(3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

\_\_\_ At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

X At a rate established by the state, which meets the requirements of 42 CFR Part 447, Subpart c, as applicable.

\_\_\_ Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

\_\_\_ (4) Section 4.19(d) (1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this state Plan.

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: GEORGIA

Citation  
42 CFR 447.45 (c)  
AT-79-50

4.19 (e) The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims.

ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

TN # 79-7  
Supersedes  
TN # \_\_\_\_\_

Approval Date 11/6/79

Effective Date: 9/30/79



Revision: HCFA-PM-87-4 (BERC)  
March 1987

OMB NO.:0938-0193

State: GEORGIA

Citation  
42 CFR 447.15  
AT-78-90  
AT-80-34  
48 FR 5730

4.19 (f) The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15.

No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

TN No. 87-6  
Supersedes  
TN No. ?

Approval Date Aug 06 1987

Effective Date: APR 1 1987  
HCFA ID: 1010P/0012P

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: GEORGIA

Citation  
42 CFR 447.201  
42 CFR 447.202  
AT-78-90

4.19(g) The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

TN # 79-4  
Supersedes  
TN # \_\_\_\_\_

Approval Date 7/17/79 Effective Date: 8/6/79

Revision: HCFA-AT-80-60 (BPP)  
August 12, 1980

State GEORGIA

Citation  
42 CFR 447.201  
42 CFR 447.203  
AT-78-90

4.19(h) The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

TN # 79-4  
Supersedes  
TN # \_\_\_\_\_

Approval Date 7/17/79 Effective Date: 8/6/79

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State GEORGIA

Citation  
42 CFR 447.201  
42 CFR 447.204  
AT-78-90

4.19(i) The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

TN # 79-4  
Supersedes  
TN # \_\_\_\_\_

Approval Date 7/17/79 Effective Date: 8/6/79

Revision: HCFA-PM-91-4  
AUGUST 1991

(BPD)

OMB No.: 0938-

State GEORGIA

Citation

42 CFR  
447.201  
and 447.205

4.19 (j) The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.

1903 (v) of the Act

(k) The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

Revision: HCFA-PM-94-8 (MB)  
July 2017

State/Territory: Georgia

Citation

4.19 (m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928(c)(2)  
(C)(ii) of  
the Act

- (i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows:
- (ii) The State:
- \_\_\_\_\_ sets a payment rate at the level of the regional maximum established by the DHHS Secretary.
- \_\_\_\_\_ is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.
- X sets a payment rate below the level of the regional maximum established by the DHHS Secretary. \*\*
- The State pays \$10 for the administration of a vaccine. \*\*
- \*\* Providers that qualify for the enhanced payments described at Attachment 4.19B, Pages 4.007 - 4.008 will be paid at the regional maximum established by the DHHS Secretary.
- \_\_\_\_\_ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.
- (iii) Medicaid beneficiary access to immunizations is assured through the following methodology:
- Enrolling all Health Departments, Rural and Community Health Centers.
- Requiring providers enrolled in the HEALTH CHECK (EPSDT) program to enroll in the Vaccines for Children (VFC) program and provide immunizations to Medicaid recipients.
- Providing a reasonable administration fee to all providers who provide immunizations to Medicaid recipients.

Revision: HCFA-AT-80-36 (BPP)  
May 22, 1980

State GEORGIA

Citation  
CFR 447.25 (b)  
AT-78-90

4.20 Direct Payments to certain Recipients for  
Physicians' or Dentists' Services

Direct payments are made to certain recipients  
as specified by, and in accordance with, the  
requirements of 42 CFR 447.25.

- Yes, for  physicians' services
- dentists' services

ATTACHMENT 4.20-A specifies the  
conditions under which such payments are  
made.

- Not applicable. No direct payments are  
made to recipients.

State GEORGIA

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Citation

4.21 Prohibition Against Reassignment of  
Provider Claims

42 CFR 447.10(c)  
AT-78-90  
46 FR 42699

Payment for Medicaid services  
furnished by any provider under this  
plan is made only in accordance with  
the requirements of 42 CFR 447.10.



Revision: HCFA-PM-94-1 (MB)  
 FEBRUARY 1994  
 State/Territory: GEORGIA

Citation

- 4.22 Third Party Liability
- 42 CFR 433.137 (a) The Medicaid agency meets all requirements of:
- (1) 42 CFR 433.138 and 433.139.
  - (2) 42 CFR 433.145 through 433.148.
  - (3) 42 CFR 433.151 through 433.154.
- 1902(a)(25)(H) and (I) of the Act (4) Sections 1902(a)(25)(H) and I of the Act.
- 42 CFR 433.138(f) (b) ATTACHMENT 4.22-A-
- (1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;
  - (2) Describes the methods the agency uses for meeting the follow-up requirements contained in §433.138(g)(1)(i) and (g)(2)(i);
  - (3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4) (ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow-up that identifies legally liable third party resources; and
  - (4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow-up that identifies legally liable third party resources.
- 42 CFR 433.138(g)(1)(ii) and (2) (ii)
- 42 CFR 433.138(g)(3)(i) and (iii)
- 42 CFR 433.138(g)(4) (i) through (iii)

Revision: HCFA-PM-94-1 (MB)  
 FEBRUARY 1994  
 State/Territory: GEORGIA

Citation

- 42 CFR 433.139(b) — (c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
- (3) (ii)(A)
- (d) ATTACHMENT 4.22-B specifies the following:
- 42 CFR 433.139(b)(3)(ii) (C) (1) The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii) (C).
- 42 CFR 433.139(f)(2) (2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.
- 42 CFR 433.139(f)(3) (3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
- 42 CFR 447.20 (e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

Revision: HCFA-PM-94-1 (MB)  
 FEBRUARY 1994  
 STATE/TERRITORY: Georgia

Citation

4.22 (continued)

42 CFR 433.151(a) (f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

Other appropriate State agency (agencies)--

\_\_\_\_\_

Other appropriate agency (agencies) of another State-

\_\_\_\_\_

Courts and law enforcement officials.

1902(a)(60) of the Act (g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act (h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following:

The Secretary's method as provided in the State Medicaid Manual, Section 3910.

The State provides methods for determining cost effectiveness on Attachment 4.22-C.

Revision: HCFA-AT-84-2 (BERC)  
01-84

State Georgia \_\_\_\_\_

Citation  
42 CFR Part 434.4  
48 FR 54013

4.23 Use of Contracts

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

Not applicable. The State has no such contracts.

7/1/84 Fiscal Agent.

Revision: HCFA-PM-94-2 (BPD)  
APRIL 1994

State/Territory: GEORGIA

Citation  
42 CFR 442.10  
and 442.100  
AT-78-90  
AT-79-18  
AT-80-25  
AT-80-34  
52 FR 32544  
P.L. 100-203  
(Sec. 4211)  
54 FR 5316  
56 FR 48826

4.24 Standards for Payments for Nursing Facility  
and Intermediate care Facility for the Mentally  
Retarded Services

With respect to nursing facilities and  
intermediate care facilities for the mentally  
retarded, all applicable requirements of  
42 CFR Part 442, Subparts B and C are met.

—— Not applicable to intermediate care  
facilities for the mentally retarded;  
such services are not provided under this  
plan.

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State GEORGIA

Citation  
42 CFR 431.702  
AT-78-90

4.25 Program for Licensing Administrators of Nursing Homes

The State has a program that, except with :  
respect to Christian Science sanatoria, meets  
the requirements of 42 CFR Part 431, Subpart  
N, for the licensing of nursing home  
administrators.

TN # 75-7  
Supersedes  
TN # \_\_\_\_\_

Approval Date 12/30/75

Effective Date: 1/1/74

Citation


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<b>1927 (g)</b> <b>42 CFR 456.700</b>	<b>4.26</b>	<b>Drug Utilization Review Program</b>
<b>1927 (g) (1) (A)</b>		<b>A.1. The Medicaid agency meets the requirements of Section 1927 (g) of the Act for a drug use review (DUR) program for outpatient drug claims.</b>
<b>1927 (g) (1) (a)</b> <b>42 CFR 456.705 (b)</b> <b>and 456.709 (b)</b>		<b>2. The DUR program assures that prescriptions for outpatient drugs are:</b> <ul style="list-style-type: none"> <li>- Appropriate</li> <li>- Medically necessary</li> <li>- Are not likely to result in adverse medical results</li> </ul>
<b>1927 (g) (1) (B)</b> <b>42 CFR 456.703 (d) and (f)</b>		<b>B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as:</b> <ul style="list-style-type: none"> <li>- Potential and actual adverse drug reactions</li> <li>- Therapeutic appropriateness</li> <li>- Overutilization and underutilization</li> <li>- Appropriate use of generic products</li> <li>- Therapeutic duplication</li> <li>- Drug disease contraindications</li> <li>- Drug-drug interactions</li> <li>- Incorrect drug dosage or duration of drug treatment</li> <li>- Drug-allergy interactions</li> <li>- Clinical abuse/misuse</li> </ul>
<b>1927 (g) (1) (B)</b> <b>42 CFR 456.703 (d) and (f)</b>		<b>C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia:</b> <ul style="list-style-type: none"> <li>- American Hospital Formulary Service Drug Information</li> <li>- United States Pharmacopeia-Drug Information</li> <li>- American medical Association Drug Evaluations</li> </ul>

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Citation		
1927 (g) (1) (D) 42 CFR 456.703 (b)	D.	DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs drugs in:  <u>  X  </u> Prospective DUR <u>  X  </u> Retrospective DUR
1927 (g) (2) (A) 42 CFR 456.705 (b)	E.1.	The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient
1927 (g) (2) (A) (i) 42 CFR 456.705 (b) (1)-(7)	2.	Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to:  - Therapeutic duplication - Drug disease contraindications - Drug-drug interactions with non-prescription or over-the-counter drugs - Incorrect drug dosage or duration of drug treatment - Drug-allergy interactions - Clinical abuse/misuse
1927 (g) (2) (A) (ii) 42 CFR 456.705 (c) and (d)	3.	Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.
1902(a)(85) and Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)	4.	The Medicaid Department meets the requirements of the SUPPORT Act for prospective safety edits for opioids to include: a. Early Refill edits b. Duplicative Therapy edits c. Quantity Level Limits edits d. Days supply
1902(a)(85) and Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)	5.	The Medicaid Department meets the requirements of the SUPPORT Act for prospective safety edits on maximum MMEs for opioids at the individual level for the treatment of chronic pain as identified by the State to include:  a. Prospective MME dose limit edits on opioid prescriptions to limit the daily morphine milligram equivalent (as recommended by clinical guidelines)
1902(a)(85) and Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)	6.	Antipsychotic Use in Children  The Medicaid Department meets the requirements of the SUPPORT Act for monitoring the use of atypical antipsychotics in children by utilizing a prior authorization program for all children under of the age of 18 including those in foster care.
1927 (g) (2) (B) 42 CFR 456.709 (a)	F.1.	The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify: - Patterns of fraud and abuse - Gross overuse - Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or group of drugs
1902(a)(85) and Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)	1.2.	The Medicaid Department meets the requirements of the SUPPORT Act for retrospective utilization alerts when a patient is prescribed an opioid and an agent of concern to include:  a. Opioids and Benzodiazepines concurrent utilization edits; b. Opioids and Antipsychotics concurrent utilization edits; c. Retrospective reviews on opioid prescriptions exceeding the following limitations (days' supply, early refills, duplicate fills and quantity limitations for clinical appropriateness, and maximum daily morphine milligram equivalents (MME) on opioids prescriptions to limit the daily morphine milligram equivalent (as recommended by clinical guidelines)).

TN No.: 20-0001  
Supersedes  
TN No.: 08-001

Approval Date March 10, 2020

Effective Date: 1-1-2020



Citation

- |  |      |  |
|--|------|--|
| 1927 (g) (2) (C)<br>42 CFR 456.709 (b)         | F.2. | The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for: <ul style="list-style-type: none"> <li>-Therapeutic appropriateness</li> <li>-Overutilization and underutilization</li> <li>-Appropriate use of generic products</li> <li>-Therapeutic duplication</li> <li>-Drug disease contraindications</li> <li>-Drug-drug interactions</li> <li>-Incorrect drug dosage or duration of drug treatment</li> <li>-Drug-allergy interactions</li> <li>-Clinical abuse/misuse</li> </ul>              |
| 1927 (g) (2) (D)<br>42 CFR 456.711             | 3.   | The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.   |
| 1927 (g) (3) (A)<br>42 CFR 456.716 (a)         | G.1. | The DUR program has established a State DUR Board either: <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Directly, or</li> <li><input type="checkbox"/> Under contract with a private organization</li> </ul>  |
| 1927 (g) (3) (B)<br>42 CFR 456.716 (A) and (B) | 2.   | The DUR Board membership includes health professionals (on-third licensed actively practicing pharmacists and on-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following: <ul style="list-style-type: none"> <li>-Clinically appropriate prescribing of covered outpatient drugs.</li> <li>-Clinically appropriate dispensing and monitoring of covered outpatient drugs.</li> <li>-Drug use review, evaluation and intervention.</li> <li>-Medical quality assurance.</li> </ul> |
| 1927 (g) (3) (C)<br>42 CFR 456.716 (d)         | 3.   | The activities of the DUR Board include: <ul style="list-style-type: none"> <li>-Retrospective DUR,</li> <li>-Application of Standards as defined in section 1927 (g) (2) (C) and</li> <li>-Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.</li> </ul>   |

## Citation

1927 (g) (3) (C) 42 CFR 456.711 (a)-(d)	G.4. The interventions include in appropriate instances:  - Information dissemination - Written, oral, and electronic reminders - Face-to-Face discussion - Intensified monitoring/review of prescribers/dispensers
1927 (g) (3) (D) 42 CFR 456.712 (A) and (B)	H. The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, and procedures as described in the report.
1927 (h) (1) 42 CFR 456.722	I.1. The State establishes, as its principal means of processing claims for covered outpatient drug under this title, a point-of-sale electronic claims management system to perform on-line:  - real time eligibility verification - claims data capture - adjudication of claims - assistance to pharmacists, etc. applying for and receiving payment.
1927 (g) (2) (A) (i) 42 CFR 456.705 (b)	2. Prospective DUR is performed using an electronic point of sale drug claims processing system.
1902(a)(85) and Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)	3. The Medicaid Department meets the requirements of the SUPPORT Act with a process that identifies potential fraud or abuse of controlled substances by individuals, health care providers prescribing drugs, and pharmacies dispersing drugs through the use of:  a. Review of Prescription Claims b. Prescription Claim Audits c. On-Site Pharmacy Audits  4. The Medicaid Department meets the requirements of the SUPPORT Act through the existence of a lock-in program managed by Program Integrity.

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State Georgia

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Citation  
42 CFR 431.115 (c)  
AT-78-90  
AT-79-74

4.27 Disclosure of Survey Information and Provider  
or Contractor Evaluation

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

TN # 79-14  
Supersedes  
TN # \_\_\_\_\_

Approval Date 3/27/80 Effective Date: 10/15/79

Revision: HCFA-PM-93-1 (BPD)  
January 1993

State/Territory: Georgia

<u>Citation</u> 42 CFR 431.152; AT-79-18 52 FR 22444; Secs. 1902(a)(28)(D) (i) and 1919(e) (7) of the Act; P.L. 100-203 (Sec. 4211(c)).	4.28	<u>Appeals Process</u> (a) The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154.  (b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.
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Revision: HCFA-PM-99-3 (CMSO)  
JUNE 1999

State \_\_\_\_\_

Citation

1902(a)(4)(C) of the  
Social Security Act  
P.L. 105-33

4.29 Conflict of Interest Provisions

The Medicaid agency meets the requirements of section 1902(a)(4)(C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.

1902(a)(4)(D) of the  
Social Security Act  
P.L. 105-33

The Medicaid agency meets the requirements of section 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

Revision: HCFA-PM-87-14 (BERC)  
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Georgia

Citation  
42 CFR 1002.203  
AT-79-54  
48 FR 3742  
51 FR 34772

4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals

(a) All requirements of 42 CFR Part 1002, Subpart B are met:

The agency, under the authority of State law, imposes broader sanctions.

Revision: HCFA-PM-87-14 (BERC)  
OCTOBER 1987

OMB No. : 0938-0193  
4.30 Continued

State/Territory: Georgia

Citation

1902(p) of the Act  
P.L. 100-93  
(secs. 7)

- (b) The Medicaid agency meets the requirements of --
- (1) Section 1902(p) of the Act by excluding from participation-
- (A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).
- (B) Any HMO (as defined in section 1903 (m) of the Act) or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that—
- (i) could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or
- (ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8) (B) of the Act.

Revision: HCFA-AT-87-14 (BERC)  
OCTOBER 1987

OMB No.: 0938-0193  
4.30 Continued

State/Territory: Georgia

Citation

1902(a)(39) of the Act  
P.L. 100-93  
(sec. 8(f))

(2) Section 1902(a)(39) of the Act by --

- (A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and
- (B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of --

1902(a)(41)  
of the Act  
P.L. 96-272,  
(sec. 308(c))

(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and

1902(a)(49) of the Act  
P.L. 100-93  
(sec. 5(a)(4))

(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.



Revision: HCFA-PM-87-14 (BERC)  
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Georgia

Citation

455.103  
44 FR 41644  
1902(a)(38)  
of the Act  
P.L. 100-93  
(sec. 8(f))

4.31 Disclosure of Information by Providers and Fiscal Agents  
The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104. through 455.106 and sections 1128(b) (9) and 1902(a)(38) of the Act.

435.940  
through 435.960  
52 FR 5967

4.32 Income and Eligibility Verification System

- (a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960.
- (b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

Revision: HCFA-PM-87-14 (BERC)  
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Georgia

Citation  
1902(a) (48)  
of the Act,  
P.L. 99-570  
(Section 11005)  
P.L. 100-93  
(sec. 5(a) (3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

- (a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.
- (b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

Revision: HCFA-PM-88-10 (BERC)  
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: Georgia

Citation  
1137 of  
the Act

P.L. 99-603  
(sec. 121)

4.34 Systematic Alien Verification for Entitlements  
The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988.

The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

Total waiver

Alternative system

Partial implementation

Revision: HCFA-PM-90-2 (BPD)  
JANUARY 1990

OMB No. : 0938-0193

State/Territory: Georgia

Citation

4.35 Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation

1919 (h) (1)  
and (2)  
of the Act,  
P.L. 100-203  
(Sec. 4213(a))

- (a) The Medicaid agency meets the requirements of section 1919(h)(2)(A) through (D) of the Act concerning remedies for skilled nursing and intermediate care facilities that do not meet one or more requirements of participation. ATTACHMENT 4.35-A describes the criteria for applying the remedies specified in section 1919(h) (2) (A) (i) through (iv) of the Act.

Not applicable to intermediate care facilities; these services are not furnished under this plan.

- (b) The agency uses the following remedy(ies):

- (1) Denial of payment for new admissions.  
(2) Civil money penalty.  
(3) Appointment of temporary management.  
(4) In emergency cases, closure of the facility and/or transfer of residents.

1919(h) (2) (B)(ii)  
of the Act

- (c) The agency establishes alternative State remedies to the specified Federal remedies (except for termination of participation). ATTACHMENT 4.35-B describes these alternative remedies and specifies the basis for their use.

1919(h) (2) (F)  
of the Act

- (d) The agency uses one of the following incentive programs to reward skilled nursing or intermediate care facilities that furnish the highest quality care to Medicaid residents:

- (1) Public recognition.  
 (2) Incentive payments.

Revision: HCFA-PM-95-4 (HSQB)  
JUNE 1995

State/Territory: Georgia

<u>Citation</u>	4.35 <u>Enforcement of Compliance for Nursing Facilities</u>
42 CFR §488.402 (f)	<p>(a) <u>Notification of Enforcement Remedies</u></p> <p>When taking an enforcement action against a non-State operated NF, the state provides notification in accordance with 42 CFR 488.402(f).</p> <p>(i) The notice (except for civil money penalties and state monitoring) specifies the:</p> <p style="padding-left: 40px;">(1) nature of noncompliance, (2) which remedy is imposed, (3) effective date of the remedy, and (4) right to appeal the determination leading to the remedy.</p>
42 CFR §488.434	<p>(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.</p>
42 CFR §488.402(f)(2)	<p>(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.</p>
42 CFR §488.456(c)(d)	<p>(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.</p>
	<p>(b) <u>Factors to be Considered in Selecting Remedies</u></p>
42 CFR §488.438.404 (b) (1)	<p>(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) &amp; (2).</p> <p style="padding-left: 40px;">_____ The State considers additional factors. Attachment 4.35-A describes the State's other factors.</p>

Revision: HCFA-PM-95-4 (HSQB)  
JUNE 1995

State/Territory: Georgia

Citation

c) Application of Remedies

- 42 CFR  
§488.410
- (i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.
- 42 CFR  
§488.417(b)  
§1919(h) (2) (C)  
of the Act.
- (ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.
- 42 CFR  
§488.414  
§1919(h) (2) (D)  
of the Act
- (iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.
- 42 CFR  
§488.408  
1919(h) (2) (a)  
of the Act
- (iv) The State follows the criteria specified at 42 CFR §488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.
- 42 CFR  
§488.412 (a)
- (v) when immediate jeopardy does not exist, the State terminates an NF's provider agreement: no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.

(d) Available Remedies

- 42 CFR  
§488.406 (b)  
§1919 (h) (2) (a)  
of the Act.
- (i) The State has established the remedies defined in 42 CFR 488.406(b).
- (1) Termination
- (2) Temporary Management
- (3) Denial of Payment for New Admissions
- (4) Civil Money Penalties
- (5) Transfer of Residents; Transfer of Residents with closure of Facility
- (6) State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

TN No. 95-034  
Supersedes  
TN No. NEW

Approval Date 3-8-96

Effective Date: 7-1-95

Revision: HCFA-PM-95-4 (HSQB)  
JUNE 1995-

State/Territory: Georgia

Citation

42 CFR  
§488.406(b)  
§1919(h) (2)(B)(ii)  
of the Act.

(ii) \_\_\_ The State uses alternative remedies.  
The State has established alternative  
remedies that the State will impose in  
place of a remedy specified in 42 CFR  
488.406(b).

- \_\_\_ (1) Temporary Management
- \_\_\_ (2) Denial of Payment for New Admissions
- \_\_\_ (3) Civil Money Penalties
- \_\_\_ (4) Transfer of Residents Transfer of  
Residents with closure of facility
- \_\_\_ (5) State Monitoring.

Attachments 4.35-B through 4.35-G describe the  
alternative remedies and the criteria for applying them.

42 CFR  
§488.303(b)  
1910(h) (2) (F)  
of the Act.

(e) \_\_\_ State Incentive Programs  
\_\_\_ (1) Public Recognition  
\_\_\_ (2) Incentive Payments

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

OMB No.: 0938-

State/Territory: GEORGIA

Citation 4.36 Required Coordination Between the Medicaid and WIC Programs

1902(a) (11)(C)  
and 1902(a) (53)  
of the Act

The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.



Revision: HCFA-PM-91-10 (BPD)  
DECEMBER 1991

State/Territory: GEORGIA

Citation

42 CFR 483.75; 42 CFR 483 Subpart D; Secs, 1902(a) (28), 1919(e) (1) and (2), and 1919(f) (2), P.L. 100-203 (sec. 4211(a) (3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

4.38 Nurse Aide Training and Competency Evaluation for Nursing Facilities

- (a) The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.
- \_\_\_ (b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).
- \_\_\_ (c) The State deems individuals who meet the requirements of 42 CFR 483.150(b) (2) to have met the nurse aide training and competency evaluation requirements.
- (d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.
- \_\_\_ (e) The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.
- \_\_\_ (f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

TN No. 91-36  
Supersedes  
TN No. NEW

Approval Date 4-14-92

Effective Date: 10-1-91

Revision: HCFA-PM-91-10 (BPD)  
DECEMBER 1991

State/Territory: GEORGIA

Citation

42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902 (a) (28), 1919(e) (1) and (2), and 1919(f) (2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

- (g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the state reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.
- (h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.
- (i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.
- (j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.
- (k) For program reviews other than the initial review, the State visits the entity providing the program.
- (l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b) (2) and (3).

Revision: HCFA-PM-91-10 (BPD)  
DECEMBER 1991

State/Territory: GEORGIA

Citation

42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e) (1) and (2), and 1919(f) (2), P.L. 100-203 (Sec. 4211(a) (3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

- (m) The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.
- (n) The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.
- (o) The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).
- (p) The state withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b) (2) or (3).
- \_\_\_\_ (q) The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483. 154.
- (r) The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the state.

Revision: HCFA-PM-91-10 (BPD)  
DECEMBER 1991

State/Territory: GEORGIA

- Citation  
42 CFR 483.75; 42 CFR 483. Subpart D; Secs. 1902(a) (28), 1919(e)(1) and (2), and 1919(f) (2), P.L. 100-203 (Sec. 4211(a) (3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).
- (s) When the state withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.
  - (t) The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.
  - (u) The state provides for the reimbursement of costs incurred 'in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.
  - (v) The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.
  - (w) Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.
  - \_\_\_\_ (x) The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).
  - (y) The state has a standard for successful completion of competency evaluation programs.

Revision: HCFA-PM-91-10 (BPD)  
DECEMBER 1991

State/Territory: GEORGIA

- Citation  
42 CFR 483.75; 42  
CFR 483 Subpart D;  
Secs. 1902(a) (28),  
1919(e) (1) and (2),  
and 1919 (f) (2),  
P.L. 100-203 (Sec.  
4211(a)(3)); P.L.  
101-239 (Secs.  
6901(b)(3) and  
(4)); P.L. 101-508  
(Sec. 4801(a)).
- (z) The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
  - \_\_\_(aa) The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
  - (bb) The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
  - \_\_\_(cc) The State includes home health aides on the registry.
  - \_\_\_(dd) The State contracts the operation of the registry to a non State entity.
  - \_\_\_(ee) ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(C)(1)(iii) and (iv).
  - \_\_\_(ff) ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

Revision: HCFA-PM-93-1 (BPD)  
January 1993

State/Territory: GEORGIA

Citation

Secs.

1902(a) (28) (D) (i)  
and 1919(e)(7) of  
the Act;

P.L. 100-203

(Sec. 4211(c));

P.L. 101-508

(Sec. 4801(b)).

4.39 Preadmission screening and Annual  
Resident Review in Nursing Facilities

- (a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 (CFR) 431.621(c).
- (b) The State operates a preadmission and annual resident review program that meets the requirements of 42 CFR 483.100-138.
- (c) The state does not claim as "medical assistance under the state Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.
- (d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the state does not claim as "medical assistance under the State plan" the cost of NF services to individuals who are found not to require NF services.
- X (e) ATTACHMENT 4.39 specifies the State's definition of specialized services.

TN No. 96-019

Supersedes

TN No. NEW

Approval Date 11-4-96

Effective Date: 7-1-96

Revision: HCFA-PM-93-1 (BPD)  
January 1993

State/Territory: GEORGIA

4.39 (Continued)

- \_\_\_\_\_ (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the state in most, if not all, NF's and that a more appropriate placement should be utilized.
- (g) The state describes any categorical determinations it applies in ATTACHMENT 4.39-A.

Revision: HCFA-PM-92-3  
April 1992

(HSQB)

OMB NO.:

State/Territory: GEORGIA

Citation4.40 Survey & Certification Process

## Sections

1919(g) (1)  
thru (2) and  
1919(g) (4)  
thru (5) of  
the Act P.L.  
100-203  
(Sec.  
4212(a))

(a) The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g) (2) (A) through (E) (iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met.

1919(g)(1)  
(B) of the  
Act

(b) The State conducts periodic education programs for staff and residents (and their representatives). Attachment 4.40-A describes the survey and certification educational program.

1919(g) (1)  
(C) of the  
Act

(c) The state provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. Attachment 4.40-B describes the State's process.

1919(g) (1)  
(C) of the  
Act

(d) The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency?

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1919(g)(1)  
(C) of the  
Act

(e) The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.

1919(g) (1)  
(c) of the  
Act

(f) The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

TN No. 93-001  
Supersedes  
TN No. NEW

Approval Date 4-6-93

Effective Date: 1-1-93  
HCFA ID: \_\_\_\_\_



Revision: HCFA-PM-92-3  
April 1992

(HSQB)

OMB NO.:

State/Territory: GEORGIA

- 1919(g)(2)  
(A) (i) of  
the Act
- (g) The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. Attachment 4.40-C describes the State's procedures.
- 1919(g) (2)  
(A)(ii) of  
the Act
- (h) The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.
- 1919(g)(2)  
(A) (iii)(I)  
of the Act
- (i) The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.
- 1919(g) (2)  
(A)(iii)(II)  
of the Act
- (j) The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
- 1919(g) (2)  
(B) of the  
Act
- (k) The State conducts extended surveys immediately or, if not practicable, not later than 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.
- 1919(g) (2)  
(C) of the  
Act
- (l) The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

TN No. 93-001  
Supersedes  
TN No. NEW

Approval Date 4-6-93

Effective Date: 1-1-93  
HCFA ID: \_\_\_\_\_

Revision: HCFA-PM-92-3  
April 1992

(HSQB)

OMB NO.:

State/Territory: GEORGIA

- 1919(g) (2) (D) of the Act (m) The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. Attachment 4.40-D describes the State's programs.
- 1919(g) (2) (E) (i) of the Act (n) The State uses a multidisciplinary team of professionals including a registered professional nurse.
- 1919(g)(2) (E) (ii) of the Act (o) The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.
- 1919(g) (2) (E) (iii) of the Act (p) The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
- 1919(g)(4) of the Act (q) The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring Attachment 4.40-E describes the State's complaint procedures.
- 1919(g) (5) (A) of the Act (r) The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, state of ownership and the information disclosed under section 1126 of the Act.
- 1919(g) (5) (B) of the Act (s) The State notifies the State long-term care ombudsman of the state's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.
- 1919(g) (5) (C) of the Act (t) If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
- 1919(g) (5) (D) of the Act (u) The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

TN No. 93-001  
Supersedes  
TN No. NEW

Approval Date 4-6-93Effective Date: 1-1-93

HCFA ID: \_\_\_\_\_

Revision: HCFA-PM-92-2 (HSQB)  
March 1992

State/Territory: GEORGIA

<u>Citation</u>	4.41	<u>Resident Assessment for Nursing Facilities</u>
Sections 1919(b) (3) and 1919 (e) (5) of the Act	(a)	The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act.
1919(e) (5) (A) of the Act	(b)	The State is using:  <u>  X  </u> the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the <u>State Operations Manual</u> ) (§1919(e)(5) (A)); or
1919(e) (5) (B) of the Act	—	a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the <u>State Medicaid Manual</u> for the Secretary's approval criteria) (§1919(e)(5) (B)).

TN No. 92-14  
Supersedes  
TN No. NEW

Approval Date 6/2/92

Effective Date: 4/1/92  
HCFA ID: \_\_\_\_\_

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

Citation 1902(a)(68)  
of the Act, P.L. 109-171  
(section 6032)

4.42 Employee Education About False Claims Recoveries.

- (a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

## (1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least \$5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the \$5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity": (e.g., a state mental health facility or school district providing school-based health services).

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

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A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the \$5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

- (2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

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- (3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.
- (4) The requirements of this law should be incorporated into each State's provider enrollment agreements.
- (5) The State will implement this State Plan amendment on January 1, 2007.
- (b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

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Citation  
1902(a)(69) of  
The Act,  
P.L. 109-171  
(section 6034)

4.43 Cooperation with Medicaid Integrity Program Efforts  
The Medicaid Agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

TN No: 08-007  
Supersedes:  
TN No: New

Approval Date: 08/12/08Effective Date: 07/01/08

State/Territory: Georgia

**Section 4 - GEORGIA PROGRAM ADMINISTRATION**

4.44 Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States

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Citation

Section 1902(a)(80) of the Social Security Act, P.L. 111 - 148 (Section 6505)

X The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

TN No. 2011-003

Supersedes

TN No: New

Approval Date: 06-29-11

Effective Date: 06-01-11



Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State Georgia

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## SECTION 5 PERSONNEL ADMINISTRATION

### Citation

42 CFR 432.10(a)  
AT-78-90  
AT-79-23  
AT-80-34

### 5.1 Standards of Personnel Administration

- (a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

### (b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.

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TN #77-8

Supersedes

TN# \_\_\_\_\_

Approval Date 3/7/78

Effective Date 10/1/77

State of Georgia

CITATION OF STATE LAWS, RULES, REGULATIONS AND POLICY STATEMENTS  
PROVIDING ASSURANCE OF CONFORMITY TO FEDERAL MERIT SYSTEM STANDARDS

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GEORGIA CITATION LISTING - Grant Aided Agencies

- I. Constitutional Provisions
  - A. Article XIV, Section I, Paragraph I, The Georgia Constitution (1945), Establishes the State Personnel Board.
  - B. Article III, Section VII, Paragraph XXIV, The Georgia Constitution (1945), Amendment (1967) Establish preference for Veterans.
- II. Georgia Laws
  - A. Act 81 (1975), Establishes the State Merit System to oversee activities in covered agencies.
  - B. Act 1398 (1976), Amends Act 81 (1975).
  - C. Act 1383 (1976), Amends Act 81 (1975).
- III. Rules and Regulations of the State Personnel Board (as amended to date).
- IV. Interpretive Memorandum issued by the Commissioner of Personnel Administrative (as released to date).
- V. Certain memorandum and letters of Authorization or understanding from the United States Civil Service Commission to the Georgia State Merit System.

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State Georgia \_\_\_\_\_

5.2 [Reserved]

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TN # \_\_\_\_\_  
Supersedes \_\_\_\_\_ Approval Date \_\_\_\_\_ Effective Date \_\_\_\_\_  
TN # \_\_\_\_\_

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State Georgia

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Citation  
42 CFR Part 432,  
Subpart B  
AT-78-90

5.3 Training Programs; Subprofessional and  
Volunteer Programs

The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.

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TN #78-1  
Supersedes  
TN# \_\_\_\_\_

Approval Date 4/27/78

Effective Date 2/27/78

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State Georgia

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SECTION 6 FINANCIAL ADMINISTRATION.

Citation  
42 CFR 433.32  
AT-79-29

6.1 Fiscal Policies and Accountability

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met

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TN #76-6  
Supersedes  
TN # \_\_\_\_\_

Approval Date 9/17/76 Effective Date 7/1/76

Revision: HCFA-AT-82-10 (BPP)

State Georgia

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Citation  
42 CFR 433.34  
47 FR 17490

6.2

Cost Allocation

There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

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TN #82-15  
Supersedes  
TN #76-6

Approval Date 1-7-83

Effective Date 11-16-82

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State Georgia

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Citation  
42 CFR 433.33  
AT-79-29  
AT-80-34

6.3 State Financial Participation

(a) State funds are used in both assistance and administration.

State funds are used to pay all of the non-Federal share of total expenditures under the plan.

There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State

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TN #76-6  
Supersedes  
TN # \_\_\_\_\_

Approval Date: 9/17/76

Effective Date: 7/1/76

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

OMB No. 0938-

State/Territory: GEORGIA

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SECTION 7 GENERAL PROVISIONS

Citation

7.1

Plan Amendments

42 CFR 430.12(c)

The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy of State agency operation.

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TN No. 91-35  
Supersedes  
TN No. 78-16

Approval Date 12-4-91

Effective Date 10-1-91  
HCFA ID: 7982E



Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

OMB No. 0938-

State/Territory: \_\_\_\_\_

Citation        7.2        Nondiscrimination

45 CFR Parts  
80 and 84

In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seg.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap.

The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.

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TN No. 91-35  
Supersedes  
TN No. 79-2

Approval Date 12-4-91

Effective Date 10-1-91  
HCFA ID: 7982E

NONDISCRIMINATION

In accordance with the Assistance Payments Manual, Policies and Procedures, Section VII-190; Part I of the Policies and Procedures Applicable to All Medicaid Providers, General Conditions of Participation, Sections 106.3 and 106.4; and Rules of the Department of Medical Assistance, Chapter 350-1-.05, all assistance programs and services of the Department are to be administered in conformity with Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973. Services will be administered in such a manner that no person in this state will on the grounds of race, color, sex, age, religion, national origin or handicap be excluded from participation in, be denied any aid, care, services or other benefits of, or e otherwise subjected to discrimination in the granting of assistance.

This policy covers not only the administrative procedures and practices within the Department but extends to individuals, agencies, institutions and organizations to whom referrals are made by the Department and who participate in the programs of the Department through purchase of service. Therefore, payments can only be made to vendors who comply with these Acts.

**Section 7 - General Provisions**  
**7.4. Medicaid Disaster Relief for the COVID-19 National Emergency**

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

*Describe shorter period here.*  
 July 1, 2020 through June 30, 2021

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

**Request for Waivers under Section 1135**

  X   The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a.   X   SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
  
- b.   X   Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

- c. \_\_\_\_ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state) Medicaid state plan, as described below:

*Please describe the modifications to the timeline.*

**Section A – Eligibility**

1. \_\_\_\_ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

*Include name of the optional eligibility group and applicable income and resource standard.*

2. \_\_\_\_ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. \_\_\_\_ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: \_\_\_\_\_

-or-

- b. \_\_\_\_ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: \_\_\_\_\_

3. \_\_\_\_ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

4. \_\_\_ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. \_\_\_ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. \_\_\_ The agency provides for an extension of the reasonable opportunity period for noncitizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

### Section B – Enrollment

1. \_\_\_ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

*Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.*

2. \_\_\_ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

*Please describe any limitations related to the populations included or the number of allowable PE periods.*

3. \_\_\_ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

*Please describe any limitations related to the populations included or the number of allowable PE periods.*

4. \_\_\_ The agency adopts a total of \_\_\_ months (not to exceed 12 months) continuous eligibility for children under age enter age \_\_\_ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. \_\_\_ The agency conducts redeterminations of eligibility for individuals excepted from MAGI based financial methodologies under 42 CFR 435.603(j) once every \_\_\_ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. \_\_\_ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

a. \_\_\_ The agency uses a simplified paper application.

b. \_\_\_ The agency uses a simplified online application.

c. \_\_\_ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

### **Section C - Premiums and Cost Sharing**

1. \_\_\_ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

*Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).*

2. \_\_\_ The agency suspends enrollment fees, premiums and similar charges for:

a. \_\_\_ All beneficiaries

b. \_\_\_ The following eligibility groups or categorical populations:

*Please list the applicable eligibility groups or populations.*

3. \_\_\_ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

**Section D – Benefits**

*Benefits:*

- 1. \_\_\_The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

- 2. \_\_\_The agency makes the following adjustments to benefits currently covered in the state plan:

- 3. \_\_\_The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

- 4. \_\_\_Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

- a. \_\_\_The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
- b. \_\_\_Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

*Telehealth:*

- 5. \_\_\_The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

*Drug Benefit:*

- 6.  The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

*Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.*

- 7.  Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.
- 8.  The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

*Please describe the manner in which professional dispensing fees are adjusted.*

- 9.  The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

**Section E - Payments**

*Optional benefits described in Section D:*

- 1.  Newly added benefits described in Section D are paid using the following methodology:
  - a.  Published fee schedules –
    - Effective date (enter date of change): \_\_\_\_\_
    - Location (list published location): \_\_\_\_\_
  - b.  Other:

*Describe methodology here.*

*Increases to state plan payment methodologies:*

- 2.  The agency increases payment rates for the following services:



The state will pay nursing homes an additional 5% to cover increase costs due to the public health emergency for the period 7/1/2020 – 6/30/2021 or the end of the Public Health Emergency, whichever is sooner.

a. \_\_\_ Payment increases are targeted based on the following criteria:

*Please describe criteria.*

b. Payments are increased through:

i. \_\_\_ A supplemental payment or add-on within applicable upper payment limits:

*Please describe.*

ii. X \_\_\_ An increase to rates as described below.

Rates are increased:

X \_\_\_ Uniformly by the following percentage: 5%

\_\_\_ Through a modification to published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

Location (list published location): \_\_\_\_\_

Up to the Medicare payments for equivalent services.

\_\_\_ By the following factors:

The state will pay nursing homes an additional 5% to cover increased costs due to the public health emergency for the period 07/01/2020 – 06/30/2021 or the end of the PHE, whichever is sooner.

*Payment for services delivered via telehealth:*

3. \_\_\_ For the duration of the emergency, the state authorizes payments for telehealth services that:

a. \_\_\_ Are not otherwise paid under the Medicaid state plan;

- b. \_\_\_ Differ from payments for the same services when provided face to face;
- c. \_\_\_ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

- d. \_\_\_ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
  - i. \_\_\_ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
  - ii. \_\_\_ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

*Other:*

- 4. \_\_\_ Other payment changes:

Please describe.

**Section F - Post-Eligibility Treatment of Income**

- 1. \_\_\_ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
  - a. \_\_\_ The individual’s total income
  - b. \_\_\_ 300 percent of the SSI federal benefit rate
  - c. \_\_\_ Other reasonable amount: \_\_\_\_\_
- 2. \_\_\_ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

*Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.*

**Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan  
Additional Information**

**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. \*\*\*CMS Disclosure\*\*\* Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

## Section 7 – General Provisions

### 7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

*Describe shorter period here.*

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

#### **Request for Waivers under Section 1135**

The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a.  SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b.  Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

TN: 21-0005\_

Supersedes TN: NEW

This SPA is in addition to the Disaster Relief SPA(s) approved on May 4th, 2020 and May 26, 2021 and does not supersede anything approved in those SPA(s).

Approval Date: September 28, 2021

Effective date April 1, 2021

- c. \_\_\_ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

*Please describe the modifications to the timeline.*

**Section A – Eligibility**

- 1. \_\_\_ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

*Include name of the optional eligibility group and applicable income and resource standard.*

- 2. \_\_\_ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. \_\_\_ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: \_\_\_\_\_

-or-

- b. \_\_\_ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: \_\_\_\_\_

- 3. \_\_\_ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

4. \_\_\_ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. \_\_\_ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. \_\_\_ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

**Section B - Enrollment**

1. \_\_\_ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

*Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.*

2. \_\_\_ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

*Please describe any limitation related to the populations or the number of allowed PE periods.*

- \_\_\_\_\_
3. \_\_\_\_ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

*Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.*

4. \_\_\_\_ The agency adopts a total of \_\_\_\_ months (not to exceed 12 months) continuous eligibility for children under age enter age \_\_\_\_ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5. \_\_\_\_ The agency conducts redeterminations of eligibility for individuals excepted from MAGI- based financial methodologies under 42 CFR 435.603(j) once every \_\_\_\_ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. \_\_\_\_ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
- a. \_\_\_\_ The agency uses a simplified paper application.
- b. \_\_\_\_ The agency uses a simplified online application.
- c. \_\_\_\_ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

### **Section C – Premiums and Cost Sharing**

1. \_\_\_\_ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

*Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).*

2. \_\_\_\_ The agency suspends enrollment fees, premiums and similar charges for:
- a. \_\_\_\_ All beneficiaries

- b.  The following eligibility groups or categorical populations:

*Please list the applicable eligibility groups or populations.*

- 3.  The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

**Section D – Benefits**

*Benefits:*

- 1.  The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

- 2.  The agency makes the following adjustments to benefits currently covered in the state plan:

Other Licensed Practitioners Benefit (42 CFR 440.60):  
 Pharmacies are qualified providers of COVID-19 vaccinations per the HHS COVID-19 PREP Act Declaration and authorizations. Qualified pharmacy interns and qualified pharmacy technicians working under the supervision of a licensed pharmacist are authorized to administer COVID-19 vaccinations.

- 3.  The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

- 4.  Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

- a.  The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.



- b. \_\_\_ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

*Please describe.*

*Telehealth:*

5. \_\_\_ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

*Please describe.*

*Drug Benefit:*

6. \_\_\_ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

*Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.*

7. \_\_\_ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. \_\_\_ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

*Please describe the manner in which professional dispensing fees are adjusted.*

9. \_\_\_ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

**Section E – Payments**

*Optional benefits described in Section D:*

1.  Newly added benefits described in Section D are paid using the following methodology:

a.  Published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

Location (list published location): \_\_\_\_\_

b.  Other:

*Describe methodology here.*

*Increases to state plan payment methodologies:*

2.  The agency increases payment rates for the following services:

Effective April 1, 2021, Increase the administration fee of the Covid-19 vaccine to 100 percent of the Medicare reimbursement rate (\$40.00 per dose) without geographic adjustment for all approved ages, with approved National Drug Codes (NDC), and Current Procedural Terminology (CPT) codes. Request a 12/11/2020 effective date to be retroactive to Emergency Use Authorization (EUA) from the Food and Drug Administration (FDA) and the Centers for Medicare and Medicaid Services (CMS). Reimbursement at the increased amount will be allowed through the last day of the COVID-19 Public Health Emergency and in accordance with the Families First Coronavirus Response Act (FFCRA), Pub. L. 116-127.

Increase the administration fee of the COVID-19 vaccine up to 100% of the Medicare rate (\$40.00 per dose), without geographic adjustment through the end of the Public Health Emergency

a.  Payment increases are targeted based on the following criteria:

All enrolled providers will be allowed reimbursement for COVID-19 vaccine administration at 100 percent of the Medicare rate without geographic adjustment (\$40.00 per dose) for all EUA approved ages. This includes the following provider types: 070-Outpatient Hospital, 430- physician, 431-Physician Assistant, 540-Federally Qualified Health Center, 541/542 Rural Health Center;

Freestanding & Hospital Based, 740-Nurse Practitioner, & 790-Diagnostic Screening & Preventative Services.

b. Payments are increased through:

- i.  A supplemental payment or add-on within applicable upper payment limits:

*Please describe.*

- ii.  An increase to rates as described below.

Rates are increased:

Uniformly by the following percentage: \_\_\_\_\_

Through a modification to published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

Location (list published location): \_\_\_\_\_

Up to the Medicare payments for equivalent services.

By the following factors:

*Please describe.*

*Payment for services delivered via telehealth:*

- 3.  For the duration of the emergency, the state authorizes payments for telehealth services that:

- a.  Are not otherwise paid under the Medicaid state plan;
- b.  Differ from payments for the same services when provided face to face;
- c.  Differ from current state plan provisions governing reimbursement for telehealth;

*Describe telehealth payment variation.*

- c.  Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
  - i.  Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
  - ii.  Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

*Other:*

4.  Other payment changes:

*Please describe.*

**Section F - Post-Eligibility Treatment of Income**

- 1.  The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
  - a.  The individual's total income
  - b.  300 percent of the SSI federal benefit rate
  - c.  Other reasonable amount: \_\_\_\_\_
- 2.  The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

*Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.*

**Section G - Other Policies and Procedures Differing from Approved Medicaid State Plan/Additional Information**

**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. \*\*\*CMS Disclosure\*\*\* Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

TN: 21-0005\_

Supersedes TN: NEW

This SPA is in addition to the Disaster Relief SPA(s) approved on May 4th, 2020 and May 26, 2021 and does not supersede anything approved in those SPA(s).

Approval Date: September 28, 2021Effective Date: April 1, 2021

**Section 7 – General Provisions****7.4. Medicaid Disaster Relief for the COVID-19 National Emergency**

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

*Describe shorter period here.*

July 1, 2021 through June 30, 2022

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

**Request for Waivers under Section 1135**

X  The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a.  X  SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b.  X  Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

TN: 22-0001

Supersedes TN: New

This SPA is in addition to the Disaster Relief SPA(s) approved on May 4th, 2020, May 26, 2021 and September 28, 2021 and does not supersede anything approved in those SPA(s).

Approval Date: 6/14/2022

Effective Date: 7/1/2021

- c. \_\_\_\_\_ Tribal consultation requirements– the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

*Please describe the modifications to the timeline.*

**Section A – Eligibility**

- 1. \_\_\_\_\_ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

*Include name of the optional eligibility group and applicable income and resource standard.*

- 2. \_\_\_\_\_ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. \_\_\_\_\_ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: \_\_\_\_\_

-or-

- b. \_\_\_\_\_ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: \_\_\_\_\_

- 3. \_\_\_\_\_ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

4. \_\_\_\_\_ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. \_\_\_\_\_ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. \_\_\_\_\_ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

**Section B – Enrollment**

1. \_\_\_\_\_ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

*Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.*

2. \_\_\_\_\_ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

*Please describe any limitations related to the populations included or the number of allowable PE periods.*

TN: 22-0001  
Supersedes TN: New

Approval Date: 6/14/2022  
Effective Date: 7/1/2021

This SPA is in addition to the Disaster Relief SPA(s) approved on May 4th, 2020, May 26, 2021 and September 28, 2021 and does not supersede anything approved in those SPA(s).



3. \_\_\_\_\_ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

*Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.*

4. \_\_\_\_\_ The agency adopts a total of \_\_\_\_\_ months (not to exceed 12 months) continuous eligibility for children under age \_\_\_\_\_ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5. \_\_\_\_\_ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every \_\_\_\_\_ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. \_\_\_\_\_ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
- \_\_\_\_\_ The agency uses a simplified paper application.
  - \_\_\_\_\_ The agency uses a simplified online application.
  - \_\_\_\_\_ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

### Section C – Premiums and Cost Sharing

1. \_\_\_\_\_ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

*Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).*

2. \_\_\_\_\_ The agency suspends enrollment fees, premiums and similar charges for:

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- a. \_\_\_\_\_ All beneficiaries
- b. \_\_\_\_\_ The following eligibility groups or categorical populations:

*Please list the applicable eligibility groups or populations.*

- 3. \_\_\_\_\_ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

*Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.*

**Section D – Benefits**

*Benefits:*

- 1. \_\_\_\_\_ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

- 2. \_\_\_\_\_ The agency makes the following adjustments to benefits currently covered in the state plan:

- 3. \_\_\_\_\_ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

- 4. \_\_\_\_\_ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

- a. \_\_\_\_\_ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

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Supersedes TN: New

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Effective Date: 7/1/2021

This SPA is in addition to the Disaster Relief SPA(s) approved on May 4th, 2020, May 26, 2021 and September 28, 2021 and does not supersede anything approved in those SPA(s).

- b. \_\_\_ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

*Please describe.*

*Telehealth:*

5. \_\_\_ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

*Please describe.*

*Drug Benefit:*

6. \_\_\_ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

*Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.*

7. \_\_\_ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. \_\_\_ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

*Please describe the manner in which professional dispensing fees are adjusted.*

9. \_\_\_ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

**Section E – Payments**

*Optional benefits described in Section D:*

1.  Newly added benefits described in Section D are paid using the following methodology:

a.  Published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

Location (list published location): \_\_\_\_\_

b.  Other:

*Describe methodology here.*

*Increases to state plan payment methodologies:*

2.  The agency increases payment rates for the following services:

*Update nursing home rate components for general liability, property insurance, property tax pass-through to the 2021 cost report.*

a.  Payment increases are targeted based on the following criteria:

*Update nursing home rate components for general liability, property insurance, property tax pass-through to the 2021 cost report.*

b. Payments are increased through:

i.  A supplemental payment or add-on within applicable upper payment limits:

*Please describe.*

ii.  An increase to rates as described below.

Rates are increased:

TN: 22-0001

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This SPA is in addition to the Disaster Relief SPA(s) approved on May 4th, 2020, May 26, 2021 and September 28, 2021 and does not supersede anything approved in those SPA(s).

\_\_\_\_\_ Uniformly by the following percentage: \_\_\_\_\_

\_\_\_\_\_ Through a modification to published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

Location (list published location): \_\_\_\_\_

\_\_\_\_\_ Up to the Medicare payments for equivalent services.

\_\_\_\_\_ By the following factors:

*Please describe.*

*Payment for services delivered via telehealth:*

3. \_\_\_\_\_ For the duration of the emergency, the state authorizes payments for telehealth services that:

- a. \_\_\_\_\_ Are not otherwise paid under the Medicaid state plan;
- b. \_\_\_\_\_ Differ from payments for the same services when provided face to face;
- c. \_\_\_\_\_ Differ from current state plan provisions governing reimbursement for telehealth;

*Describe telehealth payment variation.*

- d. \_\_\_\_\_ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
  - i. \_\_\_\_\_ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
  - ii. \_\_\_\_\_ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

*Other:*

4. \_\_\_\_\_ Other payment changes:

*Please describe.*

TN: 22-0001

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\_\_\_\_\_

**Section F – Post-Eligibility Treatment of Income**

1. \_\_\_ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
  - a. \_\_\_ The individual’s total income
  - b. \_\_\_ 300 percent of the SSI federal benefit rate
  - c. \_\_\_ Other reasonable amount: \_\_\_\_\_
  
2. \_\_\_ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

*Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.*

**Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information**

\_\_\_\_\_

**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. \*\*\*CMS Disclosure\*\*\* Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports

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This SPA is in addition to the Disaster Relief SPA(s) approved on May 4th, 2020, May 26, 2021 and September 28, 2021 and does not supersede anything approved in those SPA(s).

Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

TN: 22-0001

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This SPA is in addition to the Disaster Relief SPA(s) approved on May 4th, 2020, May 26, 2021 and September 28, 2021 and does not supersede anything approved in those SPA(s).

Revision: HCFA-PM-91-4 (BPD)  
August 1991

OMB NO. 0938 -

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

Citations(s) 7.4 State Governor's Review

42 C.F.R.  
§430.12 (B)

The Medicaid agency will provide opportunity for the office of the governor to re view Sate plan amendments, long range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments transmitted to the Centers for Medicare and Medicaid Services with such documents.

Not applicable. The Governor - -

Does not wish to review any plan material

Wishes to review only the plan materials specified in the enclosed document

Review is not required in accordance with 42 C.F.R. §430.12(b)(2)(i) (see attached)



LIST OF ATTACHMENTS

<u>No.</u>	<u>Title of Attachment</u>
*1.1-A	Attorney General's Certification
*1.1-B	Waivers under the Intergovernmental Cooperation Act
1.2-A	Organization and Function of State Agency
1.2-8	Organization and Function of Medical Assistance Unit
1.2-C	Professional Medical and Supporting Staff
1.2-D	Description of Staff Making Eligibility Determination
2.1-A	Definition of an HIMO that Is Not Federally Qualified
*2.2-A	Groups Covered and Agencies Responsible for Eligibility Determinations
* Supplement 1 -	Reasonable classifications of Individuals under the Age of 21, 20, 19 and 18
* Supplement 2 -	Definitions of Blindness and Disability ( <u>Territories only</u> )
* Supplement 3 -	Method of Determining Cost Effectiveness of Caring for Certain Disabled Children at Home
*2.6-A	Eligibility Conditions and Requirements ( <u>States only</u> )
* Supplement 1 -	Income Eligibility Levels Categorically Needy, Medically Needy and Qualified Medicare Beneficiaries
* Supplement 2 -	Resource Levels Categorically Needy, Including Groups with Incomes Up to a Percentage of the Federal Poverty Level, Medically Needy, and Other Optional Groups
* Supplement 3 -	Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
* Supplement 4 -	Section 1902(f) Methodologies for Treatment of Income that differ from those of the SSI Program

\*Forms Provided

TN No. 91-31  
Supersedes  
TN No. 87-6

Approval Date 12-18-91 Effective Date 10-1-91  
HCFA ID: 7982E

<u>No.</u>	<u>Title of Attachment</u>
* Supplement 5 -	Section 1902(f) Methodologies for Treatment of Resources that differ from those of the SSI. Program
* Supplement 5a -	Methodologies for Treatment of Resources for Individuals with Incomes up to a Percentage of the Federal Poverty Level
* Supplement 6 -	Standards for Optional State Supplementary Payments
* Supplement 7 -	Income Levels for 1902(f) States Categorically Needy Who Are Covered under Requirements More Restrictive than SSI
* Supplement 8 -	Resource Standards for 1902(f) States - Categorically Needy
* Supplement 8a -	More Liberal Methods of Treating Income Under Section 1902(r)(2) of the Act
* Supplement 8b -	More Liberal Methods of Treating Resources Under Section 1902(r)(2) of the Act
* Supplement 9 -	Transfer of Resources
* Supplement 10 -	Consideration of Medicaid Qualifying Trusts--Undue Hardship

\*2.6-A Eligibility Conditions and Requirements (Territories only)

* Supplement 1 -	Income Eligibility Levels Categorically Needy, Medically Needy, and Qualified Medicare Beneficiaries
* Supplement 2 -	Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not covered under Medicaid
* Supplement 3 -	Resource Levels for Optional Groups with Incomes Up to a Percentage of the Federal Poverty Level and Medically Needy
* Supplement 4 -	Consideration of Medicaid Qualifying Trusts--Undue Hardship
* Supplement 5 -	More Liberal Methods of Treating Income under Section 1902(r)(2) of the Act
* Supplement 6 -	More Liberal Methods of Treating Resources under Section 1902(r)(2) of the Act

\*Forms Provided

TN No. 91-31  
Supersedes  
TN No. 87-6

Approval Date 12-18-91

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE GEORGIA

DEFINITION OF A HEALTH MAINTENANCE ORGANIZATION (HMO)  
THAT IS NOT FEDERALLY QUALIFIED

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The definition of an HMO that is not federally qualified is any state licensed health care provider which meets the requirements of 42 CFR 434.20(c) (1,2,3)

TN No. 94-27      DATE/RECEIPT 6/21/94  
SUPERSEDES      DATE/APPROVED 8/24/94  
TN NO. N/A      DATE/EFFECTIVE 7-1-94

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

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Agency*	Citation(s)	Groups Covered
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The following groups are covered under this plan.

A. Mandatory coverage – Categorically Needy and Other  
Required Special Groups

IV-A 42 CFR 435.110      1. Recipients of AFDC

The approved State AFDC plan includes:

- Families with an unemployed parent for the mandatory 6-month period and an optional extension of 0 months.
- Pregnant women with no other eligible children.
- AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments are listed in Supplement I of ATTACHMENT 2.6-A.

IV-A 42 CFR 435.115      2. Deemed Recipients of AFDC

- a. Individuals denied a title IV-A cash payment solely because the amount would be less than \$10.

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
IV-A	A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)	
	2. Deemed Recipients of AFDC.	
	1902(a)(10)(A)(i)(I) of the Act	b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e) (6) of the Act.
	402(a)(22) (A) of the Act	c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.
	406(h) and 1902(a) (10)(A) (i)(I) of the Act	d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.
	1902(a) of the Act	e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

\*Agency that determines eligibility for coverage.

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Agency* Citation(s)	Groups Covered
A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)	
407(b), 1902 (a)(10)(A)(i) and 1905(m)(1) of the Act	3. Qualified Family Members (Medicaid Only)  See Item A.10, pg 4a.
1902(a)(52) and 1925 of the Act	4. Families terminated from Low Income Medicaid solely because of earnings, hours of employment, or loss of earned income disregards are entitled to up to twelve months of extended benefits in accordance with Section 1925 of the Act.

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
IV-A	42 CFR 435.113	<p data-bbox="641 430 1339 493">A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</u></p> <p data-bbox="673 525 1404 693">5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are:</p> <p data-bbox="673 630 1356 693">a. Families denied AFDC solely because of income and resources deemed to be available from—</p> <ul data-bbox="771 724 1404 1060" style="list-style-type: none"><li data-bbox="771 724 1404 829">(1) Stepparents who are not legally liable for support of stepchildren under a State law of general applicability;</li><li data-bbox="771 861 990 892">(2) Grandparents;</li><li data-bbox="771 924 1071 955">(3) Legal guardians; and</li><li data-bbox="771 987 1404 1060">(4) Individual alien sponsors (who are not spouses of the individual or the individual's parent);</li></ul> <p data-bbox="722 1092 1372 1197">b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.</p> <p data-bbox="722 1228 1356 1329">c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.</p>

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</u>
IV-A	42 CFR 435.114	6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 9.2-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.  — Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).  <u>X</u> Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).  — Not applicable with respect to intermediate care facilities; State did or does not cover this service.
IV-A	1902(a) (10) (A) (i) (III) and 1905(n) of the Act	7. Qualified Pregnant women and Children.  a. A pregnant woman whose pregnancy has been medically verified who—  (1) Would be eligible for an AFDC cash payment if the child had been born and was living with her;

\*Agency that determines eligibility for coverage.



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
*IV-A  1902(a) (10)(A) (i)(III) and 1905(n) of the Act	A. <u>Mandatory coverage Categorically Needy and other Required Special Groups (Continued)</u>  7. a. (2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents program; or  (3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.  b. Children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.  <u>X</u> Children born after <u>6/30/74</u> (specify optional earlier date) who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

\* Agency that determines eligibility for coverage.

Citation(s)	Groups Covered
IV-A 1902(a)(10)(A) (i)(IV) and 1902 (1) (1)(A) and B of the Act.	<p>A. <u>Mandatory coverage Categorically Needy and other Required Special Groups</u> (Continued)</p> <p>8. Pregnant women and infants, under 1 year of age, with family income up to 133 percent of the Federal poverty level, who are described in Section 1902(a)(10)(A)(i)(IV) and 1902(1)(I)(A) and (B) of the Act. The income level for this group is specified in <u>Supplement 1 to ATTACHMENT 2.6-A</u>.</p> <p>— The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.</p>
IV-A 1902(a)(10)(A) (i)(IV) 1902 (1) (1) (c) of the Act.	<p>9. Children</p> <p>a. who have attained 1 year of age, but have not attained 6 years of age, with family income at or below 133 percent of the Federal poverty level.</p>
IV-A 1902(a)(10)(A)(i) (VII) and 1902(1) (1)(D) of the Act.	<p>b. born after September 30, 1983, who have attained 6 years of age, but have not attained 19 years of age, with family income at or below 100 percent of the Federal poverty level.</p>
	<p>Income levels for these groups are specified in <u>Supplement 1 to Attachment 2.6-A</u>.</p>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</u>
IV-A	1902(a) (10) (A) (i) (V) and 1905(m) of the Act	10. Individuals other than qualified pregnant women and children under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.
IV-A	1902(e) (5) of the Act	11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in: which the 60th day falls.
	1902(e) (6) of the Act	b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

\*Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</u>		
XVI	1902(e) (4) of the Act	12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.
	42 CFR 435.120	13. Aged, Blind and Disabled Individuals Receiving Cash Assistance
		<input checked="" type="checkbox"/> a. Individuals receiving SSI.
		This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability of pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.
		<input checked="" type="checkbox"/> Aged <input checked="" type="checkbox"/> Blind <input checked="" type="checkbox"/> Disabled

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

435.121	1619(b)(1) of the Act	13. <input type="checkbox"/> b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified, for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)
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- Aged
- Blind
- Disabled

The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in ATTACHMENT 2.6-A).

\*Agency that determines eligibility for coverage.

State: GEORGIA

Agency*	Citation(s)	Groups Covered
XVI	1902(a) (10)(A) (i)(II) and 1905 (q) of the Act P.L. 101-508, SECTION 5032	A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)  14. Qualified severely impaired blind and disabled individuals who—  a. For the month preceding the first month of eligibility under the requirements of section 1905 (q) (2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or  b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must—  (1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;  (2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;  (3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

- (4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and
- (5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.
- Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

\*Agency that determines eligibility for coverage.

State: GEORGIA

Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)
	1619(b) (3) of the Act	<input type="checkbox"/> The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

\*Agency that determines eligibility for coverage.



State: GEORGIA

Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)
IV-A	1634 (C) of the Act	15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who— a. Are at least 18 years of age; b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility. <input type="checkbox"/> c. The state applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility. <input type="checkbox"/> d. The state applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.
IV-A	42 CFR 435.122	16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.
XVI	42 CFR 435.130	17. Individuals receiving mandatory State supplements.

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</u>		
IV-A	42 CFR 435.131	<p>18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.</p> <p><input type="checkbox"/> In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):</p> <p>___ Aged    ___ Blind    ___ Disabled</p> <p><input checked="" type="checkbox"/> Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.</p>

\*Agency that determines eligibility for coverage

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</u>
IV-A	42 CFR 435.132	19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they—  a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and  b. Remain institutionalized; and  c. Continue to need institutional care.
IV-A	42 CFR 435.133	20. Blind and disabled individuals who—  a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and  b. Were eligible for Medicaid in December 1973 as blind or disabled; and  c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

\*Agency that determines eligibility for coverage.

State: GEORGIA

Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)
IV-A	42 CFR 435.134	21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.  <input type="checkbox"/> Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).  <input checked="" type="checkbox"/> Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).  <input type="checkbox"/> Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

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|------|----------------|---|
| IV-A | 42 CFR 435.135 | <p>22. Individuals who—</p> <ul style="list-style-type: none"><li>a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and</li><li>b. Would still be eligible for SSI Or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.</li></ul> <ul style="list-style-type: none"><li><input type="checkbox"/> Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.</li><li><input type="checkbox"/> Not applicable because the state applies more restrictive eligibility requirements than those under SSI.</li><li><input type="checkbox"/> The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.</li></ul> |
|------|----------------|---|

\*Agency that determines eligibility for coverage.

State: GEORGIA

Agency*	Citation(s)	Groups Covered
<u>A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</u>		
IV-A	1634 of the Act	<p>23. Disabled widows and widowers who would be eligible for SSI Or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634 (b) of the Act.</p> <p><input type="checkbox"/> Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.</p> <p><input type="checkbox"/> The state applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.</p>

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
1634(d) of the Act	A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</u>	24. Disabled widows, disabled widowers, and surviving disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A
		_____ The state applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.
		_____ In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in S 1634 (d) (1) (A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.
		_____ In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in S 1634 (d)(1)(A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregarded is specified in supplement 4 to Attachment 2.6-A.
		_____ In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in S 1634 (d) (1) (A) in determining the income of the individual.

\*Agency that determines eligibility for coverage.

State: Georgia

Agency*	Citation(s)	Groups Covered
		<p>A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)</p>
	1902(a)(10)(E)(i), 1905(p) and 1860D-14(a)(3)(D) of the Act	<p>25. Qualified Medicare Beneficiaries –</p> <ul style="list-style-type: none"> <li>a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act);</li> <li>b. Whose income does not exceed 100 percent of the Federal poverty level; and</li> <li>c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.</li> </ul> <p>(Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)</p>
	1902(a)(10)(E)(ii), 1905(s) of the Act	<p>26. Qualified Disabled and Working Individuals –</p> <ul style="list-style-type: none"> <li>a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act;</li> <li>b. Whose income does not exceed 200 percent of the Federal poverty level; and</li> <li>c. Whose resources do not exceed two times the SSI resource limit.</li> <li>d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.</li> </ul> <p>(Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)</p>

\*Agency that determines eligibility



State: Georgia

Agency*	Citation(s)	Groups Covered
1902(a)(10)(E)(iii), 1905(p)(3)(A)(ii), and 1860D-14(a)(3)(D) of the Act	A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)	27. Specified Low-Income Medicare Beneficiaries -- <ol style="list-style-type: none"> <li data-bbox="776 562 1373 657">a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);</li> <li data-bbox="776 695 1373 789">b. whose income is greater than 100 percent but less than 120 percent of the Federal poverty level; and</li> <li data-bbox="776 827 1373 926">c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.</li> </ol>

\*Agency that determines eligibility

State: Georgia

Agency*	Citation(s)	Groups Covered
1902(a)(10)(E)(iv) And 1905(p)(3)(A)(ii) and 1860D-14(a)(3)(D) of the Act	A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)	28. Qualifying Individuals – <ol style="list-style-type: none"> <li>a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);</li> <li>b. whose income is at least 120 percent but less than 135 percent of the Federal poverty level;</li> <li>c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.</li> </ol>

\*Agency that determines eligibility

State: GEORGIA

Agency*	Citation(s)	Groups Covered
		<b>B. <u>Optional Groups Other Than the Medically Needy</u></b>
	42 CFR 435.210 1902(a) (10)(A)(ii) and 1905(a) of the Act	<input type="checkbox"/> 1. Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.  <input type="checkbox"/> The plan covers all individuals as described above.  <input type="checkbox"/> The plan covers only the following group or groups of individuals:  ___ Aged ___ Blind ___ Disabled ___ Caretaker relatives ___ Pregnant women
IV-A	42 CFR 435.211	<input checked="" type="checkbox"/> 2. Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

\*Agency that determines eligibility for coverage.

State / Territory: GEORGIA

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.212 &  
1902(e) (2) of the  
Act, P.L. 99-272  
(Section 9517) P.L.  
101-508 (Section 4732)

\_\_\_ 3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act or while enrolled in an entity described in Section 1903 (m) (2) (B) (111), (E) or (G) of the Act, or a competitive Medical Plan (CMP) with a Medicare contract under Section 1876 of the Act, but who have been enrolled in the HMO or entity for less than the minimum enrollment period listed below. The HMO or entity must have risk contract specified in 42 CFR 434.20(a). coverage under this section is limited to HMO services and family planning services described in Section 1905(a) (4) (C).

The State elects not to guarantee eligibility.

\_\_\_ The state elects to guarantee eligibility. The minimum enrollment period is \_\_\_\_\_ months (not to exceed six).

The State measures the minimum enrollment period from:

\_\_\_ The date beginning the period of enrollment in the HMO or other entity, without any intervening disenrollment, regardless of Medicaid eligibility.

\_\_\_ The date beginning the period of enrollment in the HMO as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

\_\_\_ The date beginning the last period of enrollment in the HMO as a Medicaid patient (not including periods when payment is made under this section), without any intervening disenrollment of periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section.)

\*Agency that determines eligibility for coverage.

State / Territory: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

1903 (m) (2) (F) of the Act, P.L. 98-369 (Section 2364), P.L. 99-272 (Section 9517). P.L. 101-508 (Section 4732)	The Medicaid Agency may elect to restrict the disenrollment rights of Medicaid enrollees of certain Federally qualified HMOS, Competitive Medical Plans (CMPs) with Medicare contracts under Section 1876 of the Act, and other organizations described in 42 CFR 434.27(d), in accordance with the regulations at 42 CFR 434.27. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.
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Disenrollment rights are restricted for a period of 6 months (not to exceed 6 months).

During the first month of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least twice per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

No restrictions upon disenrollment rights.

1903 (m) (2) (H), 1902(a) (52) of the Act. P.L. 101-508 (Section 4732)	In the case of individuals who have become ineligible for Medicaid for the brief period described in Section 1903 (m) (2) (H) and who were enrolled with an entity having a contract under Section 1903 (m) when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.
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The Agency elects to reenroll the above individuals who are ineligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.

The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

\*Agency that determines eligibility for coverage.

State/Territory: GEORGIA

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Agency*	Citation(s)	Groups Covered
<b>B. <u>Optional Groups Other Than the Medically Needy</u></b> (Continued)		
IV-A	42 CFR 435.217	<u>X</u> 4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

\*Agency that determines eligibility for coverage.

State: GEORGIA

Agency*	Citation(s)	Groups Covered
		<b>B. <u>Optional Groups Other Than the Medically Needy</u></b> (Continued)
IV-A XVI	1902(a) (10) (A) (ii) (VII) of the Act	<input checked="" type="checkbox"/> 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.  <input checked="" type="checkbox"/> The State covers all individuals as described above.  <input type="checkbox"/> The State covers only the following group or groups of individuals:  ___ Aged ___ Blind ___ Disabled ___ Individuals under the age of-- ___ 21 ___ 20 ___ 19 ___ 18 ___ Caretaker relatives ___ Pregnant women

\*Agency that determines eligibility for coverage.

State: Georgia

Agency*	Citation(s)	Groups Covered
B. <u>Optional Groups Other Than the Medically Needy (continued)</u>		
42 CFR 435.220	_____	6. Individuals who would be eligible for AFDC if their work-related child-care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child-care costs from income to determine the amount of AFDC.
	_____	The State covers all individuals as described above.
1902(a)(10)(A)(ii) and 1905(a) of the Act	_____	The State covers only the following group or groups of individuals: <ul style="list-style-type: none"> <li>_____ Individuals under the age of--</li> <li>_____ 21</li> <li>_____ 20</li> <li>_____ 19</li> <li>_____ 18</li> <li>_____ Caretaker relatives</li> <li>_____ Pregnant women</li> </ul>
IV-A 42 CFR 435.222 1902(a)(10)(A)(ii) and 1905 (a)(i) of the Act		7. <u>X</u> a. All individuals who are not described in Section 1902 (a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are under the age of 21, as indicated below <ul style="list-style-type: none"> <li>_____ 20</li> <li><u>X</u> 19</li> <li>_____ 18</li> </ul>



State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.222

b. Reasonable classifications of individuals described in (a) above, as follows:

(1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

(a) In foster homes (and are under the age of 21).

(b) In private institutions (and are under the age of 21).

(c) In addition to the group under b. (1) (a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of     ).

(2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of 21).

(3) Individuals in NFs (who are under the age of     ). NF services are provided under this plan.

(4) In addition to the group under (b) (3), individuals in ICFs/MR (who are under the age of     ).

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

- \_\_\_\_\_ (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of \_\_\_\_\_). Inpatient psychiatric services for individuals under age 21 are provided under this plan.
- \_\_\_\_\_ (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

1902 (a) (10)  
(A) (ii) (VIII)  
of the Act

8. A child for whom there is in effect a State adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical rehabilitative care, and who before execution of the agreement—
- a. Was eligible for Medicaid under the State's approved Medicaid plan; or
  - b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies.

The State covers individuals under the age of-

- 21
- 20
- 19
- 18

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.223  9. Individuals described below who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under title IV-A:

1902(a) (10)  
(A)(ii) and  
1905(a) of  
the Act

- Individuals under the age of--
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant woman

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.230



10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

The following groups of individuals who receive only a State -supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in the State.
- d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

\_\_\_ (1) All aged individuals.

\_\_\_ (2) All blind individuals.

\_\_\_ (3) All disabled individuals.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
		<b>B. <u>Optional Groups Other Than the Medically Needy</u></b> (Continued)
	42 CFR 435.230	<p>_____ 4. Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.</p> <p>_____ 5. Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.</p> <p>_____ 6. Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.</p> <p>_____ 7. Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.</p> <p>_____ 8. Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.</p> <p>_____ 9. Individuals in additional classifications approved by the Secretary as follows:</p>

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

Yes.

No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-4.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.230  
435. 121  
1902(a) (10)  
(A) (ii)(XI)  
of the Act

11. Section 1902(f) states and SSI criteria States without agreements under section 1616 or 1634 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is—

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in each classification and available on a Statewide basis.
- d. Paid to one or more of the classifications of individuals listed below:
  - \_\_\_\_\_ (1) All aged individuals.
  - \_\_\_\_\_ (2) All blind individuals.
  - \_\_\_\_\_ (3) All disabled individuals.



State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

- \_\_\_\_\_ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- \_\_\_\_\_ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- \_\_\_\_\_ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- \_\_\_\_\_ (7) Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
- \_\_\_\_\_ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
- \_\_\_\_\_ (9) Individuals in additional classifications approved by the Secretary as follows:

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

Yes

No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

State: GEORGIA

Agency*	Citation(s)	Groups Covered
		<b>B. <u>Optional Groups Other Than the Medically Needy</u></b> (Continued)
IV-A	42 CFR 435.231 1902(a) (10) (A)(ii) (V) of the Act	<input checked="" type="checkbox"/> 12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 6 to ATTACHMENT 2.6-A.
		<input checked="" type="checkbox"/> The State covers all individuals as described above.
		<input type="checkbox"/> The State covers only the following group or groups of individuals:
	1902(a)(10)(A) (ii) and 1905(a) of the Act	<input type="checkbox"/> Aged <input type="checkbox"/> Blind <input type="checkbox"/> Disabled <input type="checkbox"/> Individuals under the age of-- <input type="checkbox"/> 21 <input type="checkbox"/> 20 <input type="checkbox"/> 19 <input type="checkbox"/> 18 <input type="checkbox"/> Caretaker relatives <input type="checkbox"/> Pregnant women

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
<b>B. <u>Optional Groups Other Than the Medically Needy</u></b> (Continued)		
IV-A	1902(e) (3) of the Act	<input checked="" type="checkbox"/> 13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the state has made a determination as required under section 1902(e)(3)(B) of the Act.  <u>Supplement 3 to ATTACHMENT 2.2-A</u> describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.
	1902(a) (10) (A) (ii) (IX) and 1902(1) of the Act	<input checked="" type="checkbox"/> 14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in <u>Supplement 1 to ATTACHMENT 2.6-A</u> for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in <u>Supplement 2 to ATTACHMENT 2.6-A</u> :  a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and  b. Infants under one year of age.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
		<b>B. <u>Optional Groups Other Than the Medically Needy</u> (Continued)</b>
	1902(a) (ii)(x) and 1902(m) (1) and (3) of the Act	<input type="checkbox"/> 16. Individuals— <ol style="list-style-type: none"><li>a. Who are 65 years of age or older or are disabled, as determined under section 1614(a) (3) of the Act. Both aged and disabled individuals are covered under this eligibility group.</li><li>b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to <u>ATTACHMENT 2.6-A</u> for a family of the same size; and</li><li>c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in <u>Supplement 2 of ATTACHMENT 2.6-A</u>.</li></ol>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
1902(a) (47) and 1920 of the Act	<p data-bbox="631 527 1271 590"><b>B. <u>Optional Groups Other Than the Medically Needy</u></b> (Continued)</p> <p data-bbox="631 625 1398 858"><u>X</u> 17. Pregnant women who are determined by a "qualified provider" (as defined in §1920(b)(2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under <u>ATTACHMENT 2.6-A</u> and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with §1920 of the Act.</p>

State / Territory: GEORGIA

Citation(s)	Groups Covered
B. <u>Optional Groups Other Than the Medically Needy</u> <u>(Continued)</u>	
1906 of the Act	<u>  X  </u> 18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for minimum enrollment period of 3 months.
1902 (a) (10) (F) and 1902 (u) (1) of the Act	<u>  X  </u> 19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under section 1612 of the Act for purposes of the SSI program, is no more than 100% of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditure for an equivalent set of services. See Supplement 11 to Attachment 2.6A.
1902 (a) (10) (A) (ii) (XV) of the Act	<u>  X  </u> 20. Individuals who would be eligible for Medicaid under the "Ticket to Work and Work Incentives Act of 1999" (TWWIA), if they are working individuals with a disability who is at least 16, but less than 65 years of age, who except for earned income, would be eligible to receive Supplemental Security Income (SSI) and whose assets, resources, and earned and unearned income (or both) does not exceed such limitations as established. See Supplement 8a to Attachment 2.6A and Supplement 8b to Attachment 2.6A.

Citation(s)

Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(XVIII)   X   24. Women who:  
of the Act.

- a. have been screened for breast or cervical cancer under the Center for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act in accordance with the requirements of Section 1504 of the Act and need treatment for breast cervical cancer, including a pre-cancerous condition of the breast or cervix;
- b. are not otherwise covered under creditable coverage, as defined in Section 2701© of the Public Health Service Act;
- c. are not eligible for Medicaid under any mandatory categorically needy eligibility group, and
- d. have not attained age 65.

1920B of the Act.

- X   25. Women who are determined by a "qualified entry" (as defined in Section 1920B(b)] based on preliminary information, to be a woman described in 1902(aa) of the Act related to certain breast and cervical cancer patients. The presumptive period begins on the day that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the last day.



State: GEORGIA

Citation Condition or Requirement

B. Optional Groups Other Than the Medically Needy  
(Continued)

1902(a) (10) (A) (ii)  
(XVII)  
Of the Act and  
1905(w) (1)  
Of the Act

26. Individuals who are independent foster care adolescents as defined in Section 1905 (w) (1) of the Act.

a. Reasonable classifications of individuals described above, as follows:

The State covers all such individuals who:

1. are less than 21 years of age;
2. were in foster care under the responsibility of the State on their 18<sup>th</sup> birthday.
3. Other (please describe)

n/a

b. Financial requirements

1. Income test

There is no income test for this group.

The income test for this group is \_\_\_\_.

2. Resource test

There is no resource test for this group.

The resource test for this group is \_\_\_\_.

State: GEORGIA

Agency*	Citation(s)	Groups Covered
		C. <u>Optional Coverage of the Medically Needy</u>
	42 CFR 435.301	This plan includes the medically needy. <input type="checkbox"/> No. <input checked="" type="checkbox"/> Yes. This plan covers:
IV-A		1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.
IV-A	1902(e) of the Act	2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60 <sup>th</sup> day falls.
IV-A	1902(a) (10)(c)(ii)(I) of the Act	3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a) (10)(A)(i) of the Act.

State: Georgia

Agency*	Citation(s)	Groups Covered
C. <u>Optional Coverage of the Medically Needy</u> (Continued)		
IV-A	1902 (e) (4) of the Act P.L. 101-508 (Section 4603)	<p>4. Newborn children born on or after October 1, 1984 to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as:</p> <p>a. For children born prior to January 1, 1991: the woman remains eligible and the child is a member of the woman's household.</p> <p>b. For children born on or after January 1, 1991: the woman remains eligible or would remain eligible if pregnant and the child is a member of the woman's household.</p>
	42 CFR 435.308	<p>5. <u>    </u> a. Financially eligible individuals who are not described in Section C.3. above and who are under the age of--</p> <p style="margin-left: 40px;"><u>    </u> 21</p> <p style="margin-left: 40px;"><u>    </u> 20</p> <p style="margin-left: 40px;"><u>    </u> 19</p> <p style="margin-left: 40px;"><u>    </u> 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training</p> <p><u>  X  </u> b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19 or 18 as specified below:</p> <p style="margin-left: 40px;"><u>  X  </u> (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:</p> <p style="margin-left: 80px;"><u>  X  </u> (a) In foster homes (and are under the age of <u>18</u>).</p> <p style="margin-left: 80px;"><u>  X  </u> (b) In private institutions (and are under the age of <u>18</u>).</p>

State: Georgia

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Agency*	Citation(s)	Groups Covered
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C. Optional Coverage of the Medically Needy (continued)

\_\_\_\_\_ (c) In addition to the group under b. (1) (a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of \_\_\_\_.)

  X   (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of 18).

\_\_\_\_\_ (3) Individuals in NFs (who are under the age of \_\_\_\_). NF services are provided under this plan.

\_\_\_\_\_ (4) In addition to the group under (b) (3), individuals in ICFs/MR (who are under the age of \_\_\_\_).

  X   (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of 21). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

\_\_\_\_\_ (6) Other defined groups (and ages), as specified in Supplement 1 of Attachment 2.2-A.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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C. Optional Coverage of the Medically Needy (Continued)

- |                            |                                     |   |
|----------------------------|-------------------------------------|---|
| 42 CFR 435.310             | <input type="checkbox"/>            | 6. Caretaker relatives.   |
| 42 CFR 435.320 and 435.330 | <input checked="" type="checkbox"/> | 7. Aged individuals.  |
| 42 CFR 435.322 and 435.330 | <input checked="" type="checkbox"/> | 8. Blind individuals.   |
| 42 CFR 435.324 and 435.330 | <input checked="" type="checkbox"/> | 9. Disabled individuals.  |
| 42 CFR 435.326             | <input type="checkbox"/>            | 10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.  |
| 435.340                    |                                     | 11. Blind and disabled individuals who:<br><br>a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;<br><br>b. Were eligible as medically needy in December 1973 as blind or disabled; and<br><br>c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria. |

State/Territory: Georgia

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Citation(s)	Groups Covered
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C. Optional Coverage of the Medically Needy (Continued)

1906 of the Act

12. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of 3 months.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE  
PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency*	Citation(s)	Groups Covered
1935(a) and 1902(a)(66)  42 CFR 423.774 and 423.904	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act.	<ul style="list-style-type: none"><li>a. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act;</li><li>b. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined;</li><li>c. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.</li></ul>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

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Agency*	Citation(s)	Groups Covered
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The following groups are covered under this plan.

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups

IV-A 42 CFR 435.110

1. Recipients of AFDC

The approved State AFDC plan includes:

- Families with an unemployed parent for the mandatory 6-month period and an optional extension of -0- months.
- Pregnant women with no other eligible children.
- AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments are listed in Supplement 1 of ATTACHMENT 2.6-A.

IV-A 42 CFR 435.115

2. Deemed Recipients of AFDC

- a. Individuals denied a title IV-A cash payment solely because the amount would be less than \$10.

\*Agency that determines eligibility for coverage.



State: GEORGIA

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Agency*	Citation(s)	Groups Covered
IV-A		A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)
		2. Deemed Recipients of AFDC.
	1902(a)(10)(A)(i) (I) of the Act	b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e) (6) of the Act.
	402(a)(22)(A) of the Act	c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.
	406(h) and 1902(a) (10)(A) (i)(I) of the Act	d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.
	1902(a) of the Act	e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

\*Agency that determines eligibility for coverage.

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Agency*	Citation(s)	Groups Covered
A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)		
	407(b), 1902 (a)(10)(A)(i) and 1905(m)(1) of the Act	3. Qualified Family Members (Medicaid Only)  See Item A.10, pg 4a.
	1902(a)(52) and 1925 of the Act	4. Families terminated from Low Income Medicaid solely because of earnings, hours of employment, or loss of earned income disregards are entitled to up to twelve months of extended benefits in accordance with Section 1925 of the Act.

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)		
IV-A	42 CFR 435.113	5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are:  a. Families denied AFDC solely because of income and resources deemed to be available from—  (1) Stepparents who are not legally liable for support of stepchildren under a State law of general applicability;  (2) Grandparents;  (3) Legal guardians; and  (4) Individual alien sponsors (who are not spouses of the individual or the individual's parent);  b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.  c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.

\*Agency that determines eligibility for coverage.

State: GEORGIA

Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)
IV-A	42 CFR 435.114	6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.  _____ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).  _____ <u>X</u> Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).  _____ Not applicable with respect to intermediate care facilities; State did or does not cover this service.
IV-A	1902(a) (10) (A) (i) (III) and 1905(n) of the Act	7. Qualified Pregnant Women and Children.  a. A pregnant woman whose pregnancy has been medically verified who—  (1) Would be eligible for an AFDC cash payment if the child had been born and was living with her;

\*Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)
* IV-A	7. a. (2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents program; or
1902(a) (10)(A) (i)(III) and 1905(n) of the Act	(3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.
	b. children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.
	<u>X</u> Children born after <u>6/30/74</u> (specify optional earlier date) who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

Citation(s)	Groups Covered
IV-A 1902(a)(10)(A) (i)(IV) and 1902 (1) (1)(A) and B of the Act.	<p data-bbox="565 394 1260 464">A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)</p> <p data-bbox="634 495 1312 695">8. Pregnant women and infants, under 1 year of age, with family income up to 133 percent of the Federal poverty level, who are described in Section 1902(a)(10)(A)(i)(IV) and 1902(1)( I)(A) and (B) of the Act. The income level for this group is specified in <u>Supplement 1 to ATTACHMENT 2.6-A</u>.</p> <p data-bbox="634 730 1302 863">___ The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.</p>
IV-A 1902(a)(10)(A) (i)(IV) 1902 (1)(1) (c) of the Act.	<p data-bbox="634 932 792 961">9. Children</p> <p data-bbox="683 999 1302 1100">a. who have attained 1 year of age, but have not attained 6 years of age, with family income at or below 133 percent of the Federal poverty level.</p>
IV-A 1902(a)(10)(A)(i) (VII) and 1902(1) (I)(D) of the Act.	<p data-bbox="683 1136 1312 1266">b. born after September 30, 1983, who have attained 6 years of age, but have not attained 19 years of age, with family income at or below 100 percent of the Federal poverty level.</p>
	<p data-bbox="540 1304 1289 1365">Income levels for these groups are specified in <u>Supplement 1 to Attachment 2.6-A</u>.</p>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

COVERAGE AND CONDITIONS OF ELIGIBILITY

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Agency*	Citation(s)	Groups Covered
A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)		
IV-A	1902(a) (10) (A)(i) (V) and 1905 (m) of the Act	10. Individuals other than qualified pregnant women and children under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.
IV-A	1902(e)(5) of the Act	11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60 <sup>th</sup> day falls.
	1902(e)(6) of the Act	b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

\*Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)
XVI	1902(e) (4) of the Act	1. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.
	42 CFR 435.120	2. Aged, Blind and Disabled Individuals Receiving Cash Assistance  <u>X</u> a. Individuals receiving SSI.  This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.  <u>X</u> Aged <u>X</u> Blind <u>X</u> Disabled

\*Agency that determines eligibility for coverage.



State:                   GEORGIA                  

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

435.121	13. <input type="checkbox"/>	b. Individuals who meet more restrictive - requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619 (a) eligibility standard or the requirements of section 1619(b) of the Act.)
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- Aged
- Blind
- Disabled

The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in ATTACHMENT 2.6-A).

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)
XVI	1902(a) (10)(A) (i)(II) and 1905 (q) of the Act P.L. 101-508, SECTION 5032	3. Qualified severely impaired blind and disabled individuals who--  a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or  b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must—  (1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;  (2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;  (3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

- (4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and
- (5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

Not applicable with respect to individuals receiving only SSP because the state either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

1619(b)(3)  
of the Act

The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

\*Agency that determines eligibility for coverage.

State: GEORGIA

Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</u>
IV-A	1634 (C) of the Act	15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who—  a. Are at least 18 years of age;  b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.  <input type="checkbox"/> c. The state applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.  <input type="checkbox"/> d. The state applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.
IV-A	42 CFR 435.122	16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act
XVI	42 CFR 435.130	17. Individuals receiving mandatory State supplements.

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

IV-A	42 CFR 435.131	18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.
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In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):  
\_\_\_\_\_ Aged      \_\_\_\_\_ Blind      \_\_\_\_\_ Disabled

Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)		
IV-A	42 CFR 435.132	19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they—  a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and  b. Remain institutionalized; and  c. Continue to need institutional care.
IV-A	42 CFR 435.133	20. Blind and disabled individuals who—  a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and  b. Were eligible for Medicaid in December 1973 as blind or disabled; and  c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

\*Agency that determines eligibility for coverage.



State:                     GEORGIA                    

Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)
IV-A	42 CFR 435.134	21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.  <input type="checkbox"/> Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).  <input checked="" type="checkbox"/> Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).  <input type="checkbox"/> Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

\*Agency that determines eligibility for coverage.

State: GEORGIA

Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)
IV-A	42 CFR 435.135	22. Individuals who - -  a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and  b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.  <input type="checkbox"/> Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.  <input type="checkbox"/> Not applicable because the state applies more restrictive eligibility requirements. than those under SSI.  <input type="checkbox"/> The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

\*Agency that determines eligibility for coverage.

State:                     GEORGIA                    

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

IV-A	1634 of the Act	<p>23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634 (b) of the Act.</p> <p><input type="checkbox"/> Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.</p> <p><input type="checkbox"/> The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.</p>
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\*Agency that determines eligibility for coverage.

State/Territory: GEORGIA

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Agency*	Citation(s)	Groups Covered
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1634(d) of  
the Act

A. Mandatory Coverage – Categorically Needy and Other  
Required Special Groups (Continued)

24. Disabled widows, disabled widowers, and surviving disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.

\_\_\_\_\_ The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.

\_\_\_\_\_ In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in § 1634 (d) (1) (A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.

\_\_\_\_\_ In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in §1634 (d) (1) (A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregarded is specified in Supplement 4 to Attachment 2.6-A.

\_\_\_\_\_ In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in §1634 (d) (1) (A) in determining the income of the individual.

\*Agency that determines eligibility for coverage.

State: GEORGIA

Agency*	Citation(s)	Groups Covered
1902(a)(10)(E)(i), 1905(p) and 1860D-14 (a)(3)(D) of the Act	A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)	<p>25. Qualified Medicare Beneficiaries --</p> <ul style="list-style-type: none"> <li>a. Who are entitled to hospital insurance benefits under of the Act Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act);</li> <li>b. Whose income does not exceed 100 percent of the Federal poverty level; and</li> <li>c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.</li> </ul> <p>(Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)</p>
1902(a)(10)(E)(ii), 1905(s) of the Act		<p>26. Qualified Disabled and Working Individuals –</p> <ul style="list-style-type: none"> <li>a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act;</li> <li>b. Whose income does not exceed 200 percent of the Federal poverty level; and</li> <li>c. Whose resources do not exceed two times the SSI resource limit.</li> <li>d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.</li> </ul> <p>(Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)</p>

\*Agency that determines eligibility

State: Georgia

Agency*	Citation(s)	Groups Covered
1902(a)(10)(E)(iii), 1905(p)(3)(A)(ii), and 1860D-14(a)(3)(D) of the Act	A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)	27. Specified Low-Income Medicare Beneficiaries – <ol style="list-style-type: none"> <li>a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);</li> <li>b. whose income is greater than 100 percent but less than 120 percent of the Federal poverty level; and</li> <li>c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.</li> </ol>

\*Agency that determines eligibility

State: Georgia

Agency*	Citation(s)	Groups Covered
1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii), and 1860D 14(a)(3)(D) of the Act	A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)	28. Qualifying Individuals – <ol style="list-style-type: none"> <li>a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);</li> <li>b. whose income is at least 120 percent but less than 135 percent of the Federal poverty level;</li> <li>c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.</li> </ol>

\*Agency that determines eligibility

State / Territory: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.212 &  
1902(e) (2) of the  
Act, P.L. 99-272  
(Section 9517) P.L.  
101-508 (Section 4732)

\_\_\_\_\_ 3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act or while enrolled in an entity described in Section 1903(m) (2) (B) (111), (E) or (G) of the Act, or a Competitive Medical Plan (CMP) with a Medicare contract under Section 1876 of the Act, but who have been enrolled in the HMO or entity for less than the minimum enrollment period listed below. The HMO or entity must have a risk contract as specified in 42 CFR 434.20(a). Coverage under this section is limited to HMO services and family planning services described in Section 1905(a) (4) (C).

  X   The state elects not to guarantee eligibility.

\_\_\_\_\_ The State elects to guarantee. The minimum enrollment period is \_\_\_\_\_ months (not to exceed six).

The State measures the enrollment period from:

\_\_\_\_\_ The date beginning the period of enrollment in the HMO or other entity, without any intervening disenrollment, regardless of Medicaid eligibility.

\_\_\_\_\_ The date beginning the period of enrollment in the HMO as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

\_\_\_\_\_ The date beginning the last period of enrollment in the HMO as a Medicaid patient (not including periods when payment is made under this section), without any intervening disenrollment of periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section.)

\*Agency that determines eligibility for coverage.



State / Territory: GEORGIA

Agency*	Citation(s)	Groups Covered
		<p data-bbox="631 401 1271 464">B. <u>Optional Groups Other Than the Medically Needy</u> (Continued)</p>
	<p data-bbox="367 501 602 730">1903(m) (2) (F) of the Act, P.L. 98-369 (Section 2364), P.L. 99-272 (Section 9517), P.L. 101-508 (Section 4732)</p>	<p data-bbox="631 501 1403 764">The Medicaid Agency may elect to restrict the disenrollment rights of Medicaid enrollees of certain Federally qualified HMOs, Competitive Medical Plans (CMPs) with Medicare contracts under Section 1876 of the Act, and other organizations described in 42 CFR 434.27(d), in accordance with the regulations at 42 CFR 434.27. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.</p> <p data-bbox="631 800 1344 863"><u> X </u> Disenrollment rights are restricted for a period of <u> 6 </u> months (not to exceed 6 months).</p> <p data-bbox="725 905 1386 1062">During the first month of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least twice per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.</p> <p data-bbox="631 1104 1198 1136"><u> </u> No restrictions upon disenrollment rights.</p>
	<p data-bbox="367 1171 591 1329">1903(m) (2) (H), 1902(a) (52) of the Act. P.L. 101-508 (Section 4732)</p>	<p data-bbox="631 1171 1398 1367">In the case of individuals who have become ineligible for Medicaid for the brief period described in Section 1903(m) (2) (H) and who were enrolled with an entity having a contract under Section 1903 (m) when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.</p> <p data-bbox="631 1409 1398 1535"><u> X </u> The agency elects to reenroll the above individuals who are ineligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.</p> <p data-bbox="631 1577 1360 1640"><u> </u> The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.</p>

State / Territory: GEORGIA

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Agency*	Citation(s)	Groups Covered
<b>B. <u>Optional Groups Other Than the Medically Needy</u></b> (Continued)		
IV-A	42 CFR 435.217	<u>  X  </u> 4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(C) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

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\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

IV-A XVI	1902(a) (10) (A)(ii) (VII) of the Act	<input checked="" type="checkbox"/> 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.
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The State covers all individuals as described above.

The State covers only the following group or groups of individuals:

- Aged
- Blind
- Disabled
- Individuals under the age of--
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women

\*Agency that determines eligibility for coverage.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory:                     GEORGIA                    

## SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 Application, Determination of Eligibility and Furnishing  
Medicaid  
(Continued)1902(e)(13) of  
the Act

  X   (e) Express Lane Option. The Medicaid State agency elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of Medicaid eligibility. The Medicaid State agency agrees to meet all of the Federal statutory and regulatory requirements for this option. This authority may not apply to eligibility determination made before February 4, 2009, or after September 30, 2013.

(1) The Express Lane option is applied to:

 Initial Determinations       Redeterminations Both

(2) A child is defined as younger than age:

 19       20       21

(3) The following public agencies are approved by the Medicaid State agency as Express Lane agencies:

The Department of Community Health Division of Public Health - The Child and Nutrition Act of 1966 (the Special Supplemental Nutrition Program for Women, Infants and Children or WIC)

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory:                     GEORGIA                    SECTION 2 – COVERAGE AND ELIGIBILITYCitation(s)

2.1 Application, Determination of Eligibility and Furnishing  
Medicaid  
(Continued)

- (4) The following components of Medicaid eligibility are determined under the Express Lane option. Also, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between Medicaid eligibility determinations for such children and the determination under the Express Lane option.

The Department will use the following findings under the express lane option: income, identity, age and residency.

WIC is limited to children under age 5 with a nutritional need. The Department will only receive information on those children. The Department will follow up with the family to find additional children that may be in the household and use the WIC income information to determine eligibility for all children in the household. Citizenship information for all children will be obtained from the family. Identity information for non WIC children will be obtained from the family. The department will not use additional budgeting deductions and will rely solely on the WIC income finding.

The Department will use WIC income findings and apply this income to children who are applying for Medicaid. WIC income is defined as gross cash income before deductions. WIC allows an exclusion from gross family income for military housing. Gross family income must be equal to or less than 185% of the Federal Poverty Level.

The Department allows a child support income disregard of \$50 for the budget group. The Department allows the following deductions from earned income for medical eligibility determinations:

- \$90 standard work expense for each employed individual
  - \$30 earned income deduction and one-third of the remaining earned income for each employed individual
  - dependent care expenses for each child or incapacitated individual
- These disregards do not apply to WIC and do not apply to family income for ELE.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

## SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 Application, Determination of Eligibility and Furnishing  
Medicaid  
(Continued)

(5) Check off which option is used to satisfy the Screen and Enroll requirement before a child may be enrolled under title XXI.

(a) Screening threshold established by the Medicaid agency as:

(i) \_\_\_\_\_ percentage of the Federal Poverty level which exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points; specify \_\_\_\_\_ ; or

(ii) \_\_\_\_\_ percentage of the Federal poverty level (that reflects the value of any difference between income methodologies of Medicaid and the Express Lane agency); or

(b) Temporary enrollment pending screen and enroll.

(c) State's regular screen and enroll process for CHIP.

(6) The State elects the option for automatic enrollment without a Medicaid application, based on data obtained from other sources and with the child's or family's affirmative consent to child's Medicaid enrollment.

(7) Check off if the State elects the option to rely on a finding from an Express Lane agency that includes gross income or adjusted gross income shown by State income tax records or returns.

State: GEORGIA

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.220

\_\_\_\_\_ 6. Individuals who would be eligible for AFDC if their work-related child-care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child-care costs from income to determine the amount of AFDC.

\_\_\_\_\_ The State covers all individuals as described above.

1902(a)(10)(A)(ii) and  
1905(a) of the Act

\_\_\_\_\_ The State covers only the following group or groups of individuals:

\_\_\_\_\_ Individuals under the age of

\_\_\_\_\_ 21

\_\_\_\_\_ 20

\_\_\_\_\_ 19

\_\_\_\_\_ 18

\_\_\_\_\_ Caretaker relatives

\_\_\_\_\_ Pregnant women

IV-A 42 CFR 435.222  
1902(a)(10)(A)(ii) and  
1905 (a)(i) of the Act

7. X a. All individuals who are not described in Section 1902 (a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are under the age of 21, as indicated below.

\_\_\_\_\_ 20

X 19

\_\_\_\_\_ 18

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.222

X b. Reasonable classifications of described in (a) above,  
as follows:

X (1) Individuals for whom public agencies are  
assuming full partial financial  
responsibility and who are:

X (a) In foster homes (and are under the  
age of 21).

X (b) In private institutions (and are  
under the age of 21).

\_\_\_\_\_ (c) In addition to the group under b. (1)  
(a) and (b), individuals placed in  
foster homes or private institutions  
by private, nonprofit agencies (and  
are under the age of \_\_\_\_\_).

X (2) Individuals in adoptions subsidized in full  
or part by a public agency (who are under  
the age of 21).

\_\_\_\_\_ (3) Individuals in NFs (who are under the age  
of \_\_\_\_\_). NF services are provided under  
this plan.

\_\_\_\_\_ (4) In addition to the group under (b) (3),  
individuals in ICFs/MR (who are under the  
age of \_\_\_\_\_).

\*Agency that determines eligibility for coverage.



State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

\_\_\_\_\_ (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of \_\_\_\_\_). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

\_\_\_\_\_ (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

1902 (a) (10)  
(A) (ii) (VIII)  
of the Act

- X   8. A child for whom there is in effect a State adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement—
- a. Was eligible for Medicaid under the State's approved Medicaid plan; or
  - b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies.

The State covers individuals under the age of--

- X   21
- \_\_\_\_\_ 20
- \_\_\_\_\_ 19
- \_\_\_\_\_ 18

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.223

1902(a) (10)  
(A)(ii) and  
1905(a) of  
the Act

9. Individuals described below who would be eligible for AFDC if coverage under the state's AFDC plan were as broad as allowed under title IV-A:

\_\_\_\_\_ Individuals under the age of--

\_\_\_\_\_ 21

\_\_\_\_\_ 20

\_\_\_\_\_ 19

\_\_\_\_\_ 18

\_\_\_\_\_ Caretaker relatives

\_\_\_\_\_ Pregnant women

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.230

10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

The following groups of individuals who receive only a State -supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is—

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in the State.
- d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

\_\_\_\_\_ (1) All aged individuals.

\_\_\_\_\_ (2) All blind individuals.

\_\_\_\_\_ (3) All disabled individuals.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

- |                |  |
|----------------|--|
| 42 CFR 435.230 | <p>_____ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.</p> <p>_____ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.</p> <p>_____ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.</p> <p>_____ (7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.</p> <p>_____ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.</p> <p>_____ (9) Individuals in additional classifications approved by the Secretary as follows:</p> |
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State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

Yes.

No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.230  
435.121  
1902(a) (10)  
(A) (ii)(XI)  
of the Act

11. Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in each classification and available on a Statewide basis.
- d. Paid to one or more of the classifications of individuals listed below:

- \_\_\_\_\_ (1) All aged individuals.
- \_\_\_\_\_ (2) All blind individuals.
- \_\_\_\_\_ (3) All disabled individuals.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

\_\_\_\_\_ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

\_\_\_\_\_ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

\_\_\_\_\_ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

\_\_\_\_\_ (7) Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

\_\_\_\_\_ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

\_\_\_\_\_ (9) Individuals in additional classifications approved by the Secretary as follows:



State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

Yes

No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

IV-A      42 CFR 435.231  
            1902(a) (10)  
            (A)(ii) (V)  
            of the Act

12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 6 to ATTACHMENT 2.6-A.

The State covers all individuals as described above.

The State covers only the following group or groups of individuals:

1902(a)(10)(A)  
(ii) and 1905(a)  
of the Act

- Aged
- Blind
- Disabled
- Individuals under the age of - -
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women

State: Georgia

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy (Continued)

IV-A	1902(e) (3) of the Act	<input checked="" type="checkbox"/> 13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination as required under section 1902 (e)(3)(B) of the Act.
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Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.

	1902(a) (10) (A) (ii) (IX) and 1902(1) of the Act	<input checked="" type="checkbox"/> 14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in <u>Supplement 1 to ATTACHMENT 2.6-A</u> for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in <u>Supplement 2 to ATTACHMENT 2.6-A</u> :  a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and  b. Infants under one year of age.
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State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

1902(a)  
(ii)(x)  
and 1902 (m)  
(1) and (3)  
of the Act

16. Individuals--

- a. Who are 65 years of age or older or are disabled, as determined under section 1614 (a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group.
- b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and
- c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in Supplement 2 of ATTACHMENT 2.6-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

COVERAGE AND CONDITIONS OF ELIGIBILITY

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Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

1902 (a) (47)  
and 1920 of  
the Act

X 17. Pregnant women who are determined by a "qualified provider" (as defined in §1920(b)(2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under ATTACHMENT 2.6-A and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with §1920 of the Act.

OMB No.:

State / Territory: GEORGIA

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Citation(s)	Groups Covered
	<b>B. <u>Optional Groups Other Than the Medically Needy</u> (Continued)</b>
1906 of the Act	<u>X</u> 18. Individuals required to enroll in cost-effective employer- based group health plans remain eligible for a minimum enrollment period of <u>3</u> months.
1902 (a) (10) (F) and 1902 (u) (1) of the Act	<u>X</u> 19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under section 1612 of the Act for purposes of the SSI program, is no more than 100% of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditure for an equivalent set of services. See Supplement 11 to Attachment 2.6A.
1902 (a) (10) (A) (ii) (XV) of the Act	<u>X</u> 20. Individuals who would be eligible for Medicaid under the "Ticket to Work and Work Incentives Act of 1999" (TWWIA), if they are working individuals with a disability who is at least 16, but less than 65 years of age, who except for earned income, would be eligible to receive Supplemental Security Income (SSI) and whose assets, resources, and earned and unearned income (or both) does not exceed such limitations as established. See Supplement 8a to Attachment 2.6A and Supplement 8b to Attachment 2.6A.

Citation(s)

Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

- 1902(a)(10)(A)(ii)(XVIII) of the Act.      X 24. Women who:
- a. have been screened for breast or cervical cancer under the Center for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act in accordance with the requirements of Section 1504 of the Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;
  - b. are not otherwise covered under creditable coverage, as defined in Section 2701© of the Public Health Service Act;
  - c. are not eligible for Medicaid under any mandatory categorically needy eligibility group, and
  - d. have not attained age 65.
- 1920B of the Act.      X 25. Women who are determined by a “qualified entry” [as defined in Section 1920B(b)] based on preliminary information, to be a woman described in 1902(aa) of the Act related to certain breast and cervical cancer patients. The presumptive period begins on the day that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the last day.

State: GEORGIA

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Citation(s)	Condition or Requirement
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B. Optional Groups Other Than the Medically Needy  
(Continued)

1902(a) (10) (A) (ii)  
(XVII) Of the Act and  
1905(w) (1)  
Of the Act

26. Individuals who are independent foster care adolescents as defined in Section 1905 (w) (1) of the Act.

a. Reasonable classifications of individuals described above, as follows:

The State covers all such individuals who:

1. are less than 21 years of age;
2. were in foster care under the responsibility of the State on their 18th birthday.

3. Other (please describe) n/a.

b. Financial requirements

1. Income test

There is no income test for this group.

The income test for this group is \_\_\_\_\_.

2. Resource test

There is no resource test for this group.

The resource test for this group is \_\_\_\_\_.



State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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C. Optional Coverage of the Medically Needy

\*42 CFR ~~35~~.301 This plan includes the medically needy.

No.

Yes. This plan covers:

- |      |                                     |   |
|------|-------------------------------------|---|
| IV-A |                                     | 1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.   |
| IV-A | 1902(e) of the Act                  | 2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60 <sup>th</sup> day falls. |
| IV-A | 1902(a) (10) (C)(ii) (I) of the Act | 3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a) (10)(A) (i) of the Act.   |

\*Cite is 42 CFR 435.301

State:                     GEORGIA                    

Agency*	Citation(s)	Groups Covered
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C. Optional Coverage of the Medically Needy (Continued)

IV-A	1902(e) (4) of the Act P.L. 101-508 (Section 4603)	<p>4. Newborn children born on or after October 1, 1984 to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as:</p> <ul style="list-style-type: none"> <li>a. For children born prior to January 1, 1991: the woman remains eligible and the child is a member of the woman's household.</li> <li>b. For children born on or after January 1, 1991: the woman remains eligible or would remain eligible if pregnant and the child is a member of the woman's household.</li> </ul>
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42 CFR 435.308	<p>5. <u>      </u> a. Financially eligible individuals who are not described in Section C.3. above and who are under the age of--</p> <ul style="list-style-type: none"> <li><u>      </u> 21</li> <li><u>      </u> 20</li> <li><u>      </u> 19</li> <li><u>      </u> 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training</li> </ul>
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  X   b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19 or 18 as specified below:

  X   (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

  X   (a) In foster homes (and are under the age of 18).

  X   (b) In private institutions (and are under the age of 18).

State: Georgia

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Agency*	Citation(s)	Groups Covered
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C. Optional Coverage of the Medically Needy (continued)

\_\_\_\_\_ (c) In addition to the group under b. (1) (a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of \_\_\_\_.)

X (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of 18).

\_\_\_\_\_ (3) Individuals in NFs (who are under the age of \_\_\_\_\_). NF services are provided under this plan.

\_\_\_\_\_ (4) In addition to the group under (b) (3), individuals in ICFs/MR (who are under the age of \_\_\_\_\_).

X (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of 21). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

\_\_\_\_\_ (6) Other defined groups (and ages), as specified in Supplement 1 of Attachment 2.2-A.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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C. Optional Coverage of the Medically Needy (Continued)

- |                               |                                     |   |
|-------------------------------|-------------------------------------|---|
| 42 CFR 435.310                | <input type="checkbox"/>            | 6. Caretaker relatives.   |
| 42 CFR 435.320<br>and 435.330 | <input checked="" type="checkbox"/> | 7. Aged individuals.  |
| 42 CFR 435.322<br>and 435.330 | <input checked="" type="checkbox"/> | 8. Blind individuals.   |
| 42 CFR 435.324<br>and 435.330 | <input checked="" type="checkbox"/> | 9. Disabled individuals.  |
| 42 CFR 435.326                | <input type="checkbox"/>            | 10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.  |
| 435.340                       |                                     | 11. Blind and disabled individuals who:<br><ul style="list-style-type: none"><li>a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;</li><li>b. Were eligible as medically needy in December 1973 as blind or disabled; and</li><li>c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.</li></ul> |

State / Territory: GEORGIA

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Citation(s)	Groups Covered
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C. Optional Coverage of the Medically Needy (Continued)

1906 of the Act

12. Individuals required to enroll in cost- effective employer-based group health plans remain eligible for a minimum enrollment period of 3 months.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE  
PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency*	Citation(s)	Groups Covered
	1935(a) and 1902(a)(66)	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act.
42 CFR 423.774 and 423.904		<ol style="list-style-type: none"><li>1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act;</li><li>2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined;</li><li>3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.</li></ol>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

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Agency*	Citation(s)	Groups Covered
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The following groups are covered under this plan.

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups

IV-A 42 CFR 435.110

1. Recipients of AFDC

The approved State AFDC plan includes:

- Families with an unemployed parent for the mandatory 6-month period and an optional extension of -0- months.
- Pregnant women with no other eligible children.
- AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments are listed in Supplement 1 of ATTACHMENT 2.6-A.

IV-A 42 CFR 435.115

2. Deemed Recipients of AFDC

- a. Individuals denied a title IV-A cash payment solely because the amount would be less than \$10.

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
IV-A		A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)
		2. Deemed Recipients of AFDC.
	1902(a)(10)(A)(i) (I) of the Act	b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e) (6) of the Act.
	402(a)(22)(A) of the Act	c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.
	406(h) and 1902(a) (10)(A) (i)(I) of the Act	d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets. The requirements of section 406(h) of the Act.
	1902(a) of the Act	e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

\*Agency that determines eligibility for coverage.



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Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)
	407(b), 1902 (a)(10)(A)(i) and 1905(m)(1) of the Act	3. Qualified Family Members (Medicaid Only)  See Item A.10, pg 4a.
	1902(a)(52) and 1925 of the Act	4. Families terminated from Low Income Medicaid solely because of earnings, hours of employment, or loss of earned income disregards are entitled to up to twelve months of extended benefits in accordance with Section 1925 of the Act.

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)		
IV-A	42 CFR 435.113	5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are: <ul style="list-style-type: none"><li data-bbox="727 722 1406 785">a. Families denied AFDC solely because of income and resources deemed to be available from—<ul style="list-style-type: none"><li data-bbox="776 825 1406 919">(1) Stepparents who are not legally liable for support of stepchildren under a State law of general applicability;</li><li data-bbox="776 959 987 991">(2) Grandparents;</li><li data-bbox="776 1031 1068 1062">(3) Legal guardians; and</li><li data-bbox="776 1102 1406 1165">(4) Individual alien sponsors (who are not spouses of the individual or the individual's parent);</li></ul></li><li data-bbox="727 1205 1373 1289">b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.</li><li data-bbox="727 1329 1357 1421">c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.</li></ul>

\*Agency that determines eligibility for coverage.

State: GEORGIA

Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)
IV-A	42 CFR 435.114	6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.  _____ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).  <u>X</u> Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).  _____ Not applicable with respect to intermediate care facilities; State did or does not cover this service.
IV-A	1902(a) (10) (A) (i) (III) and 1905(n) of the Act	7. Qualified Pregnant Women and Children.  a. A pregnant woman whose pregnancy has been medically verified who—  (2) Would be eligible for an AFDC cash payment if the child had been born and was living with her;

\*Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)
* IV-A	7. a. (2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents program; or
	(3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.
1902(a) (10)(A) (i)(III) and 1905(n) of the Act	b. children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.
	<u>X</u> Children born after <u>6/30/74</u> (specify optional earlier date) who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

Citation(s)	Groups Covered
IV-A 1902(a)(10)(A) (i)(IV) and 1902 (1) (1)(A) and B of the Act.	A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)  8. Pregnant women and infants, under 1 year of age, with family income up to 133 percent of the Federal poverty level, who are described in Section 1902(a)(10)(A)(i)(IV) and 1902(1)( I)(A) and (B) of the Act. The income level for this group is specified in <u>Supplement 1 to ATTACHMENT 2.6-A</u> .  — The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.
IV-A 1902(a)(10)(A) (i)(IV) 1902 (1)(1) (c) of the Act.	9. Children  a. who have attained 1 year of age, but have not attained 6 years of age, with family income at or below 133 percent of the Federal poverty level.
IV-A 1902(a)(10)(A)(i) (VII) and 1902(1) (I)(D) of the Act.	b. born after September 30, 1983, who have attained 6 years of age, but have not attained 19 years of age, with family income at or below 100 percent of the Federal poverty level.  Income levels for these groups are specified in <u>Supplement 1 to Attachment 2.6-A</u> .

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)		
IV-A	1902(a) (10) (A)(i) (V) and 1905 (m) of the Act	10. Individuals other than qualified pregnant women and children under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.
IV-A	1902(e)(5) of the Act	11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60 <sup>th</sup> day falls.
	1902(e)(6) of the Act	b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

\*Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)		
XVI	1902(e) (4) of the Act	1. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.
	42 CFR 435.120	2. Aged, Blind and Disabled Individuals Receiving Cash Assistance
		<u> X </u> a. Individuals receiving SSI.
		This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.
		<u> X </u> Aged <u> X </u> Blind <u> X </u> Disabled

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

435.121	13. <input type="checkbox"/>	b. Individuals who meet more restrictive - requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619 (a) eligibility standard or the requirements of section 1619(b) of the Act.)
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Aged  
 Blind  
 Disabled

The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in ATTACHMENT 2.6-A).

\*Agency that determines eligibility for coverage.



State: GEORGIA

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Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)
XVI	1902(a) (10)(A) (i)(II) and 1905 (q) of the Act P.L. 101-508, SECTION 5032	3. Qualified severely impaired blind and disabled individuals who--  a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or  b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must—  (1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;  (2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;  (3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

- (4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and
- (5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

Not applicable with respect to individuals receiving only SSP because the state either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

1619(b)(3)  
of the Act

The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

\*Agency that determines eligibility for coverage.

State:                   GEORGIA                  

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Agency*	Citation(s)	Groups Covered
A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)		
IV-A	1634 (C) of the Act	15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who—  a. Are at least 18 years of age;  b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.  <input type="checkbox"/> c. The state applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.  <input type="checkbox"/> d. The state applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.
IV-A	42 CFR 435.122	16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements
XVI	42 CFR 435.130	17. Individuals receiving mandatory State supplements.

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

IV-A	42 CFR 435.131	18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.
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In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

\_\_\_\_\_ Aged      \_\_\_\_\_ Blind      \_\_\_\_\_ Disabled

Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)
IV-A	42 CFR 435.132	19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they—  a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and  b. Remain institutionalized; and  c. Continue to need institutional care.
IV-A	42 CFR 435.133	20. Blind and disabled individuals who—  a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and  b. Were eligible for Medicaid in December 1973 as blind or disabled; and  c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

\*Agency that determines eligibility for coverage.

State: GEORGIA

Agency*	Citation(s)	Groups Covered
A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)		
IV-A	42 CFR 435.134	<p>21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.</p> <p><input type="checkbox"/> Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).</p> <p><input checked="" type="checkbox"/> Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).</p> <p><input type="checkbox"/> Not applicable with respect to intermediate care facilities; the State did or does not cover this service.</p>

\*Agency that determines eligibility for coverage.

State: GEORGIA

Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)
IV-A	42 CFR 435.135	22. Individuals who - -  a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and  b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.  <input type="checkbox"/> Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.  <input type="checkbox"/> Not applicable because the state applies more restrictive eligibility requirements. than those under SSI.  <input type="checkbox"/> The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

\*Agency that determines eligibility for coverage.



State:                     GEORGIA                    

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

IV-A	1634 of the Act	<p>23. Disabled widows and widowers who would be eligible for SSI OF SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634 (b) of the Act.</p> <p><input type="checkbox"/> Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.</p> <p><input type="checkbox"/> The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.</p>
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\*Agency that determines eligibility for coverage.

State/Territory: GEORGIA

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Agency*	Citation(s)	Groups Covered
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1634(d) of  
the Act

A. Mandatory Coverage – Categorically Needy and Other  
Required Special Groups (Continued)

24. Disabled widows, disabled widowers, and surviving disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.

\_\_\_\_\_ The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.

\_\_\_\_\_ In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in § 1634 (d) (1) (A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.

\_\_\_\_\_ In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in § 1634 (d) (1) (A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregarded is specified in Supplement 4 to Attachment 2.6-A.

\_\_\_\_\_ In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in § 1634 (d) (1) (A) in determining the income of the individual.

\*Agency that determines eligibility for coverage.

State: GEORGIA

Agency*	Citation(s)	Groups Covered
1902(a)(10)(E)(i), 1905(p) and 1860D-14 (a)(3)(D) of the Act	A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)	<p>25. Qualified Medicare Beneficiaries --</p> <ul style="list-style-type: none"> <li>a. Who are entitled to hospital insurance benefits under of the Act Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act);</li> <li>b. Whose income does not exceed 100 percent of the Federal poverty level; and</li> <li>c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.</li> </ul> <p>(Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)</p>
1902(a)(10)(E)(ii), 1905(s) of the Act		<p>26. Qualified Disabled and Working Individuals –</p> <ul style="list-style-type: none"> <li>a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act;</li> <li>b. Whose income does not exceed 200 percent of the Federal poverty level; and</li> <li>c. Whose resources do not exceed two times the SSI resource limit.</li> <li>d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.</li> </ul> <p>(Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)</p>

\*Agency that determines eligibility

State: Georgia

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

1902(a)(10)(E)(iii),  
1905(p)(3)(A)(ii),  
and  
1860D-14(a)(3)(D)  
of the Act

27. Specified Low-Income Medicare Beneficiaries –

- a. Who are entitled to hospital insurance benefits under of the Act Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);
- b. whose income is greater than 100 percent but less than 120 percent of the Federal poverty level; and
- c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.

\*Agency that determines eligibility

State: Georgia

Agency*	Citation(s)	Groups Covered
1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii), and 1860D 14(a)(3)(D) of the Act	A. <u>Mandatory Coverage – Categorically Needy and Other Required Special Groups</u> (Continued)	28. Qualifying Individuals – <ol style="list-style-type: none"> <li>a. Who are entitled to hospital insurance benefits under of the Act Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);</li> <li>b. whose income is at least 120 percent but less than 135 percent of the Federal poverty level;</li> <li>c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.</li> </ol>

\*Agency that determines eligibility

State / Territory: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.212 &  
1902(e) (2) of the  
Act, P.L. 99-272  
(Section 9517) P.L.  
101-508 (Section 4732)

\_\_\_\_\_ 3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act or while enrolled in an entity described in Section 1903(m) (2) (B) (111), (E) or (G) of the Act, or a Competitive Medical Plan (CMP) with a Medicare contract under Section 1876 of the Act, but who have been enrolled in the HMO or entity for less than the minimum enrollment period listed below. The HMO or entity must have a risk contract as specified in 42 CFR 434.20(a). Coverage under this section is limited to HMO services and family planning services described in Section 1905(a) (4) (C).

  X   The state elects not to guarantee eligibility.

\_\_\_\_\_ The State elects to guarantee. The minimum enrollment period is \_\_\_\_\_ months (not to exceed six).

The State measures the enrollment period from:

\_\_\_\_\_ The date beginning the period of enrollment in the HMO or other entity, without any intervening disenrollment, regardless of Medicaid eligibility.

\_\_\_\_\_ The date beginning the period of enrollment in the HMO as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

\_\_\_\_\_ The date beginning the last period of enrollment in the HMO as a Medicaid patient (not including periods when payment is made under this section), without any intervening disenrollment of periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section.)

\*Agency that determines eligibility for coverage.

State / Territory: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

1903(m) (2) (F) of  
the Act, P.L. 98-  
369 (Section 2364),  
P.L. 99-272  
(Section 9517),  
P.L. 101-508  
(Section 4732)

The Medicaid Agency may elect to restrict the disenrollment rights of Medicaid enrollees of certain Federally qualified HMOs, Competitive Medical Plans (CMPs) with Medicare contracts under Section 1876 of the Act, and other organizations described in 42 CFR 434.27(d), in accordance with the regulations at 42 CFR 434.27. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

X  Disenrollment rights are restricted for a period of  6  months (not to exceed 6 months).

During the first month of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least twice per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

No restrictions upon disenrollment rights.

1903(m) (2) (H),  
1902(a) (52) of the  
Act.  
P.L. 101-508  
(Section 4732)

In the case of individuals who have become ineligible for Medicaid for the brief period described in Section 1903(m) (2) (H) and who were enrolled with an entity having a contract under Section 1903 (m) when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.

X  The agency elects to reenroll the above individuals who are ineligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.

The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

\*Agency that determines eligibility for coverage.

State / Territory: GEORGIA

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Agency*	Citation(s)	Groups Covered
<b>B. <u>Optional Groups Other Than the Medically Needy</u></b> (Continued)		
IV-A	42 CFR 435.217	<u>X</u> 4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(C) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

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\*Agency that determines eligibility for coverage.



State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

IV-A XVI	1902(a) (10) (A)(ii) (VII) of the Act	<input checked="" type="checkbox"/> 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.
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The State covers all individuals as described above.

The State covers only the following group or groups of individuals:

- Aged
- Blind
- Disabled
- Individuals under the age of--
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women

\*Agency that determines eligibility for coverage.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory:                     GEORGIA                    

## SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)2.1 Application, Determination of Eligibility and Furnishing  
Medicaid  
(Continued)1902(e)(13) of  
the Act

  X   (e) Express Lane Option. The Medicaid State agency elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of Medicaid eligibility. The Medicaid State agency agrees to meet all of the Federal statutory and regulatory requirements for this option. This authority may not apply to eligibility determination made before February 4, 2009, or after September 30, 2013.

(1) The Express Lane option is applied to:

 Initial Determinations     Redeterminations Both

(2) A child is defined as younger than age:

 19     20     21

(3) The following public agencies are approved by the Medicaid State agency as Express Lane agencies:

The Department of Community Health Division of Public Health - The Child and Nutrition Act of 1966 (the Special Supplemental Nutrition Program for Women, Infants and Children or WIC)

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory:                     GEORGIA                    SECTION 2 – COVERAGE AND ELIGIBILITYCitation(s)2.1 Application, Determination of Eligibility and Furnishing  
Medicaid  
(Continued)

- (4) The following components of Medicaid eligibility are determined under the Express Lane option. Also, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between Medicaid eligibility determinations for such children and the determination under the Express Lane option.

The Department will use the following findings under the express lane option: income, identity, age and residency.

WIC is limited to children under age 5 with a nutritional need. The Department will only receive information on those children. The Department will follow up with the family to find additional children that may be in the household and use the WIC income information to determine eligibility for all children in the household. Citizenship information for all children will be obtained from the family. Identity information for non WIC children will be obtained from the family. The department will not use additional budgeting deductions and will rely solely on the WIC income finding.

The Department will use WIC income findings and apply this income to children who are applying for Medicaid. WIC income is defined as gross cash income before deductions. WIC allows an exclusion from gross family income for military housing. Gross family income must be equal to or less than 185% of the Federal Poverty Level.

The Department allows a child support income disregard of \$50 for the budget group. The Department allows the following deductions from earned income for medical eligibility determinations:

- \$90 standard work expense for each employed individual
- \$30 earned income deduction and one-third of the remaining earned income for each employed Individual
- dependent care expenses for each child or incapacitated individual These disregards do not apply to WIC and do not apply to family income for ELE.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

## SECTION 2 – COVERAGE AND ELIGIBILITY

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Citation(s)

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2.1 Application, Determination of Eligibility and Furnishing  
Medicaid  
(Continued)

(5) Check off which option is used to satisfy the Screen and Enroll requirement before a child may be enrolled under title XXI.

 (a) Screening threshold established by the Medicaid agency as: (i) \_\_\_\_\_ percentage of the Federal Poverty level which exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points: specify \_\_\_\_\_ ; or (ii) \_\_\_\_\_ percentage of the Federal poverty level (that reflects the value of any difference between income methodologies of Medicaid and the Express Lane agency); or (b) Temporary enrollment pending screen and enroll. (c) State's regular screen and enroll process for CHIP. (6) The State elects the option for automatic enrollment without a Medicaid application, based on data obtained from other sources and with the child's or family's affirmative consent to child's Medicaid enrollment. (7) Check off if the State elects the option to rely on a finding from an Express Lane agency that includes gross income or adjusted gross income shown by State income tax records or returns.

State: GEORGIA

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.220

\_\_\_\_\_ 6. Individuals who would be eligible for AFDC if their work-related child-care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child-care costs from income to determine the amount of AFDC.

\_\_\_\_\_ The State covers all individuals as described above.

1902(a)(10)(A)(ii) and  
1905(a) of the Act

\_\_\_\_\_ The State covers only the following group or groups of individuals:

\_\_\_\_\_ Individuals under the age of

- \_\_\_\_\_ 21
- \_\_\_\_\_ 20
- \_\_\_\_\_ 19
- \_\_\_\_\_ 18
- \_\_\_\_\_ Caretaker relatives
- \_\_\_\_\_ Pregnant women

IV-A 42 CFR 435.222  
1902(a)(10)(A)(ii) and  
1905 (a)(i) of the Act

7. x a. All individuals who are not described in Section 1902 (a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are under the age of 21, as indicated below.

- \_\_\_\_\_ 20
- X   19
- \_\_\_\_\_ 18

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.222

X b. Reasonable classifications of described in (a) above,  
as follows:

X (1) Individuals for whom public agencies are  
assuming full partial financial  
responsibility and who are:

X (a) In foster homes (and are under the  
age of 21).

X (b) In private institutions (and are  
under the age of 21).

\_\_\_\_\_ (c) In addition to the group under b. (1)  
(a) and (b), individuals placed in  
foster homes or private institutions  
by private, nonprofit agencies (and  
are under the age of \_\_\_\_\_).

X (2) Individuals in adoptions subsidized in full  
or part by a public agency (who are under  
the age of 21).

\_\_\_\_\_ (3) Individuals in NFs (who are under the age  
of \_\_\_\_\_). NF services are provided under  
this plan.

\_\_\_\_\_ (4) In addition to the group under (b) (3),  
individuals in ICFs/MR (who are under the  
age of \_\_\_\_\_).

\*Agency that determines eligibility for coverage.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

\_\_\_\_\_ (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of \_\_\_\_\_). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

\_\_\_\_\_ (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

1902 (a) (10)  
(A) (ii) (VIII)  
of the Act

- X   8. A child for whom there is in effect a State adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement—
- a. Was eligible for Medicaid under the State's approved Medicaid plan; or
  - b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies.

The State covers individuals under the age of--

- X   21
- \_\_\_\_\_ 20
- \_\_\_\_\_ 19
- \_\_\_\_\_ 18

\*Agency that determines eligibility for coverage.



State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.223

1902(a) (10)  
(A)(ii) and  
1905(a) of  
the Act

9. Individuals described below who would be eligible for AFDC if coverage under the state's AFDC plan were as broad as allowed under title IV-A:

\_\_\_\_\_ Individuals under the age of--

\_\_\_\_\_ 21

\_\_\_\_\_ 20

\_\_\_\_\_ 19

\_\_\_\_\_ 18

\_\_\_\_\_ Caretaker relatives

\_\_\_\_\_ Pregnant women

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.230

10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

The following groups of individuals who receive only a State -supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is—

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in the State.
- d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

\_\_\_\_\_ (1) All aged individuals.

\_\_\_\_\_ (2) All blind individuals.

\_\_\_\_\_ (3) All disabled individuals.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
		<b>B. <u>Optional Groups Other Than the Medically Needy</u></b> (Continued)
		_____ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
42 CFR 435.230		_____ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		_____ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		_____ (7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
		_____ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
		_____ (9) Individuals in additional classifications approved by the Secretary as follows:

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State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

Yes.

No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.230  
435.121  
1902(a) (10)  
(A) (ii)(XI)  
of the Act

11. Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in each classification and available on a Statewide basis.
- d. Paid to one or more of the classifications of individuals listed below:

\_\_\_\_\_ (1) All aged individuals.

\_\_\_\_\_ (2) All blind individuals.

\_\_\_\_\_ (3) All disabled individuals.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

\_\_\_\_\_ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

\_\_\_\_\_ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

\_\_\_\_\_ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

\_\_\_\_\_ (7) Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

\_\_\_\_\_ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

\_\_\_\_\_ (9) Individuals in additional classifications approved by the Secretary as follows:

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

Yes

No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

IV-A      42 CFR 435.231  
            1902(a) (10)  
            (A)(ii) (V)  
            of the Act

12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 6 to ATTACHMENT 2.6-A.

The State covers all individuals as described above.

The State covers only the following group or groups of individuals:

1902(a)(10)(A)  
(ii) and 1905(a)  
of the Act

- Aged
- Blind
- Disabled
- Individuals under the age of - -
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women



State: Georgia

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy (Continued)

- |      |  |   |
|------|--|---|
| IV-A | 1902(e) (3)<br>of the Act                                  | <input checked="" type="checkbox"/> 13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination as required under section 1902 (e)(3)(B) of the Act.<br><br><u>Supplement 3 to ATTACHMENT 2.2-A</u> describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.   |
|      | 1902(a) (10)<br>(A) (ii) (IX)<br>and 1902(1)<br>of the Act | <input checked="" type="checkbox"/> 14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in <u>Supplement 1 to ATTACHMENT 2.6-A</u> for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in <u>Supplement 2 to ATTACHMENT 2.6-A</u> :<br><br>c. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and<br><br>d. Infants under one year of age. |

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

1902(a)  
(ii)(x)  
and 1902 (m)  
(1) and (3)  
of the Act

16. Individuals--

- a. Who are 65 years of age or older or are disabled, as determined under section 1614 (a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group.
- b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and
- c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in Supplement 2 of ATTACHMENT 2.6-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

COVERAGE AND CONDITIONS OF ELIGIBILITY

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Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

1902 (a) (47)  
and 1920 of  
the Act

X 17. Pregnant women who are determined by a "qualified provider" (as defined in §1920(b)(2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under ATTACHMENT 2.6-A and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with §1920 of the Act.

OMB No.:

State / Territory: GEORGIA

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Citation(s)	Groups Covered
	<b>B. <u>Optional Groups Other Than the Medically Needy</u> (Continued)</b>
1906 of the Act	<u>X</u> 18. Individuals required to enroll in cost-effective employer- based group health plans remain eligible for a minimum enrollment period of <u>3</u> months.
1902 (a) (10) (F) and 1902 (u) (1) of the Act	<u>X</u> 19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under section 1612 of the Act for purposes of the SSI program, is no more than 100% of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditure for an equivalent set of services. See Supplement 11 to Attachment 2.6A.
1902 (a) (10) (A) (ii) (XV) of the Act	<u>X</u> 20. Individuals who would be eligible for Medicaid under the "Ticket to Work and Work Incentives Act of 1999" (TWWIA), if they are working individuals with a disability who is at least 16, but less than 65 years of age, who except for earned income, would be eligible to receive Supplemental Security Income (SSI) and whose assets, resources, and earned and unearned income (or both) does not exceed such limitations as established. See Supplement 8a to Attachment 2.6A and Supplement 8b to Attachment 2.6A.

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Citation(s)                      Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

- 1902(a)(10)(A)(ii)(XVIII) of the Act.      X 24. Women who:
- a. have been screened for breast or cervical cancer under the Center for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act in accordance with the requirements of Section 1504 of the Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;
  - b. are not otherwise covered under creditable coverage, as defined in Section 2701© of the Public Health Service Act;
  - c. are not eligible for Medicaid under any mandatory categorically needy eligibility group, and
  - d. have not attained age 65.
- 1920B of the Act.      X 25. Women who are determined by a “qualified entry” [as defined in Section 1920B(b)] based on preliminary information, to be a woman described in 1902(aa) of the Act related to certain breast and cervical cancer patients. The presumptive period begins on the day that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the last day.

State: GEORGIA

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Citation(s)	Condition or Requirement
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B. Optional Groups Other Than the Medically Needy  
(Continued)

1902(a) (10) (A) (ii)  
(XVII) Of the Act and  
1905(w) (1)  
Of the Act

26. Individuals who are independent foster care adolescents as defined in Section 1905 (w) (1) of the Act.

a. Reasonable classifications of individuals described above, as follows:

The State covers all such individuals who:

1. are less than 21 years of age;
2. were in foster care under the responsibility of the State on their 18th birthday.

3. Other (please describe) n/a.

b. Financial requirements

1. Income test

There is no income test for this group.

The income test for this group is \_\_\_\_\_.

2. Resource test

There is no resource test for this group.

The resource test for this group is \_\_\_\_\_.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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C. Optional Coverage of the Medically Needy

	42 CFR 435.301	This plan includes the medically needy. <input type="checkbox"/> No. <input checked="" type="checkbox"/> Yes. This plan covers:
IV-A		1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.
IV-A	1902(e) of the Act	2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60 <sup>th</sup> day falls.
IV-A	1902(a) (10) (C)(ii) (I) of the Act	3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a) (10)(A) (i) of the Act.

State:                   GEORGIA                  

Agency*	Citation(s)	Groups Covered
C. <u>Optional Coverage of the Medically Needy</u> (Continued)		
IV-A	1902(e) (4) of the Act P.L. 101-508 (Section 4603)	4. Newborn children born on or after October 1, 1984 to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as: <ul style="list-style-type: none"> <li data-bbox="708 705 1390 793">a. For children born prior to January 1, 1991: the woman remains eligible and the child is a member of the woman's household.</li> <li data-bbox="708 804 1357 930">b. For children born on or after January 1, 1991: the woman remains eligible or would remain eligible if pregnant and the child is a member of the woman's household.</li> </ul>
	42 FR 435.308	5. <u>      </u> a. Financially eligible individuals who are not described in Section C.3. above and who are under the age of-- <ul style="list-style-type: none"> <li data-bbox="748 1041 857 1062"><u>      </u> 21</li> <li data-bbox="748 1073 857 1094"><u>      </u> 20</li> <li data-bbox="748 1104 857 1125"><u>      </u> 19</li> <li data-bbox="748 1136 1398 1230"><u>      </u> 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training</li> </ul> <p data-bbox="610 1272 1398 1367"><u>  X  </u> b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19 or 18 as specified below:</p> <ul style="list-style-type: none"> <li data-bbox="708 1409 1382 1503"><u>  X  </u> (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:               <ul style="list-style-type: none"> <li data-bbox="805 1545 1382 1608"><u>  X  </u> (a) In foster homes (and are under the age of <u>18</u>).</li> <li data-bbox="805 1640 1398 1703"><u>  X  </u> (b) In private institutions (and are under the age of <u>18</u>).</li> </ul> </li> </ul>



State: Georgia

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Agency*	Citation(s)	Groups Covered
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C. Optional Coverage of the Medically Needy (continued)

\_\_\_\_\_ (c) In addition to the group under b. (1) (a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of \_\_\_\_.)

X (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of 18).

\_\_\_\_\_ (3) Individuals in NFs (who are under the age of \_\_\_\_\_). NF services are provided under this plan.

\_\_\_\_\_ (4) In addition to the group under (b) (3), individuals in ICFs/MR (who are under the age of \_\_\_\_\_).

X (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of 21). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

\_\_\_\_\_ (6) Other defined groups (and ages), as specified in Supplement 1 of Attachment 2.2-A.

State: GEORGIA

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Agency*	Citation(s)	Groups Covered
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C. Optional Coverage of the Medically Needy (Continued)

- |                               |                                     |   |
|-------------------------------|-------------------------------------|---|
| 42 CFR 435.310                | <input type="checkbox"/>            | 6. Caretaker relatives.   |
| 42 CFR 435.320<br>and 435.330 | <input checked="" type="checkbox"/> | 7. Aged individuals.  |
| 42 CFR 435.322<br>and 435.330 | <input checked="" type="checkbox"/> | 8. Blind individuals.   |
| 42 CFR 435.324<br>and 435.330 | <input checked="" type="checkbox"/> | 9. Disabled individuals.  |
| 42 CFR 435.326                | <input type="checkbox"/>            | 10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.  |
| 435.340                       |                                     | 11. Blind and disabled individuals who:<br><ul style="list-style-type: none"><li>a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;</li><li>b. Were eligible as medically needy in December 1973 as blind or disabled; and</li><li>c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.</li></ul> |

State / Territory: GEORGIA

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Citation(s)	Groups Covered
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C. Optional Coverage of the Medically Needy (Continued)

1906 of the Act

12. Individuals required to enroll in cost- effective employer-based group health plans remain eligible for a minimum enrollment period of 3 months.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE  
PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency*	Citation(s)	Groups Covered
	1935(a) and 1902(a)(66)	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act.
42 CFR 423.774 and 423.904		<ol style="list-style-type: none"><li>1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act;</li><li>2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined;</li><li>3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.</li></ol>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER  
THE AGE OF 21, 20, 19, AND 18

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State / Territory: GEORGIA

Method for Determining Cost Effectiveness of Caring for Certain Disabled Children At Home

Treating physician/service provider develops treatment plan in which services such as durable medical equipment, prescriptions, therapies, and home health visits are delineated. The costs of these services are compared to the cost of institutionalization for the individual. If at home cost is lower than institutionalized cost, individual's care meets cost-effectiveness criterion.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State / Territory: GEORGIA

Method for Determining Cost Effectiveness of Caring for Certain Disabled Children At Home

Treating physician/service provider develops treatment plan in which services such as durable medical equipment, prescriptions, therapies, and home health visits are delineated. The costs of these services are compared to the cost of institutionalization for the individual. If at home cost is lower than institutionalized cost, individual's care meets cost-effectiveness criterion.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

ELIGIBILITY CONDITIONS AN REQUIREMENTS

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Citation(s)	Condition or Requirement
	<p><b>B. <u>General Conditions of Eligibility</u></b></p> <p>Each individual covered under the plan:</p>
42 CFR Part 435 Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435, Subpart F	2. Meets the applicable non-financial eligibility conditions. a. For the categorically needy:*
	(i) Except as specified under items A.2.a.(ii) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.
	(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.
1902 (1) of the Act	(iii) For financially eligible pregnant women, infants or children covered under sections 1902(a) (10)(A) (i) (IV), 1902(a) (10)(A) (i) (VI), 1902(a) (10)(A) (i) (VII), and 1902(a) (10) (A)(ii)(IX) of the Act, meets the non-financial criteria of section 1902(1) of the Act.
1902(m) of the Act.	(iv) * For financially eligible aged and disabled individuals covered under section 1902(a) (10)(A) (ii)(X) of the Act, meets the non-financial criteria of section 1902 (m) of the Act.

\* Georgia does not cover individuals at Section 1902(a)(10)(A)(ii)(X).



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Citation(s)	Condition or Requirement
	b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.
1905(p) of the Act	c. For financially eligible qualified Medicare beneficiaries covered under section 1902(a) (10)(E)(i) of the Act, meets the non-financial criteria of section 1905(p) of the Act.
1905(s) of the Act	d. For financially eligible qualified disabled and working individuals covered under section 1902(a) (10) (E) (ii) of the Act, meets the non-financial criteria of section 1905(s).
42 CFR 435.402	3. Is residing in the United States and— a. Is a citizen;
Sec. 245A of the Immigration and Nationality Act	b. Is an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law, as defined in 42 CFR 435.408;
1902 (a) and 1903(v) of the Act and 245A(h)(3)(B) of the Immigration & Nationality Act	c. Is an alien granted lawful temporary resident status under section 245A and 210A of the Immigration and Nationality Act if the individual is aged, blind, or disabled as defined in section 1614(a)(1) of the Act, under 18 years of age or a Cuban/Haitian entrant as defined in section 501(e)(1) and (2) (A) of P.L. 96-422;

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Citation(s)	Condition or Requirement
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- d. Is an alien granted lawful temporary resident status under section 210 of the Immigration and Nationality Act not within the scope of c. above (coverage must be restricted to certain emergency services during the five-year period beginning on the date the alien was granted such status); or
- e. Is an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (coverage must be restricted to certain emergency services).

42 CFR 435.403  
1902(b) of the  
Act

4. Is a resident of the State, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address.

State has interstate residency agreement with the following States:

Alabama	Kentucky	Mississippi	North Carolina	West Virginia
California	Louisiana	New Jersey	Ohio	Wisconsin
Florida	Maryland	New Mexico	Pennsylvania	
Iowa	Minnesota	New York	Tennessee	

State has open agreement(s).

Not applicable; no residency requirement.

State / Territory: Georgia

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Citation(s)	Condition or Requirement
42 CFR 435.1008	5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, nursing facilities and intermediate care facilities for the mentally retarded community residences that serve no more than 16 residents, or certain child care institution.
42 CFR 435.1008	b. is not a patient under age 65 in an institution for mental diseases 1905 (a) of the Act except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program.  <input type="checkbox"/> Not applicable with respect to individuals Under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
42 CFR 433.145	6. Is required, as a condition of eligibility, to assign his or her own rights, or 1912 of the Act the rights of any other person who is eligible for Medicaid on whose behalf the individual has legal authority to execute an assignment, to medical support and payment for medical care from any third party (Medical support is defined as support specified as being for medical care by a court or administrative order.)

State / Territory: Georgia

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Citation(s)	Condition or Requirement
42 CFR 435.910	<p>An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902 (1)(1)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirement involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.</p> <p>An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State Plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.</p> <p><u>  X  </u> Assignment of rights is automatic because of State law.</p> <p>7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number) except for aliens seeking medical assistance for the treatment of an emergency medical condition under section 1903(v)(2) of the Social Security Act (Section 1137(f) and newborn children who are eligible under Section 1902(e)(4).</p>

State: Georgia

Citation(s)	Condition or Requirement
1902 (c)(2)	8. Is not required to apply for AFDC benefits under *Title IV-A as a condition of applying for, or receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State covers under Sections 1902(a) (10) (A) (i) (IV) and 1902(a) (10) (A) (i) (IX) of the Act.
1902 (e) (10) (A) and (B) of the Act	9. 1902 (e) (10) (A) and (B) of the Act Is not required, as an individual child or pregnant woman, to meet requirements under Section 402(a) (43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a State' AFDC plan, the agency determines if they are otherwise eligible under the State's Medicaid plan.)

\* Cite should include 1902(a) (10)(A) (i) (VI) and 1902(a) (10)(A) (i) (VII).

State / Territory: GEORGIA

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Citation(s)	Condition or Requirement
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1906 of the Act	10. Is required to apply, for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).
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Citation(s)	Condition or Requirement
	<b>B. <u>Post-eligibility Treatment of Institutionalized Individuals' Incomes</u></b>
	1. The following items are not considered in the post-eligibility process:
1902(o) of the Act	a. SSI and SSP benefits paid under §1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.
Bondi v. Sullivan (SSI)	b. Austrian Reparation Payments (pension (reparation) payments made under §500 - 506 of the Austrian General Social Insurance Act). Applies only if State follows SSI program rules with respect to the payments.
1902(r)(1) of the Act	c. German Reparations Payments (reparation payments made by the Federal Republic of Germany).
105/206 of P. L. 100-383	d. Japanese and Aleutian Restitution Payments.
1. (a) of P.L. 103-286	e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).
10405 of P.L. 101-239	f. Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent orange product liability litigation, M.D.L. No.381 (E.D.N.Y.)
6(h)(2) of P.L. 101-426	g. Radiation Exposure Compensation.
12005 of P. L. 103-66	h. VA pensions limited to \$90 per month under 38 U.S.C. 5503.

State: Georgia

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Citation(s)	Condition or Requirement
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For individuals with greater need-5

(iii) Individuals under age 21 covered in this plan as specified in Item B.7. of Attachment 2.2-A \$ \_\_\_\_\_  
For individuals with greater need-

- 435.725  
435.733
- b. For the maintenance of each member of non-institutionalized family at home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the:
- o AFDC level, or
  - o Medically needy level:
    - AFDC level \$ 155
    - Medically Needy level \$ \_\_\_\_\_
    - Other \$ \_\_\_\_\_



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Citation(s)	Condition or Requirement
1924 of the Act 435.725 435.733 435.832	<p data-bbox="561 401 1430 495">2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care:</p> <p data-bbox="610 533 1386 596">Personal Needs Allowance (PNA) of not less than \$30 For Individuals and \$60 For Couples For All Institutionalized Persons.</p> <p data-bbox="610 634 915 730">a. Aged, blind, disabled: Individuals \$ 70.00 Couples \$ 140.00</p> <p data-bbox="659 768 1175 800">For the following persons with greater need:</p> <p data-bbox="659 837 1390 999">Supplement 12 to <u>Attachment 2.6-A</u> describes the greater need describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.</p> <p data-bbox="610 1037 854 1134">b. AFDC related: Children \$ 70.00 Adults \$ 70.00</p> <p data-bbox="659 1171 1175 1203">For the following persons with greater need:</p> <p data-bbox="659 1241 1390 1402">Supplement 12 to <u>Attachment 2.6-A</u> describes the greater need describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.</p> <p data-bbox="610 1440 1403 1499">c. Individual under age 21 covered in the plan as specified in Item B. 7. of <u>Attachment 2.2 -A</u></p>

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Citation(s)	Condition or Requirement
1924 of the Act	<p data-bbox="704 401 1425 596">For the following persons with greater need: Supplement 12 to <u>Attachment 2.6-A</u> describes the greater need describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.</p> <p data-bbox="561 632 1425 968">3. In addition to the amounts under item 2., the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse: a. The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in §1924 (d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.</p> <p data-bbox="657 1010 1403 1104">_____ The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level.</p> <p data-bbox="657 1146 1344 1272">_____ The poverty level component is calculated using a percentage greater than the applicable percentage, equal to _____%, of the official poverty level (still subject to maximum maintenance needs standard).</p> <p data-bbox="657 1314 1406 1543"><u> X </u> The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C). Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court-ordered support.</p>

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Citation(s)	Condition or Requirement
1924 of the Act	<p data-bbox="704 384 1425 579">For the following persons with greater need: Supplement 12 to <u>Attachment 2.6-A</u> describes the greater need describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.</p> <p data-bbox="561 617 1425 953">3. In addition to the amounts under item 2., the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse: a. The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in §1924 (d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.</p> <p data-bbox="659 989 1403 1089">_____ The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level.</p> <p data-bbox="659 1125 1344 1257">_____ The poverty level component is calculated using a percentage greater than the applicable percentage, equal to _____%, of the official poverty level (still subject to maximum maintenance needs standard).</p> <p data-bbox="659 1293 1406 1528"><u> X </u> The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C). Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court-ordered support.</p>

May 2002	Page 4c OMB No.: 0938-0673
State: Georgia Citation(s)	Condition or Requirement

In determining any excess shelter allowance, utility expenses are calculated using:

\_\_\_\_\_ the standard utility allowance under §5(e) of the Food Stamp Act of 1977 or

\_\_\_\_\_ the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.

- b. The monthly income allowance for other dependent family members living with the community spouse is:

\_\_\_\_\_ one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924 (d)(3)(B)) exceeds the dependent family member's monthly income.

X a greater amount calculated as follows: The amount by which 150% of the FPL for a family of 2 exceeds the dependent family member's monthly income.

The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924 (d)(1):

- C. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party:
- (i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.
  - (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A.)

State: GA

Citation(s)	Condition or Requirement
435.725 435.733 435.832	<p>4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple:</p> <p>a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the:</p> <ul style="list-style-type: none"><li>○ AFDC level or</li><li>○ Medically needy level:</li></ul> <p>(Check one) -X-AFDC levels in Supplement 1 --Medically needy level in Supplement 1 --Other: \$</p> <p>b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party:</p> <ul style="list-style-type: none"><li>(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.</li><li>(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to <u>ATTACHMENT 2.6-A.</u>)</li></ul>
435.725 435.733 435.832	<p>5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple:</p> <p>A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period:</p> <p><u>  X  </u> No. <u>      </u> Yes (the applicable amount is shown on page 5a.)</p>

State: GA

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Citation(s)	Condition or Requirement
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\_\_\_\_\_ Amount for maintenance of home is: \$\_\_\_\_\_.

\_\_\_\_\_ Amount for maintenance of home is the actual maintenance costs not to exceed \$\_\_\_\_\_.

\_\_\_\_\_ Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individual's home and the community spouse's home are different.

\_\_\_\_\_ Amount for maintenance of home is not deductible when countable income is determined under §1924 (d)(1) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Citation(s)	Condition or Requirement
42 CFR 435.711 435.721, 435.831	<p data-bbox="561 600 846 630">C. <u>Financial Eligibility</u></p> <p data-bbox="609 667 1409 863">For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902 (f) of the Act, or more liberal methods under section 1902 (r) (2) of the Act, as specified below.</p> <p data-bbox="609 905 1414 1031">For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply.</p> <p data-bbox="609 1073 1430 1297">* <u>Supplement 1 to ATTACHMENT 2.6-A</u> specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related to the Federal income poverty level--pregnant women and infants or children covered under sections 1902(a) (10)(A) (i) (IV), 1902(a) (10) (A) (i):(VI), 1902(a)(10)(A) (i) (VII), and 1902(a)(10)(A)(ii)(IX) of the Act and aged and disabled individuals covered under section</p> <p data-bbox="609 1304 1393 1400">** 1902(a) (10)(A)(ii)(X) of the Act--and for mandatory groups of qualified Medicare beneficiaries covered under section 1902 (a) (10)(E) (i) of the Act.</p>

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\* Cite should include 1902(a) (10)(E)(ii)

\*\* Georgia does not cover individuals described at 1902(a)(10)(A)(ii)(X)

State: Georgia

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Citation(s)	Condition or Requirement
<input checked="" type="checkbox"/>	<u>Supplement 2 to ATTACHMENT 2.6-A</u> specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.
<input type="checkbox"/>	<u>Supplement 7 to ATTACHMENT 2.6-A</u> specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.
<input type="checkbox"/>	<u>Supplement 4 to ATTACHMENT 2.6-A</u> specifies the methods for determining income eligibility used by states that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
<input type="checkbox"/>	<u>Supplement 5 to ATTACHMENT 2.6-A</u> specifies the methods for determining resource eligibility used by states that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
<input checked="" type="checkbox"/>	<u>Supplement 8a to ATTACHMENT 2.6-A</u> specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
<input checked="" type="checkbox"/>	<u>Supplement 8b to ATTACHMENT 2.6-A</u> specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Citation(s)	Condition or Requirement
1902(r)(2) of the Act	<p>1. Methods of Determining Income</p> <p>a. <u>AFDC-related individuals (except for poverty level related pregnant women, infants, and children).</u></p> <p>(1) In determining countable income for AFDC-related individuals, the following methods are used:</p> <p>_____ (a) The methods under the state's approved AFDC plan only; or</p> <p><u>X</u> (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A</u></p> <p>(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</p>
1902(e) (6) the Act	<p>(3) Agency continues to treat women eligible under the provisions of sections 1902(a) (10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.</p>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Citation(s)	Condition or Requirement
42 CFR 435.721 435.831, and 1902 (m) (1) (B),(m) (4); and 1902(r)(2) of the Act	b. <u>Aged individuals</u> . In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902 (m) (1) of the Act, the following methods are used:  <u>  X  </u> The methods of the SSI program only.  _____ The methods of the SSI program and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .

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State: Georgia

Citation(s)	Condition or Requirement
1611(e) (5)	<p><input type="checkbox"/> For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of Section 1902(f) of the Act, as specified in <u>Supplement 4 to Attachment 2.6-A</u>; and any more liberal methods described in <u>Supplement 8a to Attachment 2.6-A</u>.</p> <p><input checked="" type="checkbox"/> For institutional couples, the methods specified under Section 1611(e)(5) of the Act.</p> <p><input type="checkbox"/> Those institutionalized couples who reside in the same nursing facility shall have their incomes combined for purposes of determining eligibility for medical assistance if counting their incomes separately would result in denial of medical assistance to a member of the couple. Notwithstanding any other regulations or policies to the contrary, in determining eligibility for such couples, income of the couple shall be applied to a special income limit equal to two times the special income limit (300% of the full FBR) applied to an individual seeking medical assistance as a resident in a nursing facility</p> <p><input type="checkbox"/> For optional State supplement recipients under Section 435.230, income methods more liberal than SSI, as specified in <u>Supplement 4 to Attachment 2.6-A</u>.</p> <p><input type="checkbox"/> For optional State supplement recipients in Section 1902(f) States and SSI criteria States without Section 1616 or 1634 agreement:</p> <p style="padding-left: 40px;"><input type="checkbox"/> SSI methods only.</p> <p style="padding-left: 40px;"><input type="checkbox"/> SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to Attachment 2.6-A</u>.</p>

State: Georgia

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Citation(s)	Condition or Requirement
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\_\_\_\_\_ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to Attachment 2.6-A and more liberal methods are described in Supplement 8a to Attachment 2.6-A.

In determining relative financial responsibility the agency considers only the income of spouses living in the same household as available to spouses.

State: Georgia

Citation(s)	Condition or Requirement
42 CFR 435.721 and 435.831 1902(m)(1)(B), (m)(4), and 1902 (r)(2) of the Act	<p>c. <u>Blind individuals</u>. In determining countable income for blind individuals, the following methods are used:</p> <p><input checked="" type="checkbox"/> The methods of the SSI program only.</p> <p><input type="checkbox"/> SSI methods and/or any more liberal methods described in <u>Supplement 8a to Attachment. 2.6-A</u>.</p> <p><input type="checkbox"/> For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of Section 1902(f) of the Act, as specified in <u>Supplement. 4 to Attachment 2.6-A</u>, and any more liberal methods described in <u>Supplement 8a to Attachment 2.6-A</u>.</p>
1611(e) (5)	<p><input checked="" type="checkbox"/> For institutional couples, the methods specified under Section 1611(e) (5) of the Act.</p> <p>Those institutionalized couples who reside in the same nursing facility shall have their incomes combined for purposes of determining eligibility for medical assistance if counting their incomes separately would result in denial of medical assistance to a member of the couple. Notwithstanding any other regulations or policies to the contrary, in determining eligibility for such couples, income of the couple shall be applied to a special income limit equal to two times the special income limit (300% of the full FBR) applied to an individual seeking medical assistance as a resident in a nursing facility.</p> <p><input type="checkbox"/> For optional State supplement recipient under Section 435.230, income methods more liberal than SSI, as specified in <u>Supplement 4 to Attachment 2.6-A</u>.</p>

State: Georgia

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Citation(s)	Condition or Requirement
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For optional State supplement recipients in Section 1902(f) States and SSI criteria States without Section 1616 or 1634 Agreements - -

\_\_\_\_\_ SSI methods only.

\_\_\_\_\_ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to Attachment 2.6-A.

\_\_\_\_\_ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to Attachment 2.6-A and more liberal methods are described in Supplement 8a to Attachment 2.6-A.

State: Georgia

Citation(s)	Condition or Requirement
42 CFR 435.721 and 435.831 1902(m)(1)(B), (m) (4), and 1902(r)(2) of the Act	<p>In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</p> <p>d. <u>Disabled individuals</u>. In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in Section 1902(m) of the Act the following methods are used:</p> <p><input checked="" type="checkbox"/> The methods of the SSI program.</p> <p><input type="checkbox"/> SSI methods and/or any more liberal methods describe in <u>Supplement 8a to Attachment 2.6-A</u>.</p>
1611(e)(5)	<p><input checked="" type="checkbox"/> For institutional couples: the methods specified under Section 1611(e)(5) of the Act.</p> <p>Those institutionalized couples who reside in the same nursing facility shall have their incomes combined for purposes of determining eligibility for medical assistance if counting their incomes separately would result in denial of medical assistance to a member of the couple. Notwithstanding any other regulations or policies to the contrary, in determining eligibility for such couples, income of the couple shall be applied to a special income limit equal to two times the special income limit (300% of the full FBR) applied to an individual seeking medical assistance as a resident in a nursing facility.</p> <p><input type="checkbox"/> For optional State supplement recipients under Section 435.230: income methods more liberal than SSI, as specified in <u>Supplement 4 to Attachment 2.6-A</u>.</p>

State: Georgia

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Citation(s)	Condition or Requirement
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\_\_\_\_\_ For individuals other than optional State supplement recipients (except aged and disabled individuals described in Section 1903 (m) (1) of the Act): more restrictive methods than SSI, applied under the provision of Section 1902(f) of the Act, as specified in Supplement 4 to Attachment 2.6-A; and any more liberal methods described in Supplement 4 to Attachment 2.6-A.



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Citation(s)	Condition or Requirement
_____ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--	
_____ SSI methods only.	
_____ SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .	
_____ Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902 (m) (1) of the Act. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are specified in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .	
	In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Citation(s)	Condition or Requirement
1902 (1) (3) (E) and 1902 (r) (2) of the Act	<p>e. <u>Poverty level women, infants, and children.</u> For pregnant women and infants or children covered Under the provisions of sections 1902 (a) (10)(A) (i) (IV), (VI), and (VII), and 1902 (a) (10) (A) (ii) (IX) of the Act</p> <p>(1) The following methods are used in determining countable income:</p> <p>_____ The methods of the State's approved AFDC plan.</p> <p>_____ The methods of the approved title IV-E plan.</p> <p><u>X</u> The methods of the approved AFDC State plan and/or any more liberal methods described in <u>SUPPLEMENT 8a to ATTACHMENT 2.6-A.</u></p> <p>_____ The methods of the approved title IV-E plan and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></p>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Citation(s)	Condition or Requirement
1902(e) (6) of the Act	(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.  (3) The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.
1905(p) (1), 1902 (m) (4), and 1902(r)(2) of the Act	f. <u>Qualified Medicare beneficiaries</u> . In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E) (i) of the Act, the following methods are used:  _____ The methods of the SSI program only.  ___X___ SSI methods and/or any more liberal methods. than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .  ___X___ For institutional couples, the methods specified under section 1611(e) (5) of the Act.

State: GEORGIA

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Citation(s)	Condition or Requirement
1611(e) (5)	<p>If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.</p> <p>For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.</p> <p>For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.</p> <p>Those institutionalized couples who reside in the same nursing facility shall have their incomes combined for purposes of determining eligibility for medical assistance if counting their incomes separately would result in denial of medical assistance to a member of the couple. Notwithstanding any other regulations or policies to the contrary, in determining eligibility for such couples, income of the couple shall be applied to a special income limit equal to two times the special income limit (300% of the full FBR) applied to an individual seeking medical assistance as a resident in a nursing facility.</p>
1905 (s) of the Act	<p>g. (1) <u>Qualified disabled and working individuals.</u></p> <p>In determining countable income for qualified disabled and working individuals covered under 1902(a) (10)(E) (ii) of the Act, the methods of the SSI program are used.</p>
1905 (p) of the Act	<p>(2) <u>Specified low-income Medicare beneficiaries.</u></p> <p>In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a) (10) (E) (iii) of the Act, the same method as in f. is used.</p>

State / Territory: GEORGIA

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Citation(s)	Condition or Requirement
1902(u) of the Act	<p data-bbox="513 430 979 464">(h) COBRA Continuation Beneficiaries</p> <p data-bbox="607 499 1300 562">In determining countable income for COBRA continuation beneficiaries, the following disregards are applied:</p> <p data-bbox="607 598 1101 632">_____ The disregards of the SSI program;</p> <p data-bbox="607 667 1417 764">_____ The agency uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.</p> <p data-bbox="607 800 1417 932">NOTE: For COBRA continuation beneficiaries specified at 1902(u) (4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b) (4)(B)(ii).</p>

State / Territory: Georgia

Citation(s)	Condition or Requirement
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1902 (a) (10) (A)  
(ii) (XV) of the Act  
of 1999

(ii) Working Individuals with Disabilities-Basic Insurance Group-Ticket to Work and Work Incentives Improvement Act (TWWIIA)

In determining financial eligibility for working individuals with disabilities under this provision, the following standards and methodologies are applied:

       The agency does not apply any income or resource standard.

       NOTE: If the above option is chosen, no further eligibility-related options should be elected.

  X   The agency applies the following income and/or resource standards(s):

- The individual must have personal income less than 300% of the federal poverty level for his/her family size.
- Countable resources are determined by family size:

<u>Family Size</u>	<u>Resource Level</u>
1 (Individual only)	\$4000
2	\$6000
3	\$6200
4	\$6400

Add \$200 for each additional member.

State / Territory: Georgia

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Citation(s)	Condition or Requirement
1902 (a) (10) (A) (ii) (XV) of the Act (cont.)	<p><u>Income Methodologies</u> In determining whether an individual meets the income standard described above the agency uses the following methodologies.</p> <p><input type="checkbox"/> The income methodologies of the SSI program.</p> <p><input type="checkbox"/> The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.</p> <p><input checked="" type="checkbox"/> The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6A.</p>

State / Territory: Georgia

Citation(s)	Condition or Requirement
1902 (a) (10) (A) (ii) (XV) of the Act (cont.)	<p data-bbox="704 468 997 497"><u>Resource Methodologies</u></p> <p data-bbox="704 533 1373 630">In determining whether the individual meets the resource standard described above, the agency uses the following methodologies.</p> <p data-bbox="704 665 1430 932">Unless one of the following items is checked the agency, under the authority of section 1902(r) (2) of the Act, disregards all funds held in retirement funds accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401 (k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6-A</p> <p data-bbox="704 968 1336 1033">_____ The agency disregards funds held in employer-sponsored retirement plans.</p> <p data-bbox="704 1068 1419 1197">_____ The agency disregards funds in retirement accounts in a manner other than those described above. The agency's disregards are specified in Supplement 6b to Attachment 2.6A</p>



State / Territory: Georgia

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Citation(s)	Condition or Requirement
1902 (a) (10) (A) (ii) (XV) of the Act (cont.)	<p><input type="checkbox"/> The agency does not disregard funds in retirement accounts.</p> <p><input checked="" type="checkbox"/> The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.</p> <p><input type="checkbox"/> The agency uses the resource methodologies of the SSI program.</p> <p><input type="checkbox"/> The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6A.</p>

State / Territory: Georgia

Citation(s)

Condition or Requirement

1902(a) (10) (A) (ii)  
(XV),  
of the Act.

Payment of Premiums or Other Cost Sharing Charges

For Individuals eligible under the Basic Insurance Group described in No. 20 on page 23a of Attachment 2.2-A:

NOTE: Regardless of the option selected below, the agency MUST require that individuals whose annual adjusted gross income, as defined under IRS statute, exceeds \$75,000 pay 100 percent of premiums.

X  The agency requires individuals to pay premiums on a sliding scale based on income. For individuals with net annual income below 300 percent of the Federal poverty level for a family size involved, the amount of premiums cannot exceed 5 percent of the individuals income.

The premiums and how they are applied are described below.

The monthly premium for coverage under the Basic Insurance Group is based on income:

FPL	Premium
100% - 149%	\$0
150% - 249%	\$35
250% - 300%	\$50

There will be no premium for individuals under age 18.

A premium is not due until the first full month of eligibility. Premiums are due one month in advance, prior to the month of coverage. Members will be locked out from receiving coverage for ONE month if the premium payment is not received in advance. Members will be canceled if the premium payment is not received four business days before the last business day of the payment month. Coverage will be reinstated the month after premium payment is received.

State: Georgia

Citation(s)	Condition or Requirement
1902(k) of the Act	<p data-bbox="574 428 948 464">2. Medicaid Qualifying Trusts</p> <p data-bbox="623 499 1438 831">In the case of a Medicaid qualifying trust described in Section 1902(k) (2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded.</p> <p data-bbox="623 867 1438 999"><u>X</u> The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship <u>Supplement 10 of ATTACHMENT 2.6-A</u> specifies what constitutes undue hardship.</p>
1917 of the Act	<p data-bbox="623 1035 1438 1136"><u>X</u> The agency complies with the provisions of Section 1917 of the Act with respect to the transfer of assets, and treatment of certain trusts as provided by OBRA '93.</p>
1902(a) (10) of the Act	<p data-bbox="574 1167 1398 1203">3. Medically needy income levels (MNILs) are based on family size.</p> <p data-bbox="623 1236 1438 1365"><u>Supplement 1 to ATTACHMENT 2.6-A</u> specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under Section 1902 (f) of the Act, <u>Supplement 1</u> so indicates.</p>

State: Georgia

Citation(s)	Condition or Requirement
42 CFR 435.732, 435.831	<p>4. Handling of Excess Income Spenddown for the Medically Needy in All States and the categorically Needy in 1902 (f) States Only</p> <p>a. <u>Medically Needy</u></p> <p>(1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for a period of <u>1</u> month for non-institutionalized persons and institutionalized persons to determine the amount of excess countable income applicable to the cost of medical care and services.</p> <p>(2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:</p> <p>(a) Health insurance premiums, deductibles and coinsurance charges.</p> <p>(b) Projected costs of month's institutional expenses for institutionalized individual</p> <p>(c) Expenses for necessary medical and remedial care not included in the plan.</p> <p>(d) Expenses for necessary medical and remedial care included in the plan.</p> <p><u>X</u> Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below. Non-emergency medical transportation limited to \$.25 per mile or actual cost, whichever is less.</p>
1902 (a) (17) of the Act	<p>Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government. Application review period is <u>6</u> months for both institutionalized and non- institutionalized persons.</p>

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Citation(s)	Condition or Requirement
42 CFR 435.732	<p data-bbox="570 434 1154 462">b. <u>Categorically Needy – Section 1902 (f) States</u></p> <p data-bbox="570 501 1414 594">The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income:</p> <ol data-bbox="570 636 1458 1129" style="list-style-type: none"><li data-bbox="570 636 919 663">(1) Any SSI benefit received.</li><li data-bbox="570 705 1458 798">(2) Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act.</li><li data-bbox="570 840 1458 932">(3) Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section.</li><li data-bbox="570 974 1458 1031">(4) Other. deductions from income described in this plan at Attachment 2.6-A Supplement 4.</li><li data-bbox="570 1073 1458 1129">(5) Incurred expenses for necessary medical and remedial services recognized under State law.</li></ol>
1902(a)(17) of the Act, P.L. 100-203	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

State: Georgia

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Citation(s)	Condition or Requirement
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5. Methods for Determining Resources

a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children.

(1) In determining countable resources for AFDC-related individuals, the following methods are used:

1917 of  
the Act

**The agency complies with the provisions of Section 1917 of the Act with respect to the transfer of assets, and treatment of certain trusts as provided by OBRA '93.**

       (a) The methods under the State's approved AFDC plan and;

  X   (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

(2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State: Georgia

Citation(s)	Condition or Requirement
1905 (s), 1902(a) (10)(A), 1902(a) (10) (C), of the Act and 1902 (m) (1) (B) and and (C) of the Act, P.L. 99-509 (Section 9402 (a) 1902 (a) (10) (E) (i) 1902 (a) (10) (E) (ii) 1902 (a) (10) (E) (iii) 1902(r)(2) of the Act.	<p>6. Methods for. Determining Resources</p> <p>b. <u>Aged individuals</u>, including individuals covered under Sections 1902(a) (10) (A) (ii)(X), 1902 (m) (1) (B) 1902(a) (10) (E) (i), and 1902(a) (10) (E) (iii) of the Act. *(See below).</p> <p><u>X</u> The agency uses the same methodologies for treatment of resources as used in the SSI program (or the optional State supplement program which meets the requirements of 42 CFR 435.230, as appropriate, except for those described <u>Supplement 8b to ATTACHMENT 2.6-A</u>.</p>
1917 of the Act	<p><u>X</u> The agency complies with the provisions of Section 1917 of the Act with respect to the transfer of assets, and treatment of certain trusts as provided by OBRA '93.</p>

\* Georgia does not cover 1902(a) (10)(A) (ii) (X) individuals.

State: Georgia

Citation(s)	Condition or Requirement
1902(a) (10) (A), 1902 (a) (10)(C), 1902 (m) (1) (B), and 1902(r) of the Act	<p>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.</p> <p>c. <u>Blind individuals.</u> For blind individuals the agency uses the following methods for treatment of resources.</p> <p><u> X </u> The agency complies with the provisions of Section 1917 of the Act with respect to the transfer of assets, and treatment of certain trusts as provided by OBRA' 93.</p> <p><u> </u> The methods of the SSI program.</p>
1917 of the Act	<p><u> X </u> SSI methods and/or any more liberal methods described in <u>Supplement 8b. to ATTACHMENT 2.6-A.</u></p> <p><u> </u> Methods that are more restrictive and/or more liberal than those of the SSI program. <u>Supplement 5 to ATTACHMENT 2.6- A</u> describe the more restrictive methods and <u>Supplement 8b to ATTACHMENT 2.6-A</u> specify the more liberal methods.</p> <p>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</p>



State: Georgia

Citation(s)	Condition or Requirement
1902 (a) (10) (A), 1902(a) (10) (C), 1902 (m)(1)(B), and (C) 1902(r) (2) of the Act  1917 of the Act	<p>d. <u>Disabled individuals, including individuals covered under section 1902(a) (10)(a) (II)(x) of the Act.</u> The agency uses the following methods for the treatment of resources:</p> <p><input checked="" type="checkbox"/> The agency complies with the provisions of Section 1917 of the Act with respect to the transfer of assets, and treatment of certain trusts as provided by OBRA'93.</p> <p><input type="checkbox"/> The methods of the SSI program.</p> <p><input checked="" type="checkbox"/> SSI methods and/or any more liberal methods described in Supplement 8a to <u>ATTACHMENT 2.6-A.</u></p> <p><input type="checkbox"/> Methods that are more restrictive (except for individuals described in Section 1902 (m) (1) of the Act) and/or more liberal than those under the SSI program. More restrictive methods are described in <u>Supplement 5 to ATTACHMENT 2.6-A</u> and more liberal methods are specified in <u>Supplement 8b to ATTACHMENT 2.6- A.</u></p> <p>In determining relative financial responsibility, the agency considers only the resources of spouses living in the household available to spouses and the resources of parents as available to children living with parents until the children become 21.</p>
1902(1)(3) and 1902 (r) (2) of the Act	<p>e. <u>Poverty level pregnant women cover under sections 1902 (a)(10)(A) (i )(IV) and 1902 (a)(10)(A)(ii)( IX)(A) of the Act.</u></p> <p>The agency uses the following methods in the treatment of resources.</p> <p><input type="checkbox"/> The methods of the SSI program only.</p> <p><input type="checkbox"/> The methods of the SSI and/or any more liberal methods described in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6- A.</u></p>

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Citation(s)	Condition or Requirement
1902(1)(3) and 1902(r) (2) of the Act	<u>      </u> Methods that are more liberal than those of SSI. The more liberal methods are specified in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</u>
1902(1)(3)(C) of the Act	<u>  X  </u> Not applicable. The agency does not consider resources in determining eligibility.
1902(r)(2) of the Act	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(1)(3) and 1902(r) (2) of the Act	f. <u>*Poverty level infants covered under section 1902(a)(10) (A)(i)(IV) of the Act.</u>
1902(1)(3)(C) of the Act	The agency uses the following methods for the treatment of resources:  <u>      </u> The methods of the State's approved AFDC plan.
1902(r)(2) of the Act	<u>      </u> Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(1)(3)(C) of the Act, as specified in <u>Supplement 5a of ATTACHMENT 2.6-A.</u>
1902(1)(3)(C) of the Act	<u>      </u> Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</u>
1902(r)(2) of the Act	<u>  X  </u> Not applicable. The agency does not consider resources in determining eligibility.

\* Cite should include 1902(a)(10)(A)(ii)(IX)

STATE PLAN UNDER TITLE XIX, OF THE SOCIAL SECURITY ACT

State: GEORGIA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Citation(s)	Condition or Requirement
1902(1)(3) and 1902(r)(2) of the Act	<p>g. 1. <u>Poverty level children covered under section 1902 (a) (10)(A) (i) (VI) of the Act.</u></p> <p>The agency uses the following methods for the treatment of resources:</p> <p><u>      </u> The methods of the State's approved AFDC plan.</p>
1902(1)(3)(C) of the Act	<p><u>      </u> Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(1)(3)(C) of the Act, as specified in <u>Supplement 5a of ATTACHMENT 2.6-A.</u></p>
1902(r) (2) of the Act	<p><u>      </u> Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u></p> <p><u>  X  </u> Not applicable: The agency does not consider resources in determining eligibility.</p> <p>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</p>

STATE PLAN UNDER TITLE XIX, OF THE SOCIAL SECURITY ACT

State: GEORGIA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Citation(s)	Condition or Requirement
1902(1)(3) and 1902 (r) (2) of the Act	<p>g. <u>2. Poverty level children under section 1902(a) (10) (A) (i) (VII)</u></p> <p>The agency uses the following methods for the treatment of resources:</p> <p><u>      </u> The methods of the State's approved AFDC plan.</p>
1902(1)(3)(C) of the Act	<p><u>      </u> Methods more liberal than those in the State's approved AFDC plan (but not more restrictive) as specified in <u>Supplement 5a of ATTACHMENT 2.6-A.</u></p>
1902 (r) (2) of the Act	<p><u>      </u> Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></p> <p><u>  X  </u> Not applicable. The agency does not consider resources in determining eligibility</p> <p>In determining relative responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</p>

State: Georgia

Citation(s)	Condition or Requirement
1905 (p) (1) (C) and (D) and 1902 (r) (2) of the Act  1917 of the Act	<p>5. h. <u>For Qualified Medicare beneficiaries covered under Section 1902(a) (10) (E) (i) of the Act</u> the agency uses the following methods for treatment of resources:</p> <p><input checked="" type="checkbox"/> The agency complies with the provisions of Section 1917 of the Act with respect to the transfer of assets, and treatment of certain trusts as provided by OBRA'93.</p> <p><input type="checkbox"/> The methods of the SSI program.</p> <p><input checked="" type="checkbox"/> SSI methods and/or any more liberal methods described in Supplement Bb to <u>ATTACHMENT 2.6-A</u>.</p>
1905 (s) of the Act	i. For qualified disabled and working individuals covered under Section 1902(a) (10) (E) (ii) of the Act, the agency uses SSI program methods for the treatment of resources:
1902 (u) of the Act	<p>j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources:</p> <p><input type="checkbox"/> The methods of the SSI program only.</p> <p><input type="checkbox"/> More restrictive methods applied under Section 1902(f) of the Act as described in <u>Supplement 5 to ATTACHMENT 2.6-A</u>.</p>

State: Georgia

Citation(s)	Condition or Requirement
1902(a) (10) (E) (iii)	k. <u>Specified low-income Medicare beneficiaries covered under Section 1902 (a)(10) (E) (iii) of the Act:</u>
1917 of the Act	<p><input checked="" type="checkbox"/> The agency complies with the provisions of Section 1917 of the Act with respect to the transfer of assets, and treatment of certain trusts as provided by OBRA'93.</p> <p><input type="checkbox"/> The agency uses the same method as in 5.h of Attachment 2.6-A.</p>
	6. Resource Standard - Categorically Needy
	a. 1902 (f) states (except as specified under items 6.c and d. below) for aged, blind and disabled individuals:
	<input type="checkbox"/> Same as SSI resource standards.
	<input type="checkbox"/> More restrictive.
	The resource standards for other individuals are the same as those in the related cash assistance program.
	b. Non-1902(f) states (except as specified under items 6.c and d. below):
	<input type="checkbox"/> The resource standards are the same as those in the related cash assistance program.
	<input type="checkbox"/> <u>Supplement 8 to ATTACHMENT 2.6-A</u> specifies for 1902(f) states the categorically needy resource levels for all covered categorically needy groups.

STATE PLAN UNDER TITLE XIX, OF THE SOCIAL SECURITY ACT

State: GEORGIA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Citation(s)	Condition or Requirement
1902(1)(3)(A), (B) and (C) of the Act	<p>c. For pregnant women and infants covered under the provisions of section 1902(a)(10)(A)(i) (IV) and 1902(a) (10)(A)(ii) (IX) of the Act, the agency applies a resource standard.</p> <p><u>      </u> Yes. <u>Supplement 2 to ATTACHMENT 2.6-A</u> specifies the standard which, for pregnant women, is no more restrictive than the standard under the SSI program; and for infants is no more restrictive than the standard applied in the State's approved AFDC plan.</p> <p><u>  X  </u> No. The agency does not apply a resource standard to these individuals.</p>
1902(1)(3)(A) and (C) of the Act	<p>d. * For children covered under the provisions of section 1902(a)(10)(a) (i) (VI) of the Act, the agency applies a resource standard.</p> <p><u>      </u> Yes. <u>Supplement 2 to ATTACHMENT 2.6-A</u> specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan.</p> <p><u>      </u> No. The agency does not apply a resource standard to these individuals.</p>

\* Cite should include 1902(a)(10)(A)(i)(VII)

State: GEORGIA

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Citation(s)	Condition or Requirement
1902 (m) (1) (C) and (m) (2) (B) of the Act	e. For aged and disabled individuals described in section 1902 (m) (1) of the Act who are covered under section 1902(a)(10)(A)(ii) (X) of the Act, the resource standard is:  _____ Same as SSI resource standards.  _____ Same as the medically needy resource standard: which are higher than the SSI resource standards (if the State covers the medically needy).  <u>Supplement 2 to ATTACHMENT 2.6-A</u> specifies the resource levels for these individuals.



State: Georgia

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Citation(s)	Condition or Requirement
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<p>1902(a)(10)(C)(i) of the Act</p>	<p>7. Resource Standard - Medically Needy</p> <p>a. Resource standards are based on family size.</p> <p>b. A single standard is employed in determining resource resource eligibility for all groups.</p> <p>c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for--</p> <p style="margin-left: 40px;"> <input type="checkbox"/> Aged  <input type="checkbox"/> Blind  <input type="checkbox"/> Disabled                 </p> <p><u>Supplement 2 to ATTACHMENT 2.6-A</u> specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., <u>Supplement 2 to ATTACHMENT 2.6-A</u> so indicates.</p>
<p>1902(a)(10)(E), 1905(p)(1)(D), 1905(p)(2)(B) and 1860D-14(a)(3)(D) of the Act</p>	<p>8. Resource Standard - Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualifying Individuals</p> <p>For Qualified Medicare Beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, Specified Low-Income Medicare Beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, and Qualifying Individuals covered under 1902(a)(10)(E)(iv) of the Act, the resource standard is three times the SSI resource limit, adjusted annually since 1996 by the increase in the consumer price index.</p>

State: Georgia

Citation(s)	Condition or Requirement
1902(a)(10)(E)(ii), 1905(s) and 1860D-14(a)(3)(D) of the Act	<p>9. Resource Standard - Qualified Disabled and Working Individuals</p> <p>For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is two times the SSI resource limit.</p>
1902(u) of the Act	<p>10. For COBRA continuation beneficiaries, the resource standard is:</p> <p><u>  X  </u> Twice the SSI resource standard for an individual.</p> <p><u>      </u> More restrictive standard as applied under section 1902(f) of the Act as described in <u>Supplement 8 to Attachment 2.6-A.</u></p>

State: GEORGIA

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Citation(s)	Condition or Requirement
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10. Excess Resources

a. Categorically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals

Any excess resources make the individual ineligible

b. Categorically Needy Only

This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources.

c. Medically Needy

Any excess resources make the individual ineligible

State: Georgia

Citation(s)	Condition or Requirement
42 CFR 435.914	<p>11. Effective Date of Eligibility</p> <p>a. Groups Other Than Qualified Medicare Beneficiaries</p> <p>(1) For the prospective period.</p> <p><u>Categorically Needy</u> Coverage is available for the full month if the following individuals are eligible at any time during the month.</p> <p><input checked="" type="checkbox"/> Aged, blind, disabled  <input checked="" type="checkbox"/> AFDC-related  <input checked="" type="checkbox"/> Qualified Disabled and Working Individuals  <input checked="" type="checkbox"/> Specified Low-Income Medicare Beneficiaries</p> <p><u>Medically Needy</u> Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.</p> <p><input checked="" type="checkbox"/> Aged, blind, disabled  <input checked="" type="checkbox"/> AFDC-related</p> <p>2. For the retroactive period.</p> <p><u>Categorically Needy</u> Coverage is available beginning the first day of the third month before the date of application if the following individuals are eligible at any time during the month.</p> <p><input checked="" type="checkbox"/> Aged, blind, disabled  <input checked="" type="checkbox"/> AFDC-related  <input checked="" type="checkbox"/> Qualified Disabled and Working Individuals  <input checked="" type="checkbox"/> Specified Low-Income Medicare Beneficiaries</p> <p><u>Medically Needy</u> Coverage is available only for the period during the retroactive month(s) for which the individual meets eligibility requirements.</p>
1902(a) (34) of the Act	<p><input checked="" type="checkbox"/> Aged, blind, disabled  <input checked="" type="checkbox"/> AFDC-related</p>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Citation(s)	Condition or Requirement
1920(b) (1) of the Act	<u> X </u> (3) For a presumptive eligibility for pregnant women only. Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in <u>ATTACHMENT 2.6-A</u> of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the state agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.
1902 (e) (8) and 1905(a) of the Act	<u> X </u> b. For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905 (p)(1). The eligibility determination is valid for—  <u> X </u> 12 months  <u> </u> 6 months  <u> </u> <u> </u> months (no less than 6 months and no more than 12 months)

State: Georgia

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Citation(s)	Condition or Requirement
1902 (a) (18) 12. and 1902 (f) of the Act	Pre-OBRA 93 Transfer of resources Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals  The agency complies with the provisions of Section 1917 of the Act with respect to the transfer of resources.  Disposal of resources at less than fair market value affects eligibility for certain services as detailed in <u>Supplement 9 to Attachment 2.6-A.</u>
1917 (c)	13. Transfer of Assets – All eligibility groups  The agency complies with the provisions of Section 1917(c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets.  Disposal of assets at less than fair market value affects eligibility for certain services as detailed in <u>Supplement 9(a) to ATTACHMENT 2.6-A</u> , except in instances where the agency determines that the transfer rules would work an undue hardship.
1917 (d)	14. Treatment of Trusts All eligibility groups  The agency complies with the provisions of Section 1917(d) of the Act, as amended by OBRA 93, with regard to trusts.  <u>      </u> The agency uses more restrictive methodologies under Section 1902 (f) of the Act, and applies those methodologies in dealing with trusts.  <u>  X  </u> The agency meets the requirements in Section 1917(d) (f) (B) of the Act for use of <u>Miller</u> trusts.  The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in <u>Supplement 10 to ATTACHMENT 2.6-A.</u>

State: Georgia

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Citation(s)	Condition or Requirement
1924 of the Act	<p>15. The agency complies with the provisions of §1924 with respect to income and resource eligibility and post eligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community.</p> <p>When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is:</p> <p><u>  X  </u> the maximum standard permitted by law;</p> <p><u>      </u> the minimum standard permitted by law; or</p> <p>\$ <u>      </u> a standard that is an amount between the minimum and the maximum.</p>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY

1. AFDC-Related Groups Other Than Poverty Level Pregnant Women and Infants:

<u>Family Size</u>	<u>Need Standard</u>	<u>Payment Standard</u>	<u>Maximum Payment</u> <u>Amounts</u>
1	235	Georgia does not use a payment standard	155
2	356		235
3	424		280
4	500		330
5	573		378

2. Pregnant women and Infants under Section 1902(a) (10)(i)(IV) of the Act: Effective April 1, 1990, based on the following percent of the official Federal income poverty level-- as revised annually in the federal register for the family size involved.

X 133 percent \_\_\_\_\_ percent (no more than 185 percent) (specify)

<u>Family size</u>	<u>Income Level</u>
<u>1</u>	\$ _____
<u>2</u>	\$ _____
<u>3</u>	\$ _____
<u>4</u>	\$ _____
<u>5</u>	\$ _____



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

INCOME ELIGIBILITY LEVELS

A. Mandatory Categorically Needy (Continued)

- 1902(a)(52)
3. For children under Section 1902(a)(10)(i)(VI) of the Act (children who have attained age 1 but have not attained age 6), the income eligibility level is 133 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.
  4. For children under Section 1902(a)(10)(i)(VII) of the Act (children who were born after September 30, 1983 and have attained age 6 but have not attained age 19), the income eligibility level is 100 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.
  5. Families terminated from Low Income Medicaid solely because of new or increased earnings, hours of employment, or loss of earned income disregards are entitled to up to twelve months of extended benefits in accordance with Section 1925 of the Act. The income eligibility level during the second six month's extension is 185 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: GEORGIA

INCOME ELIGIBILITY (Continued)

B: OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOME RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women and Infants

The levels for determining income eligibility for optional pregnant women and their infants under the provisions of Sections (a)(1)(A)(ii) and 1902(1)(2) of the Act are as follows:

Based on 185 percent of the official Federal income poverty level (no less than 133 percent and no more than 185 percent).

Refer to SUPPLEMENT 8a to ATTACHMENT 2.6-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

INCOME ELIGIBILITY LEVELS (Continued)

B. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. Children born after September 30, 1983 but not yet age 19:

The levels for determining income eligibility for groups of children who are born after September 30, 1983, but have not reached age 19.

Based on 100 percent (no more than 100 percent) of the official Federal income poverty line.

1902 (1) (2)	<u>Family Size</u>	<u>Income Level</u>
	<u>1</u>	<u>\$ 552</u>
	<u>2</u>	<u>\$ 740</u>
	<u>3</u>	<u>\$ 929</u>
	<u>4</u>	<u>\$1117</u>
	<u>5</u>	<u>\$1305</u>
	<u>6</u>	<u>\$1494</u>
	<u>7</u>	<u>\$1682</u>
	<u>8</u>	<u>\$1870</u>
	<u>9</u>	<u>\$2059</u>
	<u>10</u>	<u>\$2247</u>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

INCOME ELIGIBILITY LEVELS – MANDATORY GROUP OF QUALIFIED  
DISABLED AND WORKING INDIVIDUALS WITH INCOMES UP TO FEDERAL  
POVERTY LINE

The levels for determining income eligibility for groups of qualified disabled and  
working individuals under the provisions of section 1905(s) of the Act are as follows:

Based on 200 percent of the official Federal income poverty line.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

INCOME ELIGIBILITY LEVELS (Continued)

3. Aged and Disabled Individuals

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902 (m) (4) of the Act are as follows:

Based on \_\_\_\_\_ percent of the official Federal income poverty line

<u>Family Size</u>	<u>Income Level</u>
<u>1</u>	\$ _____
<u>2</u>	\$ _____
<u>3</u>	\$ _____
<u>4</u>	\$ _____
<u>5</u>	\$ _____

If an individual receives a title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES AND QUALIFIED DISABLED AND WORKING INDIVIDUALS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provision of Section 1905 (p) (2) (A) of the Act are as follows:

1. NON-SECTION 1902(f) STATES

a. Based on the following percent of the official Federal income poverty level:

- Eff. Jan. 1, 1989: 85 percent      percent (no more than 100)
- Eff. Jan. 1, 1990: 90 percent      percent (no more than 100)
- Eff. Jan. 1, 1991: 100 percent
- Eff. Jan. 1, 1992: 100 percent

b. Levels:

Family Size

Income Levels

1

\*100 percent of the poverty level effective March 1 of each year.

2

\*100 percent of the poverty level effective March 1 of each year.

Title II cost-of-living increases will be disregarded for the months of January, February and March of each year for QMB's only.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES AND QUALIFIED DISABLED AND WORKING INDIVIDUALS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

3. SECTION 1902(f) STATES WHICH AS OF JANUARY 1, 1987 USED INCOME STANDARD MORE RESTRICTIVE THAN SSI

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan. 1, 1989: \_\_\_\_\_ 85 percent \_\_\_\_\_ percent (no more than 100)  
Eff. Jan. 1, 1990: \_\_\_\_\_ 90 percent \_\_\_\_\_ percent (no more than 100)  
Eff. Jan. 1, 1991: \_\_\_\_\_ 95 percent \_\_\_\_\_ percent (no more than 100)  
Eff. Jan. 1, 1992: 100 percent

b. Levels:

<u>Family Size</u>	<u>Income Levels</u>
<u>1</u>	\$ _____
<u>2</u>	\$ _____

3. NON-SECTION 1902 (f) STATES

The levels for determining income eligibility for qualified disabled and working individuals under provisions of 1905(s) of the Act are as follows:

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan. 1, 1990: 200 percent

b. Levels:

<u>Family Size</u>	<u>Income Levels</u>
<u>1</u>	<u>200 percent of the poverty level effective March 1 of each year.</u>
<u>2</u>	<u>200 percent of the poverty level effective March 1 of each year.</u>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

Applicable to all groups.

Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

(1) Family Size	(2) Net income level protected for maintenance for _____ months	(3) Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007 <sup>1</sup>	(4) Net income level for persons living in rural areas for _____ months	(5) Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007 <sup>1</sup>
<input type="checkbox"/> urban only				
<input type="checkbox"/> urban & rural				
1 _____	\$208	\$ _____	\$ _____	\$ _____
2 _____	\$317	\$ _____	\$ _____	\$ _____
3 _____	\$375	\$ _____	\$ _____	\$ _____
4 _____	\$442	\$ _____	\$ _____	\$ _____
For each additional person, add:	\$50	\$ _____	\$ _____	\$ _____

<sup>1</sup>The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for _____ months	Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007 <sup>1</sup>	Net income level for persons living in rural areas for _____ months	Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007 <sup>1</sup>
<input type="checkbox"/> urban only				
<input checked="" type="checkbox"/> urban & rural				
_____ 5	\$508	\$ _____	\$ _____	\$ _____
_____ 6	\$550	\$ _____	\$ _____	\$ _____
_____ 7	\$600	\$ _____	\$ _____	\$ _____
_____ 8	\$633	\$ _____	\$ _____	\$ _____
_____ 9	\$667	\$ _____	\$ _____	\$ _____
_____ 10	\$708	\$ _____	\$ _____	\$ _____
For each additional person, add:	\$50	\$ _____	\$ _____	\$ _____

<sup>1</sup>The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

RESOURCE LEVELS

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women

a. Mandatory Groups

- Same as SSI resources levels.  
 Less restrictive than SSI resource levels and is as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	_____
<u>2</u>	_____

b. Optional Groups

- Same as SSI resources levels.  
 Less restrictive than SSI resource levels and is as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	_____
<u>2</u>	_____

THE STATE WILL NOT IMPOSE A RESOURCE LIMIT FOR THIS GROUP.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

2. Infants

a. Mandatory Group of Infants

Same as resource levels in the State's approved AFDC plan.

Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	_____
<u>2</u>	_____
<u>3</u>	_____
<u>4</u>	_____
<u>5</u>	_____
<u>6</u>	_____
<u>7</u>	_____
<u>8</u>	_____
<u>9</u>	_____
<u>10</u>	_____

THE STATE WILL NOT IMPOSE A RESOURCE LIMIT FOR THIS GROUP.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:                     GEORGIA                    

b. Optional Group of Infants

Same as resource levels in the State's approved AFDC plan.

Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	_____
<u>2</u>	_____
<u>3</u>	_____
<u>4</u>	_____
<u>5</u>	_____
<u>6</u>	_____
<u>7</u>	_____
<u>8</u>	_____
<u>9</u>	_____
<u>10</u>	_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

3. Children

a. Mandatory Group of Children under Section 1902(a)(10) (i) (VI) of the Act. (Children who have attained age 1 but have not attained age 6.)

Same as resource levels in the State's approved AFDC plan.

Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	_____
<u>2</u>	_____
<u>3</u>	_____
<u>4</u>	_____
<u>5</u>	_____
<u>6</u>	_____
<u>7</u>	_____
<u>8</u>	_____
<u>9</u>	_____
<u>10</u>	_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: State: Georgia

b. Mandatory Group of children under Section 1902 (a) (10) (A) (i) (VII) of the Act. (Children born after September 30, 1983 who have attained age 6 but have not attained age 19.)

Same as resource levels in the State's approved AFDC plan.

Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	_____
<u>2</u>	_____
<u>3</u>	_____
<u>4</u>	_____
<u>5</u>	_____
<u>6</u>	_____
<u>7</u>	_____
<u>8</u>	_____
<u>9</u>	_____
<u>10</u>	_____

The state will not impose a resource limit for this group.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:                     GEORGIA                    

4. Aged and Disabled Individuals

Same as SSI resource levels.

More restrictive than SSI levels and are as follows:

<u>Family size</u>	<u>Resource Level</u>
<u>1</u>	_____
<u>2</u>	_____
<u>3</u>	_____
<u>4</u>	_____
<u>5</u>	_____

Same as medically needy resource levels (applicable only if State has a medically needy program)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

RESOURCE LEVELS (Continued)

B. MEDICALLY NEEDY

Applicable to all groups –

Except those specified below under the provisions of section 1902(f) of the Act.

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>\$ 2,000.00</u>
<u>2</u>	<u>4,000.00</u>
<u>3</u>	<u>4,100.00</u>
<u>4</u>	<u>4,200.00</u>
<u>5</u>	<u>4,300.00</u>
<u>6</u>	<u>4,400.00</u>
<u>7</u>	<u>4,500.00</u>
<u>8</u>	<u>4,600.00</u>
<u>9</u>	<u>4,700.00</u>
<u>10</u>	<u>4,800.00</u>
For each additional person	<u>\$100.00</u>



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL  
OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

1. Effective July 1, 1990, costs for all necessary medical and remedial care recognized under state law, but not covered under the Medicaid, and services which would be covered except for exceeding service limitations of amount, duration or scope (thus becoming uncovered services), are allowed as income deductions, if these costs are the legal obligation of the individual and if these costs are not subject to third party payments. The costs allowed as income deductions up to specific dollar limits as to specific services and items. The dollar limits represent reasonable fees for services and items for this state as determined by Georgia medical and dental care industries. The deduction for incurred medical expenses is included in the patient liability budget each applicable month and is based on an averaging methodology whereby actual expenses and income of the preceding three months are averaged and included on a three month basis with reconciliation to actual expenditures occurring in the fourth month, except that significant changes, defined as a change of \$20.00 or more, will result in a reconciliation for that month and establishes a new three month averaging cycle.
2. Effective April 1, 2006, the deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.
3. Effective April 1, 2009, institutional long-term care medical expenses incurred more than three months prior to the month of application for Medicaid are disallowed as a deduction. Institutional long-term care medical expenses incurred within three months prior to the month of application may be allowed as a deduction at an amount equal to the Medicaid reimbursement rate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL  
OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

1. Effective July 1, 1990, costs for all necessary medical and remedial care recognized under state law, but not covered under the Medicaid, and services which would be covered except for exceeding service limitations of amount, duration or scope (thus becoming uncovered services), are allowed as income deductions, if these costs are the legal obligation of the individual and if these costs are not subject to third party payments. The costs allowed as income deductions up to specific dollar limits as to specific services and items. The dollar limits represent reasonable fees for services and items for this state as determined by Georgia medical and dental care industries. The deduction for incurred medical expenses is included in the patient liability budget each applicable month and is based on an averaging methodology whereby actual expenses and income of the preceding three months are averaged and included on a three month basis with reconciliation to actual expenditures occurring in the fourth month, except that significant changes, defined as a change of \$20.00 or more, will result in a reconciliation for that month and establishes a new three month averaging cycle.
2. Effective April 1, 2006, the deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.
3. Effective April 1, 2009, institutional long-term care medical expenses incurred more than three months prior to the month of application for Medicaid are disallowed as a deduction. Institutional long-term care medical expenses incurred within three months prior to the month of application may be allowed as a deduction at an amount equal to the Medicaid reimbursement rate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM  
THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r)(2) of the Act. Use Supplement 8a for section 1902(r)(2) methods.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

MORE RESTRICTIVE METHODS OF TREATING RESOURCES  
THAN THOSE OF THE SSI PROGRAM – Section 1902(f) States only

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS  
WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

THE STATE DOES NOT IMPOSE A RESOURCE LIMIT FOR THESE GROUPS EXCEPT FOR INDIVIDUALS DESCRIBED AT 1902 (a) (10) (E).

State: Georgia

Standards for Institutionalized Individuals Under Special Income Test

Payment Category  (Reasonable Clarification)	Administered by		** Income Level				Income Disregards Employed
	Federal	State	<u>Gross</u>		<u>Net</u>		
			1-person	Couple	1-person	Couple	
(1) In medical institution or intermediate care facility and would not receive SSI payment or state supplement if living outside of the facility.	(2)		(3) 300% of Individual FBR	600% (2 x 300%) Individual FBR	(4) 300% of Individual FBR	600% (2 x 300%) Individual FBR	(5) All SSI exclusions
** INCOME LEVELS BASED ON NON-INSTITUTIONALIZED FBR COUPLE CROSS CAP DOES NOT EXCEED 300% OF FBR FOR EACH INDIVIDUAL							

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

INCOME LEVELS FOR 1902(f) STATES – CATEGORICALLY NEEDY  
WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: \_\_\_\_\_ GEORGIA \_\_\_\_\_

RESOURCE STANDARDS FOR 1902(f) STATES – CATEGORICALLY NEEDY



## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GeorgiaMORE LIBERAL METHODS OF TREATING INCOME  
UNDER SECTION 1902(r)(2) OF THE ACT\*   Section 1902(f) State  X   Non-Section 1902(f) State

1902(a)(10)(A)(i)(IV)	The State's approved AFDC plan except no deeming of parental income is done when a pregnant woman living with her parents applies for Medicaid as a caretaker or when a pregnant woman has a spouse and they live with his parent(s).
1902(a)(10)(E)(i) and 1902(a)(10)(E)(iii)	Title II income considered as countable income in determining eligibility is based on income received rather than income entitlement if the payment is reduced to recover a previous Title II overpayment. This applies only to 1902 (a)(10)(E)(i) and 1902 (a)(10)(E)(iii) groups.
1902(a)(10)(A)(i)(IV), (VI), (VII)	The State's approved AFDC plan. Except when a parent applies for Medicaid for his or her child and the spouse of that parent is not the parent of the child, do not deem spousal income to the parent in the Medicaid budget.
1902(a)(10)(E)(i) and 1902(a)(10)(E)(iii)	The income methodologies regarding in-kind support and maintenance will not be used in the Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries program.  Income received from temporary employment with the Census Bureau will not be used in the Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries programs  The SSI values for the one-third reduction (VTR) and the presumed maximum value (PMV) of support and maintenance will not be considered in determining gross and net income for Qualified Medicare Beneficiaries and Specified Low-income Medicare Beneficiaries. The individual's gross income less the \$20 general income exclusion will be compared to the mandated percentage of the federal poverty limit to determine eligibility for QMB and SLMB coverage.
1902(a)(10)(A)(i)(III)	The following applies to pregnant women and infants covered under Section 1902(a)(10)(A)(i)(III) of the Act, who are defined in 1905(n)(2) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

MORE LIBERAL METHODS OF TREATING INCOME  
UNDER SECTION 1902(r)(2) OF THE ACT\*

Effective July 1, 2004, for pregnant women and their infants, income in the amount of one dollar plus the amount of income by which 200 percent of the federal poverty level (for the size family involved as revised annually in the Federal Register) exceeds the State's AFDC standard is disregarded.

1902(a)(10)(A)(i) (III) and  
Section 1905(n)(2)

The following applies to children covered under Section 1902(a)(10)(A)( i )(III) of the Act, who are defined in Section 1905(n)(2) of the Act.

Effective July 1, 1993, income in the amount of one dollar plus the amount of income by which 100 percent of the Federal poverty level (for the size family involved as revised annually in the Federal Register) exceeds the State's AFDC standard is disregarded.

1902 (a) (10)(A) (ii) (XV) of  
the Act

For working individuals with Disabilities-Basic Insurance Group-TWWIIA: Only the income of the disabled individual will be used to determine eligibility. There will be no deeming of spousal income.

1902 (a) (10)(A)(i) (III)  
1902 (a) (10) (E) (i)  
1902 (a) (10) (E) (iii)  
1902 (a) (10) (A) (ii) (XV)  
1902 (a) (10)(C)  
1902 (a) (10) (A) (i) (IV)  
1902 (a) (10) (A) (i) (VI)  
1902 (a) (10)(A) (i) (VII)  
1902 (a) (10) (A) (ii) (VIII)  
1902 (a) (10) (A) (ii) (IX)

Disregard earned income from temporary employment related to Census activities.

\*More liberal methods may not result in exceeding gross income limitations under Section 1903(f).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

MORE LIBERAL METHODS OF TREATING RESOURCES  
UNDER SECTION 1902(r)(2) OF THE ACT\*

\_\_\_\_\_ Section 1902(f) State

\_\_\_\_\_ Non-Section 1902(f) State

A. Introduction

The total amount of funds that can be excluded from resources for burial fund designation per individual is ten thousand (\$10,000) dollars.

For coverage groups described in

1902 (a) (10) (A) (ii) (V),  
1902 (a) (10) (A) (ii)(VI),  
1902 (a) (10) (A) (ii) (VII),  
1902 (a) (10) (A) (ii) (XV),  
1902 (a) (10) (E) (i),  
1902 (a) (10) (C)  
1902 (a) (10) (E) (I),  
1902 (a) (10) (E) (ii).  
1902 (a) (10) (iii), and  
1902 (a) (10) (iv) (I) of the  
Act

B. Treatment of Assets Designated for Burial

1. Burial spaces and contract agreements with funeral homes, cemeteries, or other entities whose primary acts of business to provide burial services or items are exempt from countable resources. Any accrual of interest or appreciation of value of burial spaces and contract agreements is exempt if let to accumulate.
2. The first \$5,000 of assets intended for burial but not jointly owned with a funeral home, cemetery, or other entity whose primary act of business is to provide burial services or items are exempt from countable resources.
3. Any resource may be designated for burial and, if countable, included in the burial funds assets exclusion.
4. Any interest earned on any dividend accumulations for life insurance designation for burial is exempt.
5. Burial Funds may be commingled with other funds and be exempt under the burial funds assets exclusion if they are separately identifiable and can be tracked.

C. Exclusion of Resources in Determination of Eligibility

1. A life policy with a face value of \$5,000 or less is exempt subject to the total amount of exclusion from resources for burial fund designation per individual. Any cash value or dividends accrued by these policies are exempt as resources.
2. Burial space(s) are intended for the use of the individual, his or her spouse, or any other member of his or her immediate family and funds which are set aside for the burial expenses of the individual or spouse, subject to limitations specified below:

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MORE LIBERAL METHODS OF TREATING RESOURCES  
UNDER SECTION 1902(r)(2) OF THE ACT

## C. Exclusion of Resources in the Determination of Eligibility

- (a) Burial space is a burial plot; conventional gravesite; crypt; mausoleum; casket; urn; niche; or other repository customarily and traditionally used for the deceased's bodily remains. The term also includes necessary and reasonable improvements or additions to such spaces, including but not limited to vaults; headstones and markers or plaques; burial containers (e. g. caskets); and arrangements for the opening and closing of the gravesite.
- (b) Funds set aside for burial include revocable burial contracts, burial trusts, and any separately identifiable assets which are clearly designated as set aside for the expenses connected with an individual's burial. cremation or other funeral arrangements.
- (c) Immediate family members includes an individual's minor or adult children, including adoptive and stepchildren; parents, including adoptive parents; siblings (brothers and sisters), including adoptive and stepsiblings; and the spouse of the above relatives. If the relative's relationship to the recipient is by marriage only, the marriage must be in effect in order for the burial space exclusion to continue to apply.
- (d) A burial space is "held for" an individual when someone currently has: title to and/or possesses a burial space intended for the individual's use (e. g., has title to a burial plot or owns a burial urn stored in the basement for his or her own use); or a contract with a funeral service company for specified burial spaces for the individual's burial (i.e., an agreement which represents the individual's current right to the use of the items at the amount shown).

Until the purchase price is paid in full, a burial space is not "held for" an individual under an installment sales contract or similar device if the individual does not currently own the space; the individual does not currently have the right to use the space; and the seller is not currently obligated to provide the space. Until all payments are made on the contract, the amounts paid may be considered burial funds.

- (e) In order for burial funds to be excluded, the funds must be separately identifiable (that is not commingled with other funds or assets which are not set aside for burial). Additionally, the funds must be already designated as set aside for burial. If the burial funds are not so designated, the funds may be excluded if the individual attests in writing, that he or she intends to use the funds for his or her burial and agrees to submit within thirty (30) days, documentary evidence that the funds have been designated as set aside for burial.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

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MORE LIBERAL METHODS OF TREATING RESOURCES  
UNDER SECTION 1902(r)(2) OF THE ACT

C. Exclusion of Resources in the Determination of Eligibility

(f) Any increase in the value of excluded burial funds due to interest on such funds which were left to accumulate or appreciation of such funds after establishment of Medicaid eligibility shall be excluded.

3. The following resource methodology applies to children covered under section 1902 (a) (10) (A) (ii) (I) of the Act who are defined in Section 1905 (a)(i) of the Act.

Effective July 1, 1993, all resources will be excluded in determining eligibility for individuals under 19 years of age who are described in subsection 1905(a)(1) of the Act.

1902 (a) (10) (A)(ii)(XV)  
of the Act

4. The following additional resource methodology Applies to Working Individuals with Disabilities Basic Working Individuals with Disabilities Basic Insurance Group-TWWIIA.

Effective October 1, 2007 the first then thousand (\$10,000) of an "approved account" is excluded from resources.

An "approved account" can be established by the disabled individual and be used to save for any expense that will enhance the individual's independence and/or increase employment opportunities. The total amount of the funds in an approved account that can be disregarded in the resource calculation is ten thousand (\$10,000). Funds in excess of \$10,000 will be a countable resource. A designation form must be signed and the account kept separate from all non-exempt accounts such as regular savings and checking accounts. If the funds designated for the approved account are not deposited into a separate account, the will be counted as a resource.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

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STATE LONG-TERM CARE INSURANCE PARTNERSHIP

1902(r)(2)(A)      The following more liberal methodology applies to individuals who are eligible  
1902(a)(10)(A)      for medical assistance under one of the following eligibility groups:

  X   Groups consisting of aged, blind, or disabled individuals:

  X   who are in a medical institution for a period of not less than 30 consecutive days who meet the resource requirements of the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1903(f)(4)(C),

  X   who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under title XVI, or a State supplemental payment;

  X   who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be)

An individual who is a beneficiary under a long-term care insurance policy that meets the requirements of a "qualified State long-term care insurance partnership" policy (partnership policy) as set forth below, is given a resource disregard as described in this amendment. The amount of the disregard is equal to the amount of the insurance benefit payments made to or on behalf of the individual. The term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

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The State Medicaid Agency (Agency) stipulates that the following requirements will be satisfied in order for a long-term care policy to qualify for a disregard. Where appropriate, the Agency relies on attestations by the State Insurance Commissioner (Commissioner) or other State official charged with regulation and oversight of insurance policies sold in the state, regarding information within the expertise of the State's Insurance Department.

- The policy is a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.
- The policy meets the requirements of the long-term care insurance model regulation and long-term care insurance model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) as those requirements are set forth in section 1917(b)(5)(A) of the Social Security Act.
- The policy was issued no earlier than the effective date of this State plan amendment.
- The insured individual was a resident of a Partnership State when coverage first became effective under the policy. If the policy is later exchanged for a different long-term care policy, the individual was a resident of a Partnership State when coverage under the earliest policy became effective.
- The policy meets the inflation protection requirements set forth in section 1917(b)(1)(C)(iii)(IV) of the Social Security Act.
- The Commissioner requires the issuer of the policy to make regular reports to the Secretary that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

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- The State does not impose any requirement affecting the terms or benefits of a partnership policy that the state does not also impose on non-partnership policies.
  - The State Insurance Department assures that any individual who sells a partnership policy receives training, and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.
  - The Agency provides information and technical assistance the Insurance Department regarding the training described above.



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

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TRANSFER OF RESOURCES

1902(f) and 1917 of  
the Act

The agency provides for the denial of eligibility by reason of disposal of resources for less than fair market value.

1917 of the Act

For assets transferred after August 10, 1993, the agency complies with the provisions of Section 1917 of the Act with respect to the transfer of assets after August 10, 1993, and treatment of certain trusts established after August 10, 1993 as provided by OBRA'93.

A. Except as noted below, the criteria for determining the period of ineligibility are the same criteria specified in Section 1613(c) of the Social Security Act (Act) for resources transferred prior to August 10, 1993.

1. Transfer of resources other than home of an individual who is an inpatient in a medical institution.

a. X The agency uses a procedure which provides for a total period of ineligibility greater than 24 months for individuals who have transferred resources for less than fair market value when the uncompensated value disposed of resources exceeds \$12,000. This period bears a reasonable relationship to the uncompensated value of the transfer. The computation of the period and the reasonable relationship of this period to the uncompensated value is described as follows:

1. The amount of uncompensated value is first reduced by an amount equal to the difference between the individual's (or couple's) countable resources and the applicable resource limit; the next \$12,000 is deducted for 24 months of ineligibility; and
2. The remaining amount of uncompensated value is then ratably reduced by the average monthly SNF payment amount to determine the number of months of ineligibility exceeding 24 months.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

b  **The period of ineligibility is less than 24 months, as specified below:**

1) The amount of uncompensated value is first reduced by an amount equal to the difference between the individual's (or couple's) count: able resources and the applicable resource limit; and

2. The remaining amount of uncompensated value then ratably reduced by a monthly penalty amount of \$500.00 to determine the number of months of ineligibility.

c.  **The agency has provisions for waiver of denial of eligibility in any instance where the State determines that a denial would work an undue hardship.**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

Prior to July 1, 1988:

2. Transfer of the home of an individual who is an inpatient in a medical institution.

A period of ineligibility applies to inpatients in an SNF, ICF or other medical Institution as permitted under section 1917(c)(2)(B)(i).

- a. Subject to the exceptions on page 2 of this supplement, an individual is ineligible for 24 months after the date on which he disposed of the home. However, if the uncompensated value of the home is less than the average amount payable under this plan for 24 months of care in an SNF, the period of ineligibility is a shorter time, bearing a reasonable relationship (based on the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:
  - 1) The amount of uncompensated value is first reduced by an amount equal to the difference between the individual's (or couple's) countable resources and the applicable resource limit; and
  - 2) The remaining amount of uncompensated value is then ratably reduced by the average monthly SNF payment amount to determine the number of months of ineligibility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

- b. Subject to the exceptions on page 2 of this supplement, if the uncompensated value of the home is more than the average amount payable under this plan as medical assistance for 24 months after the date on which he disposed of the home. The period of ineligibility bears a reasonable relationship (based upon the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:
  - 1) The amount of uncompensated value is first reduced by an amount equal to the difference between the individual's (or couple's) countable resources and the applicable resource limit; the next \$12,000 is deducted for the first 24 months of ineligibility; and
  - 2) The remaining amount of uncompensated value is then ratably reduced by the average monthly SNF payment amount to determine the number of months of ineligibility exceeding 24 months.
3. (1634 STATE) Effective July 1, 1988 any resources transferred on or after that date result in a total period of ineligibility for payment of nursing home and home and community based services only which cannot exceed 30 months and which is determined as follows:
  - a. The amount of the uncompensated value is first reduced by an amount equal to the difference between the individual's (or couple's) countable resources and the applicable resource limit; and

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

- b) The uncompensated value of the resources so transferred, divided by the average cost, to a private patient at the time of application, of nursing facility services in the State or, at State's option, in the community in which the individual is institutionalized.

TRANSMITTAL 88-23  
APPROVED 3-16-89  
EFFECTIVE 7-1-88

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

No individual is ineligible by reason of item  
A.2 or A.3 (1634 STATE) if

Section 1917(c)(2) of the  
Act

- i. A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual can reasonably be expected to be discharged from the medical institution and to return to that home; or
- ii. any of the following conditions apply to the transferred item(s):
  - (A) the resources transferred were a home and title to the home was transferred to
    - (i) the spouse of such individual;
    - (ii) a child of such individual who (I) is under age 21, or (II) (with respect to States eligible to participate in the State program established under title XVI) is blind or "permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614;
    - (iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual, or
    - (iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least to years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;
  - (B) the resources were transferred (i) to or from (or to another for the sole benefit of) the individual's spouse, or as defined in section 1924(h)(2), (ii) to the individual's child described in subparagraph (A)(ii)(II);
  - (C) a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that (i) the individual intended to dispose of the resources either at fair market value or for other than to qualify for medical assistance; or

TRANSMITTAL 89-49  
APPROVED 9-17-91  
EFFECTIVE 10-1-89  
SUPERSEDES 88-23

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

(D) the State determines that denial of eligibility would work an undue hardship.

(i) Prior to July 1, 1988, the agency determines that denial of eligibility would work an undue hardship; and

(ii) Effective July 1, 1988, the agency determines that denial of payment for long-term care would work an undue hardship.

TRANSMITTAL 89-49  
APPROVED 9-17-91  
EFFECTIVE 10-1-89  
SUPERSEDES 88-23

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

3. 1902(f) States

Under the provisions of section 1902(f) of the Social Security Act, the following transfer of resource criteria more restrictive than those established under section 1917(c) of the Act, apply:

B. Other than those procedures specified elsewhere in the supplement, the procedures for implementing denial of eligibility by reason of disposal of resources for less than fair market value are as follows:

1. If the uncompensated value of the transfer is \$12,000 or less:
  
  
  
  
  
  
  
  
  
  
2. If the uncompensated value of the transfer is more than \$12,000:



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

3. If the agency sets a period of ineligibility of less than 24 months and applies it to all transfers of resources (regardless of uncompensated value):

4. Other procedures:

- a) Individuals, who applied for and/or became eligible for Medicaid from 3/1/81 through 6/30/84 and have continuously received since that time and who transfer assets for uncompensated value, are ineligible for a period of 24 months or for a shorter period of ineligibility determined by ratably reducing the uncompensated value by a penalty amount of \$500.00 per month; and
- b) There is no penalty applied for transfer of homeplace property for uncompensated value.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

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TRANSFER OF ASSETS

1917 (c)

The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

1. Institutionalized individuals may be denied certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency withholds payment to institutionalized individuals for the following services:

Payments based on a level of care in a nursing facility;

Payments based on a nursing facility level of care in a medical institution;

Home and community-based services under a 1915 waiver.

2. Non-institutionalized individuals:

\_\_\_\_\_ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in Section 1905 (a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (Section 1905 (a) (7));

Home and community care for functionally disabled and elderly adults (Section 1905 (a) (22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in Section 1905(a) (24).

\_\_\_\_\_ The following other long-term care services for which medical assistance is otherwise available under the agency plan:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

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TRANSFER OF ASSETS

3. Penalty Date – The beginning date of each penalty period imposed for an uncompensated transfer of assets is:

X the first day of the month in which the asset was transferred;

\_\_\_\_\_ the first day of the month following the month of transfer.

4. Penalty Period – Institutionalized Individuals --

In determining the penalty for an institutionalized individual, the agency uses:

X the average monthly cost to a private patient of nursing facility services in the agency;

\_\_\_\_\_ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.

5. Penalty Period – Non-Institutionalized Individuals--

The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services:

\_\_\_\_\_ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

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TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care -

a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:

X does not impose a penalty;

\_\_\_\_\_ imposes a penalty for less than a full month, based on the proportion of the agency's private nursing facility rate that was transferred.

b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:

X does not impose a penalty;

\_\_\_\_\_ imposes a series of penalties, each for less than a full month.

7. Transfers made so that penalty periods would overlap

The agency:

\_\_\_\_\_ totals the value of all assets transferred to, produce a single penalty period;

X calculates the individual penalty periods and imposes them sequentially.

8. Transfers made so that penalty periods would not overlap

The agency:

X assigns each transfer its own penalty period;

\_\_\_\_\_ uses the method outlined below:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

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TRANSFER OF ASSETS

9. Penalty periods – transfer by a spouse that results in a penalty period for the individual –

- a. The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

When the above conditions are met, the remaining penalty in effect will be apportioned equally between both spouses not to exceed the length of the penalty originally imposed on the individual.

- b. If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset –

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value using the average monthly cost to a private patient of nursing facility services in the agency.

\_\_\_\_\_ The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment using the average monthly cost to a private patient of nursing facility services in the agency.

\_\_\_\_\_ For transfers of individual income payments, the agency will impose partial month penalty periods.

\_\_\_\_\_ For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.

\_\_\_\_\_ The agency uses an alternate method to calculate penalty periods, as described below:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

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TRANSFER OF ASSETS

11. Imposition of a penalty would work an undue hardship -

The agency does not apply the transfer of assets provisions in any case in which the agency determines that such application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

Undue hardship will be said to exist if an individual would be deprived of medical care such that his/her health or life would be endangered, or the individual would be deprived of food, clothing, shelter, or other necessities of life.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

TRANSFER OF ASSETS

1917 (c)

**FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER February 8, 2006**, the agency provides for the denial of certain Medicaid services.

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

Nursing facility services;

Nursing facility level of care provided in a medical institution;

Home and community-based services under a 1915 (c) or (d) waiver.

2. Non-institutionalized individuals:

\_\_\_\_\_ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905 (a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905 (a) (7));

Home and community care for functionally disabled elderly adults (section 1905 (a) (22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905 (a) (24).

\_\_\_\_\_ The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:

3. Penalty Date--The beginning date of each penalty period

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

TRANSFER OF ASSETS

imposed for an uncompensated transfer of assets is the later of:

- the first day of a month during or after which assets have been transferred for less than fair market value;

X The State uses the first day of the month in which the assets were transferred

\_\_\_\_\_ The State uses the first day of the month after the month in which the assets were transferred

or

- the date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level care services described in paragraphs 1 and 2 that, were it not for the imposition of the penalty period, would be covered by Medicaid;

AND

which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

4. Penalty Period – Institutionalized Individuals—

In determining the penalty for an institutionalized individual, the agency uses:

X the average monthly cost to a private patient of nursing facility services in the State at the time of application;

\_\_\_\_\_ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.

5. Penalty Period - Non-institutionalized Individuals—

The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

TRANSFER OF ASSETS

\_\_\_\_\_ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

6. Penalty period for amounts of transfer less than cost of nursing facility care—

X Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4,

X The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

7. Penalty periods transfer by a spouse that results in a penalty period for the individual—

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

8. Treatment of a transfer of income-

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

X For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

X For transfers of the right to an income stream.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

TRANSFER OF ASSETS

the agency will base the penalty period on the combined actuarial value of all payments transferred.

9. Imposition of a penalty would work an undue hardship—

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

Application of a transfer of assets penalty would deprive the individual:

- (a) of medical care such that the individual's health or life would be endangered; or
- (b) of food, clothing, shelter, or other necessities of life.

10. Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

- (a) Notice to a recipient subject to a penalty that an undue hardship exception exists;
- (b) A timely process for determining whether an undue hardship waiver will be granted; and
- (c) A process, which is described in the notice, under which an adverse determination can be appealed.

These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's personal representative.

11. Bed Hold Waivers For Hardship Applicants

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

TRANSFER OF ASSETS

\_\_\_\_\_ Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed \_\_\_\_\_ days (may not be greater than 30).

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State: GEORGIA

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The agency does not apply the trust provisions in any case in which the agency determines that such application would work an undue hardship.

The following criteria will be used to determine whether the agency will not count assets transferred because doing so would work an undue hardship:

Under the agency's undue hardship provisions, the agency exempts the funds in an irrevocable burial trust.

The maximum value of the exemption for an irrevocable burial trust is \$5,000.00.

State/Territory: GEORGIA

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Citation	Condition or Requirement
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**COST EFFECTIVENESS METHODOLOGY FOR  
COBRA CONTINUATION BENEFICIARIES**

1902 (u) of the  
Act

Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods:

  X   The methodology as described in SMM section 3598.

       Another cost-effective methodology as described below.

State/Territory: GEORGIA

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Citation

Condition or Requirement

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**COST EFFECTIVENESS METHODOLOGY FOR  
COBRA CONTINUATION BENEFICIARIES**

1902 (u) of the  
Act

Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods:

  X   The methodology as described in SMM section 3598.

       Another cost-effective methodology as described below.

Revision: CMS-02-1  
May 2002

SUPPLEMENT 12 TO  
ATTACHMENT 2.6-A  
Page 1  
OMB No.: 0938-0673

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

Disclosure Statement for Post-Eligibility Preprint

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is #0938-0673. The time required to complete this information collection is estimated at 3 hours per response, including the time to review instructions, searching existing data resources, gathering the data needed and completing and reviewing the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland, 21244-1850 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C., 20503.

The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

- Deduct \$1,500 from the equity value of one vehicle.
- The cash surrender value of life insurance policies is considered as a resource.
- Earned income of a child who meets the in school test is excluded from the budgeting process for six (6) months of the calendar year. For the other six (6) months, the income is counted toward the gross income ceiling test.
- Income received from employment with the Census Bureau is considered as earned income

  X   The Agency continues to apply the following waivers of provisions of Part A of Title IV in effect as of July 16, 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997.

- Drop any prior workforce requirements and eliminate the 100-hour rule (i.e., drop the requirement that the principal wage earner in an intact family be employed less than 100 hours per month).

       The Agency applies lower income standards which are no lower than the AFDC standards in effect on May 1, 1998, as follows:

       The Agency applies higher income standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:

       The Agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF work requirements.

       The Agency provides Medicaid for up to twelve (12) months to working families who become ineligible for Low Income Medicaid because of new or increased earnings of a caretaker or other adult or the expiration of the 1/3 or \$30.00 or loss of the earned income deduction.



**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**State: Georgia**

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SECTION 1924 PROVISIONS

- A. Income and resource eligibility policies used to determine eligibility for Institutionalized individuals who have spouses living in the community are consistent with Section 1924.
- B. In the determination of resource eligibility the State resource standard is dollar maximum allowed in Section 1924(f) (2) as modified by Section 1924 (g) of the Act.
- C. Per HCFA Program Issuance Transmittal Notice, MCD-3-91, dated January 11, 1991, Georgia acknowledges the existence of the undue hardship provision of Section 1924(c)(3) (C) of the Act whereby an institutionalized spouse who (or whose spouse) has excess resources shall not be found ineligible under Title XIX of the Act where the state determines that denial of eligibility on the basis of having excess resources would work an undue hardship. This provision is applied to determinations of eligibility as appropriate.
- D. The agency complies with the provisions of Section 1917 of the Act with respect to the transfer of assets, and treatment of certain trusts as provided by OBRA '93.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State: Georgia

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**CONSIDERATION OF TRANSFER ASSETS AND TRUSTS UNDUE HARDSHIP**

Sections 1917 (c)  
and 1917 (d) of the  
Act (P.L. 103-66)  
Section 13600

The agency provides that an individual shall not be found ineligible under Title XIX of the Act where the State determines that such denial would work an undue hardship if the provisions of Sections 1917 (c) and 1917 (d) of the Act were applied. Undue hardship will be said to exist if an individual would be deprived of medical care such that his/her health or life would be endangered, or the individual would be deprived of food, clothing, shelter, or other necessities of life.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

## ASSET VERIFICATION SYSTEM

1940 (a)  
of the Act

1. The agency will provide for the verification of assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements.
  - A. The request and response system must be electronic:
    - (1) Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).
    - (2) The system cannot be based on mailing paper-based requests.
    - (3) The system must have the capability to accept responses electronically.
  - B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institute of Standards and Technology, or NIST).
  - C. The system must establish and maintain a database of FIs that participate in the agency's AVS.
  - D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or redetermine the individual's eligibility.
  - E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

## ASSET VERIFICATION SYSTEM

## 2. System Development

A. The agency itself will develop an AVS.

In 3 below, provide any additional information the agency wants to include.

B. The agency will hire a contractor to develop an AVS.

In 3 below provide any additional information the agency wants to include.

C. The agency will be joining a consortium to develop an AVS.

In 3 below, identify the States participating in the consortium. Also, provide any other information the agency wants to include pertaining to how the consortium will implement the AVS requirements.

D. The agency already has a system in place that meets the requirements for an acceptable AVS.

In 3 below, describe how the existing system meets the requirements in Section 1.

E. Other alternative not included in A. – D. above.

In 3 below, describe this alternative approach and how it will meet the requirements in Section 1.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

ASSET VERIFICATION SYSTEM

3. Provide the AVS implementation information requested for the implementation approach checked in Section 2, and any other information the agency may want to include.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Georgia

DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH  
SUBSTANTIAL HOME EQUITY

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1917(f)

The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State plan for an individual who does not have a spouse, child under 21 or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

X \$500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest \$1,000).

An amount that exceeds \$500,000 but does not exceed \$750,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest \$1,000).

The amount chosen by the State is \_\_\_\_\_.

This higher standard applies statewide.

This higher standard does not apply statewide. It only applies in the following areas of the State:

This higher standard applies to all eligibility groups.

This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be waived in cases of undue hardship.

State / Territory: GEORGIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided :  No limitations  With limitations\*

2.a. Outpatient hospital services.

Provided :  No limitations  With limitations\*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic which are otherwise included in the state plan.

Provided :  No limitations  With limitations\*

Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Provided :  No limitations  With limitations\*

~~d. Ambulatory Services offered by health center receiving funds under Section 329, 330, or 346 of the Public Health Service Act to a pregnant Woman or individual under 18 years of age.~~

3. Other laboratory and x-ray services.

Provided :  No limitations  With limitations\*

\* Description provided on attachment.

1. INPATIENT HOSPITAL SERVICES

The maximum reimbursable length of stay without prior approval for psychiatric services is thirty (30) days. There is no other limitation on number of inpatient hospital days for eligible recipients if services are medically justified. Claims are subject to review for medical necessity.

Limitations

1. Reimbursement for private rooms will be made at the most common semi-private room rate. Special care units are covered if medically justified by the attending physician.
2. Admission for diagnostic purposes is covered only when the diagnostic procedures cannot be performed on an outpatient basis.
3. Chest x-rays and other diagnostic procedures performed as part of the admitting procedure will be covered only when:
  - The test is specifically ordered by a physician responsible for the patient's care.
  - The test is medically necessary for the diagnosis or treatment of the individual patient's condition.
  - The test does not unnecessarily duplicate the same test done on an outpatient basis before admission or one done in connection with a recent admission.
4. Surgical procedures deemed to be appropriately performed on an outpatient basis are not covered as inpatient services unless medical necessity for inpatient admission is documented.
5. Hysterectomies, sterilizations and abortions are covered only when applicable Federal requirements are met.
6. Hospital services in connection with the acquisition of an organ from a living donor for transplant in an eligible recipient are considered as services for the treatment of the recipient and are covered as such, although the donor may or may not be Medicaid eligible.
7. Kidney transplants are covered for recipients with documented end stage renal disease. Prior approval is not required unless the procedure is performed out-of-state.
8. In applying standards to cover organ transplants, similarly situated individuals are treated alike. Any restriction on the facilities or practitioners which may provide such procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State Plan.



Inpatient Hospital Services (cont'd)

9. The maximum reimbursable length of stay without prior approval for psychiatric services is thirty (30) days.
10. Inpatient dialysis services are covered for maintenance dialysis of a patient with end stage renal disease only if the admitting hospital does not have a Hospital-Based Dialysis Facility.
11. Medically necessary magnetic resonance imagings (MRI) are covered, in accordance with accepted medical standards, for the brain, spine, knee, lower extremity, orbit or myocardium, when CT scans or SPECT procedures are not definitive or appropriate. Only one MRI per day will be paid without submission of documentation for medical necessity.

PRECERTIFICATION

Precertification for inpatient admissions must be obtained by the attending physician prior to the rendering of services. Precertification pertains to medical necessity and appropriateness of setting. Normal deliveries and recipients who have Medicare Part A are excluded from this requirement.

Approval for liver transplantation may be requested for eligible recipients with the disorders listed below. Records for all candidates for coverage will be reviewed for determination of disorder, prognosis and factors of contraindication.

End state cirrhosis with liver failure due to:

Primary biliary cirrhosis.  
Primary sclerosing cholangitis;  
Post necrotic cirrhosis, hepatitis B surface antigen negative;  
Alcoholic cirrhosis;  
Alpha-1 antitrypsin deficiency;  
Wilson's disease; or  
Primary hemochromatosis

Organ transplant center criteria is specified in Attachment 3.1-E.

For All EPSDT Eligible Recipients:

All medically necessary diagnostic and treatment services will be provided to correct and ameliorate defects and physical and mental illnesses whether or not such services are covered or exceed the benefit limitations in the hospital program if medical necessity is properly documented and prior approval is obtained.

Non Covered Services and Procedures

1. Services and supplies which are inappropriate or medically unnecessary as determined by the Department, the Georgia Medical Care Foundation, or other authorized agent.
2. Private duty nurses or sitters/companions.
3. Take home drugs, medical supplies, durable medical equipment, artificial limbs or appliances.
4. Non-therapeutic sterilizations performed on persons under age 21 or persons who are not legally competent to give informed consent.
5. Services not medically necessary; i.e., television, telephone, guest meals, cots, etc.
6. Services or items furnished for which the hospital does not normally charge.
7. Experimental or investigational services, drugs or procedures which are not generally recognized by the Food and Drug Administration, the U. S. Public Health Service, Medicare and the Department's contracted Peer Review Organization as acceptable treatment.

The following list is representative of non-covered procedures that are considered to be experimental or investigational and is not meant to be exhaustive:

- Carotid body resection/carotid body denervation
  - Fetal surgery
  - Implantation of infusion pumps
  - Intestinal bypass surgery
  - Wrapping of abdominal aneurysm
  - Transvenous (catheter) pulmonary embolectomy
  - Transsexual surgery
8. Cosmetic surgery and all related services

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POLICIES AND PROCEDURES APPLICABLE TO HOSPITAL SWING-BED SERVICES

- A. The Department provides reimbursement for nursing facility services rendered in hospitals which have swing-bed agreements with Medicare under Section 1883 of the Act. Swing-beds are defined as hospital beds that may be used for either nursing facility or hospital acute levels of care on an as needed basis. All services are subject to reimbursement limitations without regard to diagnosis, type of illness or condition.

1. Covered Services

The Department covers swing-bed services only for nursing facility services. The term "nursing facility services" means services which are or were required to be given an individual who needs of needed on a daily basis nursing care (provided directly by or requiring the supervision of nursing personnel) or other rehabilitation services which as a practical matter can only be provided in a nursing facility on an inpatient basis.

A physician must certify that nursing facility care is needed for continued treatment of a medical condition which cannot be managed in the home setting. The certification for nursing facility care must be obtained at the time of admission to the swing-bed, or the next working day if admitted on a weekend or holiday.

Coverage of swing-bed services involves only services in those hospitals which have Georgia Medicaid swing-bed agreements. The reimbursement rate established by the department is an all inclusive rate based on the statewide average Medicaid per diem rate paid to skilled nursing facilities and intermediate care facilities for routine services furnished during the previous calendar year. The payment rate established by the State Agency is in accordance with the requirements Sections 1902 (a) (13) (A) and 1913(a) of the Act. The rate covers the cost of the following:

- (a) Patient's room and board (including special diets and special dietary supplements used for tube or oral feedings, specifically prescribed by a physician);
- (b) Laundry (including personal laundry); and
- (c) Nursing and routine services: Routine services, physical therapy, speech therapy, restorative nursing care, tray service, durable medical equipment (such as, but not limited to beds, bed rails, walkers, wheelchairs), incontinency care and incontinency pads, hand feedings, special mattresses and pads, massages, syringes, personal comfort or cosmetic items, extra linens, assistance in personal care and grooming, laboratory procedures not requiring laboratory personnel, non-prescription drugs (such as, but not limited to antacids, aspirin, suppositories, mild of magnesia, mineral oil, rubbing alcohol), prophylactic medications (such as, but

not limited to influenza vaccine) and other items not on the Medical Assistance Drug List but which are distributed or used individually as ordered by the attending physician. In addition, supplies (such as, but not limited to oxygen, catheters, catheter sets, drainage apparatus, intravenous solutions, administration sets and water for injections) are to be covered under the approved reimbursement rate.

Diagnostic or therapeutic x-ray services, laboratory procedures requiring laboratory personnel, physician services, and pharmacy services (except as described above) may be billed separately to the Department by the enrolled providers of service.

## 2. Non-Covered Services

The services listed below are non-covered by the Department in the swing-bed program. Adverse action will be taken against those providers who willfully continue to bill the Department for non-covered services identified in this manual.

- a) Services which do not meet nursing facility level of care criteria;
- b) Services provided by hospitals out of state which do not have a swing-bed provider agreement; and,
- c) Services not provided in compliance with the provisions of the Policies and Procedures for Swing-Bed Services manual.

## 3. Medicaid/Medicare Services

When a Medicaid recipient also has Medicare Part A coverage, payment for swing-bed services for up to one hundred days may be allowed by Medicare. In this instance, the swing-bed services must be billed to Medicare prior to billing the Department. The Medicare intermediary reimburses for the first through the twentieth day of coverage at 100% of the Medicare per diem rate. For the twenty-first through the one hundredth day, the Medicare intermediary pays a reduced amount and Medicaid pays the applicable coinsurance amount. When Medicare Part A swing-bed benefits, i.e., skilled nursing facility care, are exhausted for these recipients, charges for days in excess of Medicare covered days may be submitted to the Department for reimbursement at the Medicaid per diem rate.

2.a. **OUTPATIENT HOSPITAL SERVICES**

Hospital outpatient coverage is provided for preventive, diagnostic, therapeutic, rehabilitative or palliative items or services furnished under the direction of a physician or dentist.

Limitations

1. More than one non-emergency visit by the same recipient in one day is subject to review and possible denial, depending on medical necessity.
2. Sterilizations and abortions are covered only when applicable Federal requirements are met.
3. Outpatient dialysis services are covered in the Dialysis Services program.
4. One series of birthing and parenting classes is provided per twelve-month period for pregnant women.
5. Medically necessary magnetic resonance imagings (MRI) are covered, in accordance with accepted medical standards, for the brain, spine, knee, lower extremity, orbit or myocardium, when CT scans or SPECT procedures are not definitive or appropriate. Only one MRI per day will be paid without submission of documentation for medical necessity.

Precertification

Precertification must be obtained by the attending physician for certain outpatient procedures prior to the rendering of services. Precertification pertains to medical necessity and appropriateness of setting. Emergency outpatient services and recipients who have Medicare Part B are excluded from this requirement.

Non-Covered Services

1. Items and services which are not medically necessary for, or related to, the prevention, rehabilitation, palliative services, diagnosis or treatment of illness or injury.
2. Take-home drugs, medical supplies and appliances. (The hospital receives reimbursement for these services by enrolling as a provider of the specific service.)
3. Routine physical examinations are a non-covered service because 10% or less of the hospitals in Georgia offer routine physical examinations as a service.
4. Cosmetic surgery or mammoplasties for aesthetic purposes.
5. Services or items furnished for which the hospital does not normally charge.
6. Experimental services or procedures or those which are not recognized by the profession or the U.S. Public Health Service as universally accepted treatment.

**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.

5. Services or procedures performed by a facility not certified to perform them.
6. Experimental services or procedures or those which are not recognized by the profession or the U.S. Public Health Service as universally accepted treatment.
- 10-1-89 7. Laboratory services that are routinely furnished and included in the reimbursement for hemodialysis services.



4.a. Nursing facilities provide nursing or rehabilitative care on a daily basis. Covered services include room and board (including special diets and special dietary supplements used for tube or oral feedings, when specifically prescribed by a physician), laundry (including personal laundry), nursing services (except private duty nurses), medical social services, physical therapy, speech therapy, restorative nursing care, tray services, durable medical equipment, incontinency care and incontinency pads, hand feedings, special mattresses and pads, massages, syringes, enemas, dressings, laboratory procedures not requiring laboratory personnel, non-prescription drugs such as, antacids, aspirin, suppositories, magnesium hydroxide liquid, mineral oil, rubbing alcohol, prophylactic medications, oxygen, catheters, catheter sets, drainage apparatus, intravenous solutions, administration sets and water for injections. Personal comfort or cosmetic items not covered.

Adjunctive services (those not included in the established reimbursement rate) are covered only on written authorization in the plan of care by the attending physician. Drugs included on the Medical Assistance Drug List or those specially approved by the Department are available through the Pharmacy Services Program.

Pre-admission approval of a nursing facility level of care must be obtained from a physician authorizing nursing facility placement by completing and signing a DMA-6 form for those applying to Medicaid for payment of facility services.

Voluntary supplementation may be paid directly to providers by relatives or other persons for the additional cost of a private room and/or sitter for Title XIX recipients in nursing homes (Ga. Act. 1323). These supplemental payments are not considered as income when determining the amount of patient liability toward vendor payments. Provision of a private room and/or sitter through supplemental payment will not constitute discrimination against other recipients. No recipient who is admitted/transferred to a private room due to a shortage of beds in semi-private rooms may be discharged due to lack of voluntary supplementation. Charges for private rooms may not exceed rates charged to private patients.

4. b. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT).

In administering the EPSDT Program, the Department has established procedures to (1) inform all eligible individuals of the availability of EPSDT services; (2) provide or arrange for requested screening services; and (3) arrange for corrective treatment of health problems found as a result of screening.

EPSDT services are available through state health departments, rural health clinics, and a variety of individual practitioners both in single and group practice.

Appropriate immunizations according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines will be provided.

Lead screening services are provided at 12 and 24 months per CMS guidelines, and for children between the ages of 36 months and 72 months of age if they have not been previously screened for lead poisoning.

Screening services are available based on the American Academy of Pediatrics nationally recognized periodicity schedule.

Medically necessary interperiodic screens are available when applicable.

All medically necessary diagnostic and treatment services will be provided to correct and ameliorate defects and physical and mental illnesses and conditions discovered during an EPSDT screen, periodic or interperiodic, whether or not such services are covered or exceed the benefit limitations in the State Plan. Appropriate limits may be placed on EPSDT services based on medical necessity.

Periodic and interperiodic screenings, assessments and immunizations are covered under the EPSDT program. All other EPSDT services are covered under the individual programs as described in Attachments 3.1-A, B, and E of this plan.

Services which are medically necessary but which are not currently provided under the plan must be prior approved and will be reimbursed according to the reimbursement methodologies described on Supplement 1 to "Attachment 4.19-8. Page 1. Medical necessity is defined per Part I Policies and Procedures for Medicaid/Peachcare for Kids.

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4.b. **EPSDT-Related Rehabilitative Services - Community Based**

The covered rehabilitative services for the Children's Intervention Services program are audiology, nursing, occupational therapy, physical therapy, nutrition, counseling and speech-language pathology which include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under State law, and are provided by a licensed practitioner of the healing arts to EPSDT eligible recipients (ages 0-20). These services may be provided in practitioners offices, community centers, and in the recipient's home.

The services are defined as follows:

- **Audiology Services**

Audiological testing; fitting and evaluation of hearing aids. Providers' qualifications are in accordance with 42 CFR 440.60(a).

- **Nursing Services**

Skilled intermittent nursing care to administer medications or treatments. Skilled intermittent nursing care is provided by licensed nurses (registered or licensed practical nurses under the supervision of a registered nurse, licensed to practice in the state of Georgia). Providers' qualifications are in accordance with the requirements of federal regulation 42 CFR 440.60(a).

- **Occupational Therapy Services**

Occupational therapy evaluation of gross and fine motor development and clinical services related to activities of daily living and adaptive equipment needs. Providers' qualifications are in accordance with 42 CFR 440.110.

- **Physical Therapy Services**

Physical therapy evaluation of neuromotor development and clinical services related to improvement of gait, balance and coordination skills. Providers' qualifications are in accordance with 42 CFR 440.110.

- **Counseling Services**

Evaluation to determine the nature of barriers (social, mental, cognitive, emotional, behavioral problems, etc.) to effective treatment, that impacts the child's medical condition, physical disability and/or developmental delay and the child's family. The provision of counseling and intervention services to resolve those barriers relating to effective treatment of the child's medical condition and which threaten the health status of the child. Services are provided by Licensed Clinical Social Workers in accordance with standards of applicable state licensure and certification requirements, must hold a current license, and adhere to the scope of practice as defined by the applicable licensure board in accordance with the federal requirements in 42 CFR 440.60(a).

4.b. **EPSDT Related Rehabilitative Services – Community Based** (continued)

- **Speech-Language Pathology Services**  
Speech-language evaluation of auditory processing, expressive and receptive language and language therapy. Providers' qualifications are in accordance with 42 CFR 440.110, and adhere to the scope of practice as defined by the applicable state licensure board.
- **Nutrition Services**  
Nutritional assessment, management and counseling to children on special diets due to genetic metabolic or deficiency disorders or other complicated medical problems. Nutritional evaluation and monitoring of their nutritional and dietary status, history and any teaching related to the child's dietary regimen (including the child's feeding behavior, food habits and in meal preparation), biomedical and clinical variables and anthropometric measurements). Development of a written plan to address the feeding deficiencies of the child that is incorporated into the child's treatment program. Providers' qualifications must meet the applicable State licensure and certification requirements, hold a current state license, and adhere to the scope of practice as defined by the applicable licensure board in accordance with the federal requirements in 42 CFR 440.60(a).

**Limitations**

Provider enrollment is open only to individual practitioners, who are licensed in Georgia under their respective licensing board such as a licensed audiologist, registered nurse, occupational therapist, physical therapist, licensed clinical social worker, licensed counselor, licensed dietician or speech language pathologist. For annual re-enrollment beginning July 1, 1996, all providers must obtain a minimum of one (1) continuing education credit annually in pediatrics in their area of professional practice. Where applicable, providers will be in compliance with federal requirements defined in 42 CFR 440.110 or 42 CFR 440.60(a).

**Prior Approval**

Services which exceed the limitations as listed in the policies and procedures manual must be approved prior to service delivery.

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4.b. **EPSDT related Rehabilitative Services - Community**-Based (continued)

The following services are not provided through the EPSDT-Related Rehabilitative Services - Community Based program:

1. Services provided to children who do not have a written service plan.
2. Services provided in excess of those indicated in the written service plan.
3. Services provided to a child who has been admitted to a hospital or other institutional setting as an inpatient.
4. Service of an experimental or research nature.
5. Services in excess of those deemed medically necessary by the Department, its agents or the federal government, or for services not directly related to the child's diagnosis, symptoms or medical history.
6. Failed appointments or attempts to provide a home visit when the child is not at home.
7. Services normally provided free of charge to all patients.
8. Services provided by individuals other than the enrolled licensed practitioner of the healing arts.
9. Services provided for temporary disabilities that would reasonably be expected to improve spontaneously as the patient gradually resumes normal activities.

4.b. Rehabilitative Services (continued).

**EPSDT-Related Rehabilitative Services – School Based Health Services**

The Children's Intervention School Services (CISS) program includes covered rehabilitative services provided by or through Georgia State Department of Education (DOE) or a Local Education Agency (LEA) to children with or suspected of having disabilities, who attend public school in Georgia, recommended by a physician or other licensed practitioners of the healing arts to EPSDT eligible special education students (from ages 0-20). These services are provided pursuant to an Individual Education Program (IEP) or Individual Family Service Plan (IFSP).

The services are defined as follows:

- **Audiology Services**

Audiological testing, fitting and evaluation for hearing aids. Providers' qualifications must meet the requirements of federal regulations 42 CFR 440.110.

- **Nursing Services**

Skilled intermittent nursing care to administer medications or treatments. Skilled intermittent nursing care is provided by licensed nurses (registered or licensed practical nurses under the supervision of a registered nurse, licensed in the state of Georgia). Providers' qualifications are in accordance with the requirements of federal regulation 42 CFR 440.60(a).

- **Occupational Therapy Services**

Occupational therapy evaluation of gross and fine motor development and clinical services related to activities of daily living and adaptive equipment needs. Providers' qualifications must meet the federal requirements in 42 CFR 440.110.

- **Physical Therapy Services**

Physical therapy evaluation of neuromotor development and clinical services related to improvement of gait, balance, and coordination skills. Providers' qualifications must meet the federal requirements in 42 CFR 440.110.

4.b. Rehabilitative Services

**EPSDT-Related Rehabilitative Services - School Based Health Services** (continued)

- **Counseling Services**  
Evaluation to determine the nature of barriers (social, mental, cognitive, emotional, behavioral problems, etc.) to effective treatment that impacts the child's medical condition, physical disability and/or developmental delay and the child's family. The provision of counseling and intervention services to resolve those barriers relating to effective treatment of the child's medical condition and which threaten the health status of the child. Services are provided by Licensed Clinical Social - workers in accordance with the standards of applicable state licensure requirements, must hold a current license, and adhere to the scope of practice as defined by the applicable licensure board in accordance with the federal requirements in 42 CFR 440.60(a).
- **Speech-Language Pathology Services**  
Speech language evaluation of auditory processing, expressive and receptive language and language therapy. Providers' qualifications must meet the federal requirements in 42 CFR 440.110 and adhere to the scope of practice as defined by the applicable board.
- **Nutrition Services**  
Nutritional assessment, management and counseling to children on special diets due to genetic, metabolic or deficiency disorders or other complicated medical problems. Nutritional evaluation and monitoring of their nutritional and dietary status, history and any other teaching related to the child's dietary regimen (including the child's feeding behavior, food habits and in meal preparation), biochemical and clinical variables and anthropometrics measurements). Development of a written plan to address the feeding deficiencies of the child. Providers' qualifications must meet the applicable state licensure requirements, hold a current state license, and adhere to the scope of practice as defined by the applicable licensure board in accordance with the federal requirements in 42 CFR 440.60(a).

4.b. Rehabilitative Services**EPSDT-Related Rehabilitative Services - School Based Health Services** (continued)Requirements

The medically necessary rehabilitative services must be documented in the Individual Education Program (IEP) or Individualized Family Service Plan (IFSP).

Limitations

The covered services are available only to the EPSDT eligible recipients (ages 0 - 20) with a written service plan (an IEP/IFSP) which contains medically necessary services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under State law.

Provider enrollment is only open to individual practitioners who are licensed in Georgia under their respective licensing board as a licensed audiologist, registered nurse, occupational therapist, physical therapist, licensed clinical social worker, licensed dietician, or speech-language pathologist. For annual re-enrollment beginning July 1, 1996, all providers must obtain a minimum of one (1) continuing education credit annually in pediatrics in their area of professional practice. Where applicable providers will be in compliance with federal requirements defined in 42 CFR 440.110 or 42 CFR 440.60(a).



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4.b. Rehabilitative Services

**EPSDT-Related Rehabilitative Services - School Based Health Services** (continued)

Limitations (continued)

The following services are not provided through the EPSDT-Related Rehabilitative Services-School based program:

1. Services provided to children who do not have a written service plan.
2. Services provided in excess of those indicated in the written service plan.
3. Services provided to a child who has been admitted to a hospital or other institutional setting as an inpatient.
4. Services of an experimental or research nature (investigational) which are not generally recognized by professions, the Food and Drug Administration, the U.S. Public Health Service, Medicare, and the Department's contracted Peer Review Organization, as universally accepted treatment.
5. Services in excess of those deemed medically necessary by the Department, its agents, or the federal government, or for services not directly related to the child's diagnosis, symptoms, or medical history.
6. Failed appointments or attempts to provide a home visit when the child is not home.
7. Services normally provided free of charge to all patients.
8. Services provided by individuals other than the enrolled licensed practitioner of the healing arts.
9. Services provided for temporary disabilities, which would reasonably be expected to improve spontaneously as the patient gradually resumes normal activities.

4.b. Rehabilitative Services

**EPSDT-Related Rehabilitative Services - School Based Health Services** (continued)

**Limitations** (continued)

The following services are also not provided through the EPSDT-Related Rehabilitative Services-School Based program:

10. Services provided for temporary disabilities, which would reasonably be expected to improve spontaneously as the patient gradually resumes normal activities.
11. Billing for more than one travel fee per location when more than one patient is treated.

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 AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND

## SERVICE PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided :  No limitations  With limitations

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.'

4.c. Family planning services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided :  No limitations  With limitations

4d. Tobacco Cessation Counseling Services for Pregnant Women Provided:

Provided :  No limitations  With limitations

5.a. Physician's services whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided :  No limitations  With limitations

5.b. Medical and surgical services furnished by a dentist (in accordance with Section 1905(a)(5)(B) of the Act).

Provided :  No limitations  With limitations

6. Medical care and any other types of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services

Provided :  No limitations  With limitations

\* Description provided on attachment.

#### **4. c. FAMILY PLANNING SERVICES**

Family planning services are provided to eligible Medicaid members who wish to prevent pregnancies, plan the number of pregnancies, plan the spacing between pregnancies, or obtain confirmation of pregnancy.

##### **Covered Services**

Covered services include at a minimum:

- Education and counseling (including behavioral counseling) necessary to make informed choices and understand contraceptive methods;
- Initial and annual complete physical examinations including a pelvic examination and Pap test;
- Follow up brief and comprehensive visits;
- Pregnancy testing;
- Contraceptive methods, supplies and follow – up care;
- Sterilizations for members at least twenty-one (21) years of age at the time consent is obtained who are mentally competent and who voluntarily give informed consent in accordance with state policies and procedures.
- Diagnosis of sexually transmitted infections;
- Treatment of sexually transmitted infections; and
- Infertility assessments.

##### **Non-Covered Services**

- Abortions or abortion-related services performed for family planning purposes.
- Sterilization of recipients institutionalized in correction facilities, mental hospitals, or other rehabilitative facilities.
- Hysterectomies performed for family planning purposes.
- Indirect services to recipients, such as telephone contacts, and case management.

#### 4d. EPSDT Nursing Services

##### **EPSDT Private Duty (Continuous) Nursing Services**

- (1) Skilled continuous nursing care provided by licensed nurses (registered or licensed practical nurses under the supervision of a registered nurse, licensed to practice in the state of Georgia)
- (2) Nursing services are provided to recipients who require more individual and continuous care than intermittent nursing care services.
- (3) Private duty nursing is provided in settings prescribed by level of care. Private duty nursing is based on the need of the recipients for these services.
- (4) Private duty nursing is dependent upon the intensity of the required care and does not encompass routine medical procedures that a layperson or a nursing assistant can be trained to do.

**Tobacco Cessation Counseling Services for Pregnant Women**

4d. 1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

(i) By or under supervision of a physician;

(ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; or\*

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations, (None are designated at this time; this item is reserved for future use.)

\*describe if there are any limits on who can provide these counseling services

2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided:  No limitations  With limitations\*

\*Recommended benefit package should include at least four (4) counseling sessions per quit attempt with a minimum of two (2) quit attempts per 12 month period.

Please describe any limitations:

The procedure codes 99406 and 99407 are to be rendered in a face-to-face setting with the pregnant member for the purpose of promoting healthy habits during pregnancy. Prescribing pharmacotherapy medication is not a prerequisite for use of these procedure codes. However, if any of the pharmacotherapy medications is prescribed by the provider, a face to face counseling must be documented in the pregnant member's medical record every 30 days during the 12 week treatment period. The member may begin therapy during any trimester.

**5a PHYSICIAN SERVICES**

All medically necessary, non-experimental physicians' services are covered when provided for EPSDT recipients under age 21.

Limitations

1. For recipients 21 years of age and over, Medicaid will not provide reimbursement to any physician for office visits that exceed 12 per recipient per calendar year unless medically justified through prior authorization.
2. The Medicaid Program will not provide reimbursement to any physician for visits to a nursing home which exceed 12 per recipient per calendar year, unless medically justified through prior authorization.
3. The Medicaid Program will not provide reimbursement to a physician for any pre-operative hospital visits to a recipient hospitalized for elective surgery, unless sufficient medical documentation is provided to substantiate such visits. Only one pre-operative hospital visit to a recipient hospitalized for non-elective surgery is reimbursable unless sufficient medical documentation is provided to substantiate additional pre-operative visits.
4. The Medicaid Program will not provide reimbursement to a physician for more than one hospital visit per patient per day of hospitalization.
5. The Medicaid Program will not provide reimbursement to non-enrolled, out-of-state physicians for "term" obstetrical deliveries on recipients who travel to other states to bear their children for reasons other than medical.
6. Reimbursement for injectable drugs is restricted to those listed in the Physicians Injectable Drug List.
7. Routine refractive services and optical/prosthetic devices are reimbursable according to policies governing the Vision Care Services Program.
8. The Department has no provision for direct enrollment of or payment to auxiliary personnel employed by the physician, such as nurses, non-physician anesthetists, unlicensed surgical assistants or other aides. Physician's Assistant services, provided under the supervision of a physician, are reimbursable only under criteria set forth in subsection 601.9 of the Policies & Procedures for Physician Services manual. Certified Pediatric, OB/GYN, Family Nurse Practitioners, and CRNAs are eligible for enrollment. Licensed physical, occupational, and speech pathology therapists are eligible for enrollment to provide services to recipients less than twenty-one years of age.

When the physician employs auxiliary personnel to assist in rendering services to patients and bills the charges as part of the physician's charge for the service, the Department may reimburse the physician for such services if the following criteria are met:

- a) the services are rendered in a manner consistent with the requirement of Section 901.1 of the Policies & Procedures for Physician Services manual;

PHYSICIAN SERVICES (continued)

**5a PHYSICIAN SERVICES** (continued)

- b) the services furnished are "incident to" services performed under the direct supervision of the physician as an adjunct to the physician's personal service;
  - c) the services are of kinds that are "commonly furnished" in the particular medical setting; and
  - d) the services are not traditionally reserved to physicians.
9. Kidney transplants are covered for recipients with documented end stage renal disease. Prior approval is not required unless the procedure is performed out-of-state.

Prior Approval

The Department requires that the following services be approved prior to the delivery of such services, except in documented emergency, life threatening situations:

1. Tonsillectomies and/or adenoidectomies;
2. Removal of keloids;
3. Any surgery to correct morbid obesity and adjunctive surgery, i.e., lipectomies;
4. Plastic surgeries that are associated with functional disorders; (cosmetic surgeries for aesthetic purposes are not covered.)
5. Hyperbaric oxygen pressurization;
6. Ligation and stripping of varicose veins of the lower limb(s);
7. Mammoplasties that are associated with functional disorders or post cancer surgery. Mammoplasties for aesthetic purposes are not covered;
8. More than six prescriptions per month for life-sustaining drugs for any one recipient;
9. More than twelve medically necessary office or nursing home visits per year (July 1 through June 30) for any one recipient
10. Prior approval for liver transplantation may be requested for eligible recipients with the following disorders. Records for all candidates for coverage will be reviewed for determination of disorders, prognosis and factors of contraindication. In applying standards to provide liver transplants, similarly situated individuals will be treated alike.



Physician Services Continued

End stage cirrhosis with liver failure due to:

Primary biliary cirrhosis;

Chronic active hepatitis (except as below);

Secondary biliary cirrhosis;

Other disorders not likely to recur in the graft and which are not associated with serious coexisting systemic disease;

Cause unknown.

Metabolic disorders involving the liver, including:

Alpha-1-antitrypsin deficiency;

Protoporphyrria;

Crigler-Najjar syndrome type I;

Other metabolic disorders involving the liver for which no effective therapy exists and which are not associated with serious extrahepatic diseases.

Miscellaneous disorders including:

Extra-hepatic biliary atresia (excluding persistent viremia)

Hepatic vein thrombosis

Sclerosing cholangitis

Other disorders not listed above which are not associated with serious and irreversible extrahepatic disease, which produce life-threatening illness, for which no other effective therapy exists, and for which transplantation would be beneficial.

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**5a. PHYSICIAN SERVICES** (continued).Non-Covered Services.

1. Cosmetic surgery.
2. Laboratory services furnished by the state or a public laboratory.
3. Experimental services drugs, or those procedures that are not generally recognized by the medical profession or the U.S. Public Health Service as acceptable treatment.
4. Non-essential foot care for recipients twenty-one years of age or older, including, but not limited to, elective.

**5b. MEDICAL AND SURGICAL SERVICES furnished by a Dentist (in accordance with Section 1905(a) (5) (B) of the Act) are covered when:**

1. A doctor of dental medicine or dental surgery who is authorized to furnish those services in the State in which he or she furnishes the services;
2. The services are within the scope of practice of medicine or osteopathy as defined by State law; and,
3. The services are furnished by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

**6a. PODIATRY SERVICES.**

## Limitations.

1. The Medicaid program will not provide reimbursement to a podiatrist for nail debridement on patients who are not diabetic or do not have peripheral vascular disease.
2. The Medicaid program will not provide reimbursement to a podiatrist for more than one inpatient hospital visit per recipient per day of hospitalization.
3. The Medicaid program will not provide reimbursement to a podiatrist for services rendered in a nursing home unless referral is made by the patient's attending physician.
4. Reimbursement for injectable drugs is restricted to those listed in the Physician Administered Drug List.

**Prior Approval.** All surgery performed in a nursing home by a podiatrist must be approved by the Department prior to the surgery except the following:

1. Routine debridement of mycotic nails
2. Incision and drainage of abscess with documented cellulites.

**Podiatry Services (Continued).**

Prior Approval (Continued).

3. Surgical debridement of stasis, performing, or decubitus ulcer.
4. Emergency relief of pain and infection except that all procedures involving soft tissue or bone surgery must be prior approved by the Department.

Prior approval is required for the surgical correction of flat feet.

Non-Covered Services.

1. Ancillary services unrelated to the diagnosis or treatment of the patient.
2. Services performed outside the scope of the practice of Podiatry as outlined in the applicable State law.
3. Experimental services or procedures or those which are not recognized by the profession or the U.S. Public Health Service as universally accepted treatment.
4. Charges for the following services:
  - a. Flatfoot: The evaluation or non-surgical treatment of a flatfoot condition regardless of the underlying pathology.
  - b. Subluxation: The evaluation of subluxation of the foot and non-surgical measures to correct the condition or to alleviate symptoms.
  - c. Routine Foot Care: Routine foot care for ambulatory or bedridden patients; includes cutting or removal of corns, warts, or callouses; the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleansing, soaking, and the use of skin creams.
  - d. Supportive Devices - Orthopedic shoes rather than shoes that are an integral part of a brace and arch support. An orthopedic shoe that is built into a leg brace is reimbursable. Biomechanical orthotics are not reimbursable.
  - e. Vitamin B-12 Injection- To strengthen tendons, ligaments, etc., of the foot.
5. Non-essential foot care for recipients twenty-one years of age or older including elective procedures such as, but not limited to, hammertoe repair, bunionectomies and related services, and treatment of ingrown nails.

6.b. OPTOMETRIC SERVICES

Limitations:

1. Routine refractive services and optical devices are available annually, without prior approval to individuals eligible for EPSDT.
2. Medical diagnostic services which aid in the evaluation and/or diagnosis of ocular diseases are covered regardless of the recipient's age. Practitioners must have the training and license required by State law.
3. Routine refractive services or optical devices provided in a nursing home must be specifically requested by a recipient's attending physician.
4. Optical devices, with the exception of contact lenses, devices for retinitis pigmentosa and customized prosthetic eyes are provided through contract with a single source supplier
5. Post-cataract surgery follow-up care provided by an optometrist is covered if the recipient is referred in writing by the surgeon. The optometrist will not be reimbursed for follow-up care until the referring surgeon's fees has been paid.
6. Covered optometric services will include any medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of their practice as defined under State law.

Prior Approval is required for the following:

1. Eyeglasses with both lenses of less than  $\pm 1.00$  diopter, in any meridian.
2. Lenses with less than a  $\pm 1.25$  "Add."
3. Contact lenses, regardless of diopter.
4. Replacing or dispensing optical devices within the same calendar year.
5. Refractive examination within the same calendar year that the recipient last had a refractive exam.
6. Customized prosthesis (stock eyes are covered without prior approval).

6b. **OPTOMETRIC SERVICES** (continued)

Prior Approval is required on the following: (continued)

7. Ultraviolet tint for prosthetic lenses and/or goggles for retinitis pigmentosa, albinism, and aphakia.
8. Change of eyeglass prescription when the power of the axis is less than 5 degrees or a diopter change in sphere or cylinder power. New lenses must also improve visual acuity by at least one line on a standard acuity chart.
9. Oversized Frames (Flatter Fit)
10. Trifocal Lenses
11. Slab off lens(es)
12. Hi-index plastic lenses (for prescription of less than + 6 diopters\_
13. polycarbonate lenses

**Non-Covered Services**

1. Tinting lenses (except for albinism and retinitis pigmentosa)
2. Experimental services or procedures or those that are not recognized by the profession or the U.S. Public Health Services as universally accepted treatment.
3. Routine refractive services and optical devices provided for recipients twenty- one years of age or older.

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b. Optometrists' services.

Provided:  No limitations  With limitations\*  
 Not provided.

c. Chiropractors' services.

Provided:  No limitations  With limitations\*  
 Not provided.

d. Other practitioners' services.

Provided: Identified on attached sheet with description of limitations, if any.  
 Not provided. Psychologists' Services

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided:  No limitations  With limitations\*

b. Home health aide services provided by a home health agency.

Provided:  No limitations  With limitations\*

a. Medical supplies, equipment, and appliances suitable for use in the home.

Provided:  No limitations  With limitations\*

\* Description provided on attachment.

## 6.d OTHER PRACTITIONER'S SERVICES

### A. PSYCHOLOGICAL SERVICES

#### Limitations:

1. Medically necessary psychological services are provided only to EPSDT eligible individuals
2. Psychological services are limited to 24 hours (48 units) per calendar year per recipient. Exceptions to the limitation can be exceeded based on medical necessity—in accordance with the State's guidelines.

Coverage of psychological services is limited to those providers fully and permanently licensed by the State Board of Examiners of Psychologists as required by Title 43, Chapter 39, of the Official Code of Georgia Annotated and Chapter 510 of the Rules and Regulations of the State of Georgia

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d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

Provided:                       No limitations                       With limitations\*  
 Not provided.

8. Private duty nursing services.

Provided:                       No limitations                       With limitations\*  
 Not provided.

\* Services are limited to individuals ages 0-20 years.



## 6d. OTHER PRACTITIONER'S SERVICES.

## 8. NURSE PRACTITIONER SERVICES.

Limitations.

1. The scope of service for certified Ob/ Gyn Nurse Practitioners is the care of children and adults for Ob/ Gyn services.

The scope of service for Certified Registered Nurse Anesthetists (CRNA) is the management and care of children and adults for anesthesia services.

The scope of service for certified Adult Nurse Practitioners is the management and care of adults for primary and preventive health care.

The scope of service for Certified Gerontological Nurse Practitioners is the management and care for geriatric adults for primary and preventive health care.

Providers must be currently licensed as registered professional nurses, be currently certified as Ob/ Gyn Nurse Practitioners, Adult Nurse Practitioners, Gerontological Nurse Practitioners or Certified Registered Nurse Anesthetists, by the appropriate certifying body and be registered with the Georgia Board of Nursing for the specialty.

1. The Medicaid program will not provide reimbursement to a nurse practitioner for the following:

- a. Office visits which exceed 12 per recipient per calendar year unless medically justified.
- b. Nursing home visits that exceed 12 per recipient per calendar year unless medically justified.
- c. More than one hospital visit per patient per day of hospitalization, except when additional visits can be medically justified and approved.

2. Reimbursement for injectable drugs is restricted to those listed in the Physician's Administered Drug List.

Prior Approval.

More than twelve medically necessary offices or nursing home visits per year (January 1 through December 31) for any one recipient.

Non-Covered Services (continued).

1. Laboratory services furnished by the State or a Public Laboratory.
2. Experimental services, drugs or procedures which are not generally recognized by the advanced nursing profession, the medical profession or the U.S. Public Health Service as acceptable treatment.
3. Any procedure outside the legal scope of Ob/ Gyn CRNA, Adult, or Gerontological Nurse Practitioner services.
4. Services not covered under the Physicians' Program.

6d. OTHER LICENSED PRACTITIONER'S SERVICES

**C. TOBACCO CESSATION COUNSELING SERVICES FOR NON-PREGNANT INDIVIDUALS**

Limitations:

Tobacco Cessation Counseling services are covered for all non-pregnant beneficiaries when medically necessary and provided by the following licensed practitioners within the scope of practice as defined by State law:

1. Physician Assistant;
2. Nurse Practitioner's;
3. Certified Nurse Midwives;
4. Psychologist; and
5. Any other fully licensed practitioner who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation counseling services.

Tobacco Cessation Counseling Codes:

1. 99406 – Smoking and tobacco use cessation counseling visit (intermediate); greater than 3 minutes up to 10 minutes; face-to-face
2. 99407 – Smoking and tobacco use cessation counseling visit (intensive); greater than 10 minutes; face-to-face

The benefit package should include at least four (4) counseling sessions per quit attempt with a minimum of two (2) quit attempts per 12 month period.

The procedure codes 99406 and 99407 are to be rendered in a face-to-face setting with the member for the purpose of promoting healthy habits. Prescribing pharmacotherapy medication is not a prerequisite for use of these procedure codes. However, if any of the pharmacotherapy medications are prescribed by the provider, a face to face counseling must be documented in the member's medical record every 30 days during the 12 week treatment period.

6.e. AMBULATORY SURGICAL CENTER SERVICES

10-1-87 Ambulatory surgical center (ASC) services are covered under Section 1905(a)(18) as any other medical care, and any other type of remedial care recognized under state law, specified by the Secretary.

Limitations

For ambulatory surgical centers, services are limited to those procedures that can be safely done outside of the inpatient hospital setting as determined by Medicare and the state agency policy.

Services are provided by distinct entities that operate exclusively for the purpose of providing surgical services to eligible recipients not requiring hospitalization.

Services are provided to outpatients.

Services are provided by facilities that meet requirements of 42 CFR 416.25 through 416.49.

Ambulatory surgical centers are recognized by state law under OCGA Section 31-7-1(1)(D).

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7. HOME HEALTH SERVICES

Limitations

- a. Services are provided by Medicare certified home health agencies which have met all conditions of participation
- b. Nursing visits (as defined in the State Nurse Practice Act), home health aide, physical, occupational and speech therapies are provided up to 50 visits per recipient per calendar year. Visits in excess of 50 may be provided for eligible recipients if medically necessary and prior approval is obtained. Certain skilled nursing services may be provided by an LPN, under the direction and supervision of the registered nurse. An LPN, when appropriately trained, may participate in the assessment, planning, implementation and evaluation of the delivery of health care services. Home Health Aides must also be closely supervised by a registered nurse. Written instructions for patient care *shall* be prepared by a registered nurse or therapist as appropriate. The duties of the aide shall be limited to the performance of simple procedures such as an extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's condition and needs, and completing appropriate records. A registered nurse shall make a supervisory visit to the patient's residence at least every two weeks, to observe, assist and assess the relationships and determine whether goals are being met. Aides shall be closely supervised to assure their competence in providing care. (Rules and Regulations for Home Health Agencies; Rule 290-5-38-.o7 (6) (a)-(g). Authority Ga. L. 1980, pp. 1790 - 1793.

Home health provides the medical supplies and equipment for use in the home referred to under the Scope of Services in Part II Policies and Procedures for Home Health Services, located on the fiscal agent's website.

- c. Any appliance needs are provided by the Durable Medical Equipment Program (DME) or through the Pharmacy program, as referred to under the Scope of Services in Part II Policy and Procedures for DME. Examples of supplies and equipment include but may not be limited to:
  - Syringes, enemas, dressings, rubbing alcohol, tape, gloves,
  - Catheters, catheter sets, drainage apparatus, saline solutions, venipuncture supplies
  - Laboratory procedures not requiring laboratory personnel,
  - Phototherapy service (bilirubin level), lancets and strips for glucose monitoring

DME supplies and services are provided by enrolled DME suppliers that have met all conditions of participation and certification requirements as outlined in the Part I Policy and Procedure Manual for Medicaid and PeachCare for Kids and Part II Policy and Procedure Manual for DME Services.

DME supplies and services are provided in accordance with the scope of services as outlined in Part II Policy and Procedure Manual for DME Services. The items must be prescribed by the attending

physician, is medically necessary and reasonable and generally do not have value to patients in the absence of illness or injury.

The DME program reimburses for the purchase or rental of certain medical equipment and accessories and the purchase of certain medical supplies for a patient's use in a non- institutional setting. The equipment must be appropriate for home use. Home is defined as a member's own residence or a relative's home. And, it may not be considered a member's home if it functions primarily a hospital or nursing facility for inpatients. The Division does not reimburse under this program for equipment that is rented, purchased or repaired for members in institutional settings.

Durable Medical Equipment is covered for members in a hospice for non-hospice related conditions.

#### Non-Covered Services

Devices and equipment that are primarily and customarily used for non-medical purposes are not covered. partial list of non-covered items is listed below:

- a. Environmental control equipment (e.g., air conditioners, dehumidifiers, air filters or purifiers);
  - b. Comfort or convenience equipment (e.g., vibrating beds, over-the-bed trays, chair lifts, or bathtub lifts);
  - c. Institutional-type equipment (e.g., cardiac or breathing monitors except infant apnea monitors and ventilators);
  - d. Equipment designed specifically for use by a physician and trained medical personnel (e.g., EKG monitor, oscillating bed and laboratory testing equipment);
  - e. Physical fitness equipment (e.g., exercycle, Moore Wheel and exercise treadmill);
  - f. Most self-help devices (e.g., Braille teaching texts);
  - g. Training equipment;
  - h. Precautionary-type equipment (e.g., preset portable oxygen units);
  - i. Furnishing-type equipment (e.g., infant cribs);
  - j. Incontinence items (e.g., diapers, pads and adult briefs);
  - k. Nutritional supplements and formula for members who eat by mouth (see exceptions under Section 806.11);
  - l. Reimbursement for delivery or delivery mileage of medical supplies;
  - m. Equipment considered experimental or under investigation by Public Health Service;
  - n. Infant and child car seats; and
  - o. Blood pressure monitors and weight scales;
  - p. Safety alarms and alert systems
- d. All therapy services provided by a home health agency shall be provided by a qualified therapist in accordance with the plan of treatment. Examples of physical, speech, and occupational therapy are provided below:

## 7. HOME HEALTH SERVICES

### Limitations (continued)

Physical Therapy Services include: Therapeutic exercise programs including muscle strengthening, neuromuscular facilitation, sitting and standing balance and endurance and range of motion, gait evaluation and training and transfer training and instructions in care and use of wheelchair, braces, prostheses, etc.

Speech Therapy Services include: Evaluating and recommending appropriate Speech and hearing services, providing necessary rehabilitative services for patients with speech, hearing or language disabilities, and providing instructions for the patient and family to develop and follow a speech pathology program

Occupational Therapy Services include Teaching skills that will assist the patient in the management of personal care, including bathing, dressing and cooking/meal preparation, assisting in improving the individual's functional abilities, teaching adaptive techniques for activities of daily living and working with upper extremity exercises.

- e. Patient admission to the Home Health Program shall be based on the Department's expectation that the care and services are medically reasonable and necessary for the treatment of an illness or injury as indicated by the physician's orders.
- f. Georgia Medicaid recipients that meet the requirement for a nursing facility level of care will receive the first 50 home health visits through the home health state plan benefit. The 51st visit will be covered under the skilled home health provisions for the waiver.

### Non-Covered Services:

Social Services (medical social consultation)

Chore services (Homemakers)

Meals on Wheels

Audiology Services

Visits in excess of 50 per recipient per calendar year Visits in excess of 50 may be provided for EPSDT eligible recipients if medically necessary and prior approval is obtained.

- 8. Private Duty Nursing (PDN) is provided to EPSDT individuals only. See Section 4 of the State Plan.

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9. Clinic services.

Provided:  No limitations  With limitations\*  
 Not provided.

10. Dental services.

Provided:  No limitations  With limitations\*  
 Not provided.

11. Physical therapy and related services.

a. Physical therapy.

Provided:  No limitations  With limitations\*  
 Not provided.

b. Occupational therapy.

Provided:  No limitations  With limitations\*  
 Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

Provided:  No limitations  With limitations\*  
 Not provided.

\* Description provided on attachment.

9. CLINIC SERVICES

**MENTAL HEALTH CLINICS**

Limitations

Outpatient mental health clinics meet the standards prescribed in the Division of Mental Health Policy Memorandum 40-01. Services are provided to eligible recipients who are emotionally or mentally disturbed, drug or alcohol abusers, mentally retarded or developmentally disabled. Available services are:

Partial hospitalization. Limited to extensive outpatient care and shall not include stays of twenty-four (24) hours or more.

Day Treatment.

Methodone Maintenance.

Individual therapy--includes diagnostic assessment, family therapy and crisis management.

Group therapy--includes ambulatory detoxification.

Psychiatric/medical assessment.

Special services--includes physical, speech, hearing and occupational therapies.

Non-Covered Services

Mental health services provided by outpatient community mental health centers to patients at their residences or in institutions such as skilled nursing or intermediate care facilities and residential care facilities.

**FAMILY PLANNING CLINICS**

See Attachment 3.1-A, page 2a for a description of Family Planning Services and Limitations.

(Clinic Services continued on page 4a-1)



## DIALYSIS CLINICS

Dialysis services include those services and procedures designed to promote and maintain the functioning of the kidney and related organs.

### Limitations

Hemodialysis or peritoneal dialysis services are limited to recipients who have a diagnosis of chronic renal failure [End Stage Renal Disease (ESRD)]. Reimbursement will be made to any Medicare Certified Dialysis Facility (Hospital or Freestanding) enrolled in the Medicaid Dialysis Program. Providers will be reimbursed for the physician or facility services rendered in an inpatient or outpatient hospital or in a freestanding dialysis clinic setting. Coverage of ESRD recipients is limited to:

1. Services rendered by providers enrolled in the dialysis program:
2. Recipients enrolled in the program:
3. Recipients not eligible for Medicare, and
4. Services provided during the ninety-day (90) waiting period required for Medicare eligibility determination.

### Non-Covered Services

Non-covered services in the program include:

1. Services provided for acute renal failure:
2. Services not listed as separately billable in the policy manual:
3. Experimental services or procedures, or those that are not recognized by the profession, the Department or the United States Public Health Service as universally accepted treatment, and
4. Services provided to recipients not enrolled in the program.

## 9. CLINIC SERVICES CONTINUED

### AMBULATORY SURGICAL CENTER SERVICES (ASC)

#### ASC Limitations

Services are limited to those surgical procedures which are covered by Medicare and which have been identified by HHS pursuant to 42 CFR 416.60-75, and to those surgical procedures deemed cost effective by the Department.

Services are provided by distinct entities that operate exclusively for the purpose of providing surgical services to eligible recipients not requiring hospitalization.

Services are furnished to outpatients.

Services are furnished by facilities that meet requirements in 42 CFR 416.25 through 416.49.

Ambulatory surgical centers are recognized by state law under OCGA Section 31-7-1(1)(D).

**Attachment 3.1A: freestanding Birth Center Services**

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: X  No limitations     With Limitations     None licensed or approved

Please describe any limitations:

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: X  No limitations     With Limitations (please describe below)

Not applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Please check all that apply:

X  (a) Practitioners furnishing mandatory services described in another category and otherwise covered under the State Plan (i.e., physicians and certified nurse midwives).

(b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 9e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). \*

(c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.). \*

\*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

10a. ADULT DENTAL SERVICES

Limitations

Dental services are available to recipients age 21 and over. Covered procedures include only those described below:

Diagnostic radiographs: Panoramic and individual periapicals.

Emergency examinations during office hours and after hours emergency examinations.

Oral and maxillofacial surgery services.

Anesthesia including nitrous oxide, intravenous sedation and general anesthesia.

Hospital admissions, inpatient and outpatient, when approved.

10b. EPSDT DENTAL

All medically necessary dental services will be provided to all recipients under age 21 when these services are provided at intervals that meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved with child health care, and at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition.

Prior Approval is required for the following dental services:

Emergency services are exempt from prior approval but must be submitted for post- treatment review.

Hospital admissions, inpatient and outpatient.

Root canal therapy.

Anesthesia including nitrous oxide, intravenous sedation and general anesthesia.

Chemotherapy, therapeutic.

Other drugs and medicants.

More than two denture adjustments, one laboratory relining, or two tissue conditionings per recipient, per calendar year.

Catastrophic procedures, except emergency treatment.

Orthodontic treatment.

Dentures.

Management of difficult children.

Hospital time/consultation.

Periodontal Services.

Alveoplasty with extractions.

Alveoplasty without extractions.

Ambulatory Surgical Center Outpatient Admissions.

**10c. Dental Services for Pregnant Women**

Expanded dental services for eligible pregnant women shall begin on the date of service following verification of pregnancy and extend to the date of delivery.

Pursuant to FY2006 Legislative Session and FY06 Budget document, only the following Current Dental Terminology (CDT) codes are approved for eligible pregnant women:

D1110	D2160	D2392	D4910
D0120	D2161	D2393	D7286
D0150	D2330	D2394	D9110
D0180	D2331	D4240	D9215
D1204	D2332	D4241	
D2140	D2335	D4341	
D2150	D2391	D4342	

All covered dental services and procedures are subject to the terms and conditions outlined Part I Policy and Procedure manual for Medicaid/PeachCare for Kids and Part II Policy and Procedure manual for Dental Services.

11. a.b.c. THERAPY SERVICES (Physical, Occupational and Speech Pathology)

Limitations:

1. Physical Therapy, Occupational Therapy and Speech Pathology services are limited to:
  - Recipients under the age of 21 years.
  - Services included in a written treatment plan established by a Georgia licensed physician.
  - Medically necessary services.
2. Providers must meet the qualifications specified in 42 CFR 440.110 applicable to each type of therapy provided.

Providers must also be currently licensed by their respective Boards as follows:

- a. Occupational Therapists licensed by the Georgia State Board of Occupational Therapy.
  - b. Physical Therapists licensed by the Georgia State Board of Physical Therapy.
  - c. Speech Pathology Therapists licensed by the Georgia State Board of Examiners for Speech-Language Pathology and Audiology.
3. For enrollment or re-enrollment beginning July 1, 1994 providers stated above must receive four (4) contact hours of pediatric training or experience.

All medically necessary occupational therapy, speech pathology therapy and physical therapy services will be provided to all EPSDT eligible recipients whether or not such services are covered or exceed the benefit limitations in the program if medical necessity is properly documented and prior approval is obtained.

11. a.b.c. THERAPY SERVICES (Continued)

Prior Approval

- a. Physical Therapy: More than ten hours per month.
- b. Occupational Therapy: More than ten sessions per month.
- c. Speech Pathology Therapy: More than ten sessions per month.

Non-Covered Services

- services associated for vocational or employment purposes
- services that do not require a licensed therapist
- services provided for temporary disabilities which would reasonably be expected to improve spontaneously as the patient gradually resumes normal activities
- preventive health care
- biofeedback
- physical therapy, occupational therapy or speech pathology therapy services provided in an in-patient hospital, outpatient hospital or nursing facility
- physical therapy, occupational therapy or speech pathology therapy services in the home if the services are available and provided through Home Health or Waivered Home Care Services programs
- services provided in a state-owned facility, and experimental services, investigational procedures or those procedures which are not recognized by the profession or the United States Public Health Service as universally accepted treatments.



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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

Provided:  No limitations  With limitations\*  
 Not provided.

b. Dentures.

Provided:  No limitations  With limitations\*  
 Not provided.

c. Prosthetic devices.

Provided:  No limitations  With limitations\*  
 Not provided.

d. Eyeglasses.

Provided:  No limitations  With limitations\*  
 Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

Provided:  No limitations  With limitations\*  
 Not provided.

\* Description provided on attachment.

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**12a. PRESCRIBED DRUGS****Limitations**

Pharmacy services will be provided to recipients under age 21 for medically accepted indications when these services are provided within the laws and regulations governing the practice of pharmacy by the State.

**Covered Services**

Drugs, for which Medical Assistance reimbursement is available, are limited to the following:

Covered outpatient drugs of any manufacturer that has entered into and complied with an agreement under Section 1927(a) of the Act, which are prescribed for a medically accepted indication.

As provided by Section 1927(d)(2) of the Act, certain outpatient drugs may be excluded from coverage. Those excluded are:

- A) Agents used for anorexia, weight loss or weight gain.
- B) Agents used to promote fertility.
- C) Agents used for cosmetic purposes or hair growth.
- D) Drugs identified by the Centers for Medicare and Medicaid Services (CMS) as less than effective (DESI), as provided under Section 1927(k)(2).
- E) Legend Prescription Vitamins and Mineral Products with the following exceptions:
  - (1) Covered Legend Vitamin and Mineral Products include:
    - i. Prenatal vitamins for women
    - ii. Fluoride preparations that are not in combination with other vitamins
    - iii. Carnitor
    - iv. Folic Acid 1 mg
    - V. Vitamin B 12 injection
    - vi. Vitamin and Mineral Products for recipients <21 years of age

F) Nonprescription drugs with the following exceptions:

*NOTE: all covered OTC drugs require a prescription.*

- Enteric coated aspirin (covered under per diem for nursing home members)
- Ibuprofen suspension for members <21
- Diphenhydramine
- Meclizine
- Select generic over-the-counter (OTC) non-sedating antihistamines, H-2 Receptor antagonists, topical antifungals and proton pump inhibitors.

**12a. PRESCRIBED DRUGS (cont'd)**

- G) Legend agents when used for the symptomatic relief of cough and colds for members 21 years of age and over.
- H) Agents prescribed for any indication that is not medically accepted.
- I) Drugs from manufacturers that do not have a signed rebate agreement.
- J) Non-FDA approved drugs
- K) Any Medicare Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.
- L) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

12a. PRESCRIBED DRUGS (continued)

No payment will be made for innovator multiple source drugs for which federal upper limits have been established unless the physician has certified that the brand is medically necessary in his own handwriting on the prescription and prior authorization is granted.

Prior Approval is required for recipients to obtain certain types of drugs with therapy limitations and for certain drugs prior to dispensing.

- Effective July 1, 1991, prior authorization is provided through a vendor contractual agreement pursuant to 42 U.S.C. section 1396-r. The state is establishing a preferred drug list. The process for prior authorization of drugs not included on the preferred drug list will be determined. Prior authorization will be provided with a 24-hour turn-around from receipt of request and a 72-hour supply of drugs will be provided in emergency situations.
- Prior authorization will be established for certain drug classes or particular drugs in accordance with Federal law.
- The state will utilize the drug utilization review board to ensure that in addition to pricing consideration preferred drugs are clinically appropriate.

Supplemental Rebate Program

The state is in compliance with Section 1927 of the Social Security Act. Based on the requirements for Section 1927 of the act, the State has the following policies for the supplemental drug rebate program for the Medicaid population. All covered drugs of federal rebate participating manufacturers remain available to the Medicaid program but may require prior authorization. The state is in compliance with reporting requirements for utilization and restrictions to covered populations.

- A. CMS has authorized the State of Georgia to collect supplemental rebates by way of a supplemental rebate agreement (SSSRA) program effective July 1, 2009. The Supplemental Drug Rebate Agreement was updated and submitted to CMS on April 10, 2018 and has been authorized by CMS for pharmaceutical manufacturer agreements.
- B. Any contracts not authorized by CMS will be submitted to the Centers for Medicare and Medicaid Services for approval.
- C. All drugs covered by the program irrespective of a supplemental agreement, will comply with the provisions of the national drug rebate agreement.
- D. Supplemental rebates received by the state in excess of those required under the national drug rebate agreement will be shared with the federal government. The state will remit the federal portion of any cash state supplemental rebates collected on the same percentage basis as applied under the national rebate agreement.
- E. The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification, in accordance with Section 1927(b)(3)(D):
- F. Acceptance of supplemental rebates for products covered in the Medicaid program does not exclude the manufacturer's product(s) from prior authorization or other utilization management requirements.
- G. Rebates paid under CMS-approved SSSRA for the Georgia Medicaid population does not affect AMP or best price under the Medicaid program.

**Amendment to Supplemental Drug-Rebate Agreement  
Between  
The State of Michigan, First Health Services Corporation  
And**

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WHEREAS, the State of Michigan, First Health Services Corporation (“First Health”), and \_\_\_\_\_ (“Manufacturer”) have entered into a Supplemental Drug-Rebate Agreement Contract # NMPI-\_\_\_\_\_ (the “Agreement”), effective as of April 1, 2006: and

WHEREAS, the Centers for Medicare and Medicaid Services (“CMS”) is now requiring certain changes to the Agreement before it will authorize them; and

WHEREAS, additional states have indicated their willingness to become Participating States, as defined in Section 3.14 of the Agreement, and thereby participate in the State Supplemental Rebates (as defined in Section 3.19 of the Agreement) available under the Agreement.

NOW, THEREFORE, IN CONSIDERATION OF THE MUTUAL COVENANTS, PROMISES, AND CONDITIONS CONTAINED HEREIN, THE PARTIES AGREE TO THE FOLLOWING AMENDMENTS TO THE AGREEMENT.

1. Section 1.1: “State” is changed to “States.”
2. Any and all references to “U.S. Territories” is stricken from the entire Agreement.
3. Section 2.1: On line 3 “State” is changed to “States” and the clauses beginning immediately thereafter with “and/or” are deleted down to “Participating States” on line 8. On the third line, the words “CMS approved state-funded programs” are replaced with “non-Medicaid programs approved by CMS in the Medicaid state plan(s)”.
4. Section 3.3: Is deleted in its entirety and “Client State(s)” is stricken from the entire agreement
5. Section 3.11: “State” within the parentheses on line one is made “States.” In line three, “HHS approved state-funded programs” is deleted and replaced with “non- Medicaid programs approved by CMS in the Medicaid state plan(s)”.
6. Section 3.12: This section is deleted in its entirety. “First Health Client's States and “FH Client's States” are stricken from this Agreement.
7. Section 3.14: This section is modified to read as follows:

“Participating State(s)” means the (i) States as named in Section 1.1 hereof, and (ii) other states that, subsequent to the execution of this Agreement by the States, elect to participate under this Agreement and have all necessary authorizations and approvals from CMS to do so. Unless otherwise approved by CMS on a state by state basis, Participating States shall be limited to ones that have a CMS approved contract under which First Health has been engaged to provide PBA Services to that state. For each new Participating State, a unilateral amendment (“New Participating State

Amendment”) to this Agreement shall be executed by the new Participating State and First Health and sent to the Manufacturer prior to the Participation Commencement Date. Each Participating State, including the new Participating State, must submit a state plan amendment adding the new Participating State to the Agreement to CMS for approval. A copy of the form Amendment is attached hereto as Exhibit A.”

8. Section 3.16: This section is modified to read as follows:

“‘Participation Commencement Date’ means the latter of the date (i) a Manufacturer's Supplemental Covered Product is effectively placed in a Participating States Preferred Drug List Program by distribution of it (via website or otherwise) to providers and prescribers, or (ii) the New Participating State Amendment is received by the Manufacturer from a new Participating State. It is the date when the Participating States entitlement to a rebate from the Manufacturer begins to accrue.”

9. Section 3.20: On the second line: the phrase "state funded, HHS approved programs" is deleted and replaced with “non-Medicaid programs approved by CMS in the state plan(s) as provided in Section 2.1 hereof”.

10. Section 5.1: The last sentence of this section is modified to read:

“Each Participating State will notify Manufacturer and First Health, within ten (10) business days of adoption and publication of a new or revised Preferred Drug List, when Manufacturer's Supplemental Covered Product is added to the Participating State's Preferred Drug List by providing Manufacturer and First Health a copy of the Preferred Drug List in accordance with the notice provisions of Section 9.2 hereof.”

11. Section 8.3 is modified by deleting items (ii) and (iii) so that it now reads as follows:

“Termination by a FH Client of its PBA Services Agreement with First Health shall, as of the same termination effective date, terminate this Agreement as to that Participating State.”

12. Section 9.9: This section is modified to read as follows:

"This Agreement will not be altered except by (i) an amendment in writing signed by all the parties, other than (ii) in the case of the addition of a new Participating State(s), by its execution of the New Participating State Amendment, both (i) and (ii) of which shall require the approval of CMS. It is acknowledged that the intent of the previous sentence is that the addition of a new Participating State(s) by amendment shall only require the consent of First Health and the approval of CMS, not Manufacturer. Manufacturer agrees that any Participating State may be added to this Agreement by amendment and that said Participating State's covered Medicaid (and other non-Medicaid programs approved by CMS in the Medicaid state plan(s)) lives shall apply to the provisions of Schedules 2 and 3 and will affect the rebates to all Participating States in accordance with Schedules 2 and 3. The New Participating State Amendment shall be executed by First Health and the new Participating State with a copy provided to Manufacturer for its records. Other than as stated herein, no individual is authorized to alter or vary the terms or make any representation or

inducement relative to it, unless the alteration appears by way of a written amendment, signed by duly appointed representatives of the Participating State(s), First Health, and the Manufacturer."

- 13. Section 9.11: In the second line, replace "other state funded" with "non-Medicaid programs approved by CMS in the Medicaid state plan(s)".
- 14. Except as expressly amended herein, all other terms, conditions and provisions of the Agreement shall remain in full force and effect and the parties hereto hereby ratify and confirm the same as of the date hereof. To the extent that any provisions of this Amendment conflict with the provisions of the Agreement, the provisions of Amendment shall control.

As evidence of their agreement to the foregoing terms and conditions, the parties have signed below.

MANUFACTURER

By: \_\_\_\_\_  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_

Date: \_\_\_\_\_

FIRST HEALTH SERVICES CORPORATION

By: \_\_\_\_\_  
Name: James G. Council  
Title: V.P. & Corporate Counsel

Date: \_\_\_\_\_

STATE OF MICHIGAN, DEPARTMENT OF COMMUNITY HEALTH

By: \_\_\_\_\_  
Name: David McLaury  
Title: Medical Services Administration

Date: \_\_\_\_\_

**SUPPLEMENTAL DRUG-REBATE AGREEMENT**  
**CONTRACT # NMPI-\_\_\_\_\_**

**PARTIES/PERIOD**

1.1 This Supplemental Drug-Rebate Agreement ("Agreement") is made and entered into this 1st day of April, 2006, by and between the State of Michigan ("State"), represented by the Department of Community Health ("State"), First Health Services Corporation ("First Health"), \_\_\_\_\_ ("Manufacturer"), Labeler Code \_\_\_\_\_ and such other states that subsequently join into this Agreement upon the terms hereafter set forth ("Participating State(s)") The parties, in consideration of the covenants, conditions, agreements and stipulations expressed in this Agreement, do agree as follows:

**PURPOSE**

2.1 It is the intent of this Agreement that (i) states that have entered into agreements for First Health to provide pharmacy benefit administration services ("PBA Services") to the state Medicaid and other CMS approved state pharmaceutical assistance programs that do not affect Best Price ("FH Clients"), including the State, and/or (ii) states that have entered into intergovernmental agreements, with the State for the latter to provide certain PBA Services to the state (" Client States") and/or (iii) states that have entered into intergovernmental agreements with a FH Client, for the FH Client to provide certain PBA Services to the state (FH Client's States) (states in categories (i), (ii), and (iii) often collectively referred to herein as "Participating States"), will receive State Supplemental Rebates, in addition to the rebates received under the CMS Rebate Agreement, pursuant to Section 1927 of the Social Security Act (42 U.S.C. §1396r-8), for the Manufacturer's Supplemental Covered Product(s) quarterly utilization in the Participating States' Medicaid Programs in which there is Medicaid federal financial participation. It is also the intent of this Agreement that State Supplemental Rebates will be paid for utilization of the Manufacturer's Supplemental Covered Product(s) in other state funded programs that have been approved for inclusion by the Secretary of Health and Human Services ("HHS"). The parties also intend for this Agreement to meet the requirements of federal law at Section 1927 of the Social Security Act (42 U.S.C. §13961-8).

**DEFINITIONS**

3.1 'Average Manufacturer Price' (AMP) means Manufacturer's price for the Covered Product(s). AMP will be calculated as specified in Manufacturer's CMS Agreement.



3.2 'Best Price' means, in accordance with 42 U.S.C. §13965-8(c)(1)(C), with respect to a Single Source Drug or Innovator Multiple Source Drug of a Manufacturer, the lowest price available from the Manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or government entity within the United States, excluding: (a) any price charged on or after October 1, 1992, to the Indian Health Services, the Department of Veterans Affairs, a State home receiving funds under Section 1741 of Title 38, United States Code, the Department of Defense, the Public Health Service, or a covered entity described in subsection (a)(5)(B) of Section 1927 of the Social Security Act; (b) any prices charged under the Federal Supply Schedule of the General Services Administration; (c) any prices used under a State Pharmaceutical Assistance Program; and (d) any depot prices and single award contract prices, as defined by the Secretary of any agency of the Federal Government. "Best Price" shall: (a) be inclusive of cash discounts, free goods that are contingent on any purchase requirement, volume discounts, and rebates (other than rebates under this section); (b) be determined without regard to special packaging, labeling, or identifiers on the dosage form or product or package; and (c) not take into account prices that are merely nominal in amount.

3.3 'Client State(s)' means those states who enter into an agreement with the State, with First Health's continuing consent, for the provision of PBA Services to the states' Medicaid and other CMS approved state pharmaceutical assistance programs.

3.4 'Covered Product(s)' means the pharmaceutical product(s) of the Manufacturer pursuant to Section 1927 of the Social Security Act (42 U.S.C. § 1396r-8).

3.5 'CMS Agreement' means the Manufacturer's drug rebate contract with the Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration, entered pursuant to Section 1927 of the Social Security Act (42 U.S.C. § 1396r-8).

3.6 'CMS Basic Rebate' means, with respect to the Covered Product(s), the quarterly payment by Manufacturer pursuant to Manufacturer's CMS Agreement, made in accordance with Section 1927(c)(1) or Section 1927(c)(3) of the Social Security Act [42 U.S.C. §1396r-8(c)(1) and 42 U.S.C. § 1396r8(c)(3)].

3.7 'CMS CPI Rebate' means, with respect to the Covered Product(s), the quarterly payment by Manufacturer pursuant to Manufacturer's CMS Agreement, made in accordance with Section 1927(c)(2) of the Social Security Act [42 U.S.C. §1396r-8(c)(2)].

3.8 'CMS Rebate' means, with respect to the Covered Product(s), the quarterly payment by Manufacturer pursuant to Sections 4.1 of this Agreement.

3.9 'CMS Unit Rebate Amount' means, the unit amount computed by CMS to which the Medicaid utilization information may be applied by States in invoicing the Manufacturer for the rebate payment due.

3.10 'Drug Reimbursement Amount' means the total amount per unit allowable as calculated by the Participating States, specific to each drug, that the Participating States reimburse pharmacy providers per unit of drug under their Medicaid (and other state funded, HHS approved) programs, in accordance with applicable state and federal laws and regulations,

3.11 'First Health Client(s)' or 'FH Clients' means those states (including the State) that have entered or subsequently enter into agreements with First Health for the provision of PBA Services to the states' Medicaid and other CMS-approved state pharmaceutical assistance programs, subject to the supervision and oversight of such States.

3.12 'First Health Client's States' or 'FH Client's States' means those states that enter into an agreement with a FH Client, with First Health's continuing consent, for the provision of PBA Services to the states' Medicaid and other CMS-approved state pharmaceutical assistance programs.

3.13 'Manufacturer' means, for purposes of this Agreement, the party identified as such in Section 1.1 of this Agreement, which may be a pharmaceutical manufacturer, labeler or other entity not prohibited by law from entering into this Agreement.

3.14 'Participating State(s)' means the State, Client States, FH Clients and FH Client's States. all as defined herein.

3.15 'Participating States' Net Price Per Unit' or 'Net Price' means the amount(s) agreed upon by the parties to this Agreement in the attached "Supplemental Rebate Matrix, Schedule 2". 'Net Price' will vary in accordance with Schedule 2 and is dependent upon the factors detailed therein, which includes, but may not be limited to, the number of Medicaid (and other state funded, HHS approved) eligible recipient lives and the number of products in a Preferred Drug List's product category. Per the attached

"Supplemental Rebate Matrix. Schedule 2", Net Price will be a factor in the equation that is determinative of the Supplemental Rebate Amount.

3.16 'Participation Commencement Date' means the date a Manufacturer's Supplemental Covered Product is effectively placed in a Participating States Preferred Drug List Program by distribution of it (via website or otherwise) to providers and prescribers. It is the date when the Participating States entitlement to a rebate from the Manufacturer accrues.

3.17 'Pharmacy Provider' means an entity licensed or permitted by law to dispense legend drugs, and enrolled as a State Medicaid Provider.

3.18 'Rebate Summary' means the individual Participating States' reports itemizing the State Utilization Data supporting each Participating State's invoice for Rebates. The Rebate Summary will comply in all respects with requirements for Medicaid Utilization Information in the CMS Agreement.

3.19 'State Supplemental Rebate' means, with respect to the Supplemental Covered Product(s), the quarterly payment by Manufacturer pursuant to Section 4.2 of this Agreement.

3.20 'State Utilization Data' means the data used by Participating States to reimburse pharmacy providers under Participating States' Medicaid Program (and other state funded, HHS approved programs). State Utilization Data excludes data from covered entities identified in Title 42 U.S.C. §256b(a)(4) in accordance with Title 42 V.S.C. §256b(a)(5)(A) and 1396r-8(a)(5)(C).

3.21 'Supplemental Covered Product' means the pharmaceutical product(s) of the Manufacturer, as detailed in the attached Supplemental Rebate Matrix. Schedule 2, upon which a State Supplemental Rebate will be paid pursuant to this Agreement.

3.22 'Supplemental Covered Product Category' or 'Product Category' means a defined group of pharmaceutical products considered to compete with one another in the market and that are also thought to be therapeutic alternatives in many situations. First Health Services has determined and defined the Product Categories in which manufacturers will bid. The Product Categories, set forth on the "Product Categories, Schedule 1" hereto, may be changed as deemed appropriate by Participating States.

3.23 'Supplemental Rebate Amount' means, with respect to the Supplemental Covered Product(s), the amount(s) specified in the attached Supplemental Bid Matrix. Schedule 2 and Supplemental Rebate Calculation, Schedule 3 that the Manufacturer has agreed to reimburse Participating States per unit of drug in accordance with the formula detailed in the above Schedules.

3.24 'Wholesale Acquisition Cost' or 'WAC' means the Manufacturer's U.S. Dollar wholesale acquisition price in effect on the last day of a quarter on a unit basis as published by a third party source, such as First Databank, for each product and represents the Manufacturer's published price for a drug product to wholesalers.

#### **MANUFACTURER'S RESPONSIBILITIES**

4.1 Manufacturer will calculate and provide each Participating State a CMS Rebate for the Covered Product(s), which includes the CMS Basic Rebate and CMS CP1 Rebate, as appropriate. The CMS Rebate represents the discount obtained by multiplying the units of the Covered Product(s) reimbursed by each Participating State in the preceding quarter by the per unit rebate amount provided to each Participating State by CMS. CMS will calculate the CMS Rebate amount in accordance with Manufacturer's CMS Agreement. Manufacturer's obligation for CMS Rebates will continue for the duration of the Manufacturer's CMS Agreement.

4.2 In addition to the CMS Rebates described in Section 4.1 of this Agreement, Manufacturer will remit to each Participating State a State Supplemental Rebate for the Supplemental Covered Product(s) that are in each Participating States Preferred Drug List Program. The State Supplemental Rebates will be calculated on a calendar quarter basis and provided via invoices to the Manufacturer's CMS financial contact. The State Supplemental Rebates for the quarter will be determined by mu the number of units of the Supplemental Covered Product(s) reimbursed by each Participating State in the preceding quarter by its Supplemental Rebate Amount. The Manufacturer's obligation for State Supplemental Rebates will continue for the duration of this Agreement. The Supplemental Rebate calculation is described in "Supplemental Rebate Calculation, Schedule 3".

4.3 The Manufacturer's obligation for State Supplemental Rebates will begin with the Rebate Billing Period for the second calendar quarter 2006, which begins April 1, 2006 (even if this Agreement is not fully executed by such date) and will continue through the Rebate Billing Period that ends March 31, 2009, subject to each Participating States' actual Participation Commencement Date as described in Section 3.16, *supra*. Notwithstanding the above, the Participating States reserve the right to solicit

annually more favorable State Supplemental Rebates from Manufacturer by giving written notice thereof no less than ninety (90) days prior to the yearly anniversary of the effective date of this Agreement.

4.4 The quarters to be used for calculating the Rebates in Section 4.2 of this Agreement will be those ending on March 31, June 30, September 30, and December 31 of each calendar year during the term of this Agreement

4.5 The participating Manufacturer will be required to submit each Participating State's State Supplemental Rebate payment within 38 days of the Manufacturer's receipt of the Participating State's Rebate Summary

4.6 Manufacturer will pay the State Supplemental Rebates, including any applicable interest in accordance with Section 1903 (d)(5) of the Act. Interest on the Rebates payable under Section 4.2 of this Agreement begins accruing 38 calendar days from the postmark date of each Participating State's invoice and supporting Rebate Summary sent to the Manufacturer and interest will continue to accrue until the postmark date of the Manufacturer's payment. For the rebate programs invoiced under this Agreement, if the date of mailing of a Rebate payable under Section 4.2 of this Agreement is 69 days or more from the date of mailing of the invoice, the interest rate will be calculated as required under federal guidelines for rebates described in Section 4.1 but will be increased by ten percentage points or the maximum allowed by that Participating State's state law. If a Participating State has not received the Rebates payable under Section 4.2 of this Agreement, including interest, within 180 days of the postmark date of said Participating State's invoice and supporting Rebate Summary sent to the Manufacturer. Such Participating State may deem the Manufacturer to be in default and Participating State may terminate its participation in this Agreement by giving Manufacturer and First Health ninety (90) days advance written notice.

4.7 Manufacturer agrees to continue to pay State Supplemental Rebates on the Supplemental Covered Product(s) for as long as this Agreement or any of its Addenda are in force, and State Utilization Data shows that payment was made for that drug, regardless of whether the Manufacturer continues to market that drug. Manufacturer's obligation to pay State Supplemental Rebates on the Supplemental Covered Product(s) shall terminate twelve (12) months following the last expiration date of the last lot of Supplemental Covered Product sold by the Manufacturer. Notwithstanding the above, in the event Manufacturer's Supplemental Covered Product(s) is/are sold to another manufacturer, the original Manufacturer shall have no liability for rebates on utilization beyond those required by the Medicaid

program. Manufacturer shall provide the State and First Health with notice of the sale of said Supplemental Covered Product(s) concurrent with Manufacturer's notice to CMS.

4.8 Unless notified otherwise, Manufacturer will send Rebate payments by certified mail, return receipt requested, to the address provided to Manufacturer in each individual Participating State's Addendum.

#### **PARTICIPATING STATE(S)' RESPONSIBILITIES**

5.1 Each Participating State will consider the Manufacturer's Supplemental Covered Product(s) for inclusion in the Participating State's Preferred Drug List Program. Each individual Participating State reserves the right to select the products that will be in its Preferred Drug List Program and will only receive State Supplemental Rebates for Manufacturer's Supplemental Covered Products that are actually included in its Preferred Drug List Program. Manufacturer shall pay Participating States State Supplemental Rebates based upon Participating State(s)' utilization of Manufacturer's Supplemental Covered Product(s) that did not require prior authorization. Participating States shall not be entitled to State Supplemental Rebates for utilization of Manufacturer's Supplemental Covered Product(s) that occurred only subsequent to the obtaining of prior authorization unless the Supplemental Covered Product(s) have been assigned to a Product Category and all products in the Product Category are subject to prior authorization requirements. Each individual Participating State also reserves the right to determine, as a result of a Product Category review, that prior authorization is required for all preferred drugs in a Product Category. If a Participating State determines that prior authorization is required for any Supplemental Covered Product, then the Participating State will comply with all provisions of Section 1927( d) of the Social Security Act applicable to Prior Authorization programs. Each Participating State will notify, within ten (10) business days, First Health and the State when Manufacturer's Supplemental Covered Product is added to the Participating State's Preferred Drug List.

5.2 The State and/or First Health shall notify the Manufacturer whenever a Participating State adds one of Manufacturer's Supplemental Covered Products to its Preferred Drug List or when one of Manufacturer's Supplemental Covered Products is moved to a prior authorization status.

5.3 Each Participating State will provide aggregate State Utilization Data to the Manufacturer on a quarterly basis. This data will be based on paid claims data (data used to reimburse pharmacy providers) under each Participating State's Medicaid (and other state funded, HHS approved) Program(s), will be consistent with any applicable Federal or State guidelines, regulations and standards for such data and will be the basis for the Participating State's calculation of the State Supplemental Rebate.

5.4 Each Participating State will maintain those data systems used to calculate the State Supplemental Rebates. In the event material discrepancies are discovered, the Participating State will promptly justify its data or make an appropriate adjustment, which may include a credit as to the amount of the State Supplemental Rebates, or a refund to Manufacturer as the parties may agree.

5.5 Each Participating State shall maintain electronic claims records for the most recent four quarters that will permit Manufacturer to verify through an audit process the Rebate Summaries provided by the Participating State.

5.6 Upon implementation of this Agreement, and from time to time thereafter, Participating States and Manufacturer will meet to discuss any data or data system improvements which are necessary or desirable to ensure that the data and any information provided by the Participating States to Manufacturer are adequate for the purposes of this Agreement.

5.7 First Health, as the pharmacy benefit administrator, may assist the Participating States in fulfilling its responsibilities hereunder and is a party to this Agreement solely in its capacity as agent for, and subject to the supervision and oversight of the Participating State(s).

5.8 The State and each Participating State shall obtain CMS approval of its state Medicaid plan of which this Agreement forms a part. Manufacturer shall not be obligated to remit any Supplemental Rebates that have accrued and are due under this Agreement until after the affected State or Participating State has obtained CMS approval of its Supplemental Rebate Program of which this Agreement forms a part.

#### **DISPUTE RESOLUTION**

6.1 In the event that in any quarter a discrepancy in a Participating State's State Utilization Data is questioned by the Manufacturer, which the Manufacturer and the Participating State in good faith are unable to resolve, the Manufacturer will provide written notice of the discrepancy to the Participating State and First Health.

6.2 If the Manufacturer in good faith believes the Participating State's State Utilization Data is erroneous, the Manufacturer shall pay the Participating State that portion of the rebate claimed, that is not

in dispute by the required date. The balance in dispute, if any, will be paid by the Manufacturer to the Participating State by the due date of the next quarterly payment after resolution of the dispute.

6.3 The Participating State and the Manufacturer will use their best efforts to resolve the discrepancy within 60 days of receipt of written notification. Should additional information be required to resolve disputes, the Participating State and First Health will cooperate with the Manufacturer in obtaining the additional information.

6.4 In the event that the Participating State and the Manufacturer are not able to resolve a discrepancy regarding State Utilization Data as provided for in Sections 6.1 through 6.3, the Manufacturer may request a reconsideration of the Participating State's determination within 30 days after the end of the 60 day period identified in Section 6.3. The Manufacturer shall submit with its written request its argument in writing, along with any other materials, supporting its position to the Participating State and First Health. The Participating State shall review the written argument and materials and issue a decision in the matter.

## **CONFIDENTIALITY PROVISIONS**

7.1 The parties agree that confidential information will not be released to any person or entity not a party to this contract. Confidential information, including trade secrets, will not be disclosed, or used except in connection with this Agreement or as may be required by law or judicial order.

7.2 The Manufacturer will hold Participating State' State Utilization Data confidential. If the Manufacturer audits this information or receives further information on such data from First Health or a Participating State, that information shall also be held confidential. The Manufacturer shall have the right to disclose Participating State(s)'s State Utilization Data to auditors who agree to keep such information Confidential

7.3 Pursuant to 42 USC 1396r-8(b)(3)(D), and other applicable state or federal laws, the parties agree that this Agreement and all information provided pursuant to this Agreement will not be disclosed and that the parties will not duplicate or use the information, except in connection with this Agreement or as may be required by judicial order. The parties further agree that any information provided by Manufacturer to the State, First Health, or the Participating State(s) pursuant to this Agreement and this Agreement itself constitute trade secrets and/or confidential or proprietary commercial and financial



information not subject to public disclosure. Furthermore, the parties agree that any Manufacturer information received by First Health pursuant to this Agreement and distributed by First Health to the State and/or Participating States shall constitute trade secrets and/or confidential or proprietary commercial and financial information of the Manufacturer not subject to public disclosure, except as otherwise provided for herein. If the services of a third party are used to administer any portion of this Agreement, Sections 7.1 through 7.4 of this Agreement shall apply to the third party. In the event a Participating State cannot give satisfactory assurance that rebate pricing data will be exempt from public disclosure under applicable state law, then First Health (without assuming responsibility for any wrongful disclosure by a Participating State) shall limit the amount of such data made available to the Participating State by not disclosing to the Participating State any NDC-level pricing information. For purposes hereof "satisfactory assurance" shall be deemed given when the Participating State enters the statutory cite of the applicable exemption on its Participating State Addendum. In the event that either party is required by law to disclose any provision of this Agreement or pricing information to any person, such party shall provide advance written notice to the other party sufficiently advance of the proposed disclosure to allow the other party to seek a protective order or other relief.

7.4 Notwithstanding the non-renewal or termination of this Supplemental Rebate Agreement for any reason, these confidentiality provisions will remain in full force and effect.

#### **NON-RENEWAL or TERMINATION**

8.1 This Agreement shall be effective as of April 1, 2006 and shall have the term indicated in Section 4.3, *supra*.

8.2 Any Participating State may terminate its participation in this Agreement by giving Manufacturer and First Health written notice at least (90) days prior to the anniversary date of this Agreement, in which case termination shall become effective on the anniversary date of the date of execution of this Agreement. The termination of this Agreement by one or more Participating States shall not affect the Manufacturer's, First Health's or the other Participating States' obligations under this Agreement, other than any effect the reduction in the number of lives covered by the Agreement may have on the Supplemental Rebate payable hereunder. Manufacturer may terminate this Agreement and all Addenda by giving all Participating States and First Health written notice at least ninety (90) days prior to the anniversary date of this Agreement, in which case termination shall become effective on the anniversary date of the date of execution of this Agreement. Manufacturer's right of termination is limited to the right

to terminate the entire Agreement, Manufacturer may not terminate specific Addendum/Addenda of less than all Participating State(s).

8.3 Termination by (i) a FH Client of its PBA Services agreement with First Health, or (ii) by a Client State of its intergovernmental agreement with the State, or (iii) by a FH Client State of its intergovernmental agreement with a FH Client State shall, as of the same termination effective date, terminate this Agreement as to that Participating State.

8.4 Notwithstanding any non-renewal or termination of this Agreement, State Supplemental Rebates will still be due and payable from the Manufacturer under Section 4.2 for any Supplemental Covered Products for which Participating State(s)' obligation to reimburse arose prior to the effective date of termination of this Agreement.

8.5 On at least an annual basis or as mutually agreed upon by Manufacturer and First Health, Manufacturer shall have the opportunity to decrease the Net Price of jus Covered Products to increase the likelihood of product(s) utilization and/or inclusion in the Participating States Preferred Drug List Programs

#### GENERAL PROVISIONS

9.1 This Agreement will be governed and construed in accordance with 42 U.S.C. § 1396r-8 and all other applicable federal and state law and regulations.

9.2 Any notice required to be given pursuant to the terms and provisions of this Agreement will be in writing and will be sent by certified mail, return receipt requested. Notice will be mailed to the addressees) specified in each individual Participating State's Addendum to this Agreement.

Notice to the State shall be sent to:

State of Michigan  
Department of Community Health Medical Services Administration  
Attn: Dave McLaury  
400 S. Pine Street  
Lansing, MI 48933

Notice to First Health shall be sent to:

First Health Services Corporation  
Attn: Teresa R. DiMarco, President  
With a copy to: Legal Department  
4300 Cox Road  
Glen Allen, Virginia 23060

Notice to Manufacturer will be sent to:

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9.3 The Manufacturer agrees to be bound by the laws of the United States of America and with respect to each Participating State, the law of that Participating State. Proper venue in any legal action shall be the venue of the Participating State that is party to the proceeding. Any action brought by Manufacturer must be brought separately against individual Participating States or First Health, unless all affected Participating States and First Health consent to joinder of the actions.

9.4 Nothing herein shall be construed or interpreted as limiting or otherwise affecting First Health or Participating State(s) ability to pursue its rights arising out of the terms and conditions of the Agreement in the event that a dispute between the parties is not otherwise resolved.

9.5 Manufacturer and the agents and employees of Manufacturer in the performance of this Agreement will act in an independent capacity and not as officers, employees or agents of First Health or any Participating State.

9.6 Manufacturer may not assign this Agreement, either in whole or in part, without the written consent of the Participating States and First Health. However, in the event of a transfer in ownership of the Manufacturer, the Agreement is automatically assigned to the new owner subject to the conditions in this Agreement. If the Agreement is assigned pursuant to this Section, Manufacturer shall provide First Health and the Participating States with an update of the information contained in Section 9.2, *supra*.



9.7 Nothing in this Agreement will be construed so as to require the commission of any act contrary to law. If any provision of this Agreement is found to be invalid or illegal by a court of law, or inconsistent with federal requirements, this Agreement will be construed in all respects as if any invalid, unenforceable, or inconsistent provision were eliminated, and without any effect on any other provision.

9.8 First Health, Participating State(s) and Manufacturer declare that this Agreement, including attachments, schedules and addenda, contains a total integration of all rights and obligations of the parties. There are no extrinsic conditions, collateral agreements or undertakings of any kind. In regarding this Agreement as the full and final expression of their contract, it is the express intention of the parties that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period of time governed by this Agreement which are not expressly set forth herein are to have no force, effect, or legal consequences of any kind

9.9 This Agreement will not be altered except by an amendment in writing signed by the parties or the addition of Participating State(s) by its execution of the Participating State Addendum, a copy of which is attached hereto. The addition of Participating State(s) by addendum/addenda shall only require the consent of First Health. Manufacturer agrees that any Participating State may be added to this Agreement by addendum, and that said Participating State's covered Medicaid (and other state funded, HHS/CMS approved state pharmaceutical assistance programs) lives shall apply to the provisions of Schedules 2 and 3 and will affect the rebates to all Participating States in accordance with Schedules 2 and 3. The addendum shall be executed by First Health and the new Participating State with a copy provided to Manufacturer for its records. Other than as stated herein, no individual is authorized to alter or vary the terms or make any representation or inducement relative to it, unless the alteration appears by way of a written amendment, signed by duly appointed representatives of the Participating State(s), First Health, and the Manufacturer.

9.10 The parties do not contemplate any circumstances under which indemnification of the other parties would arise. Nevertheless, should such circumstances arise, Manufacturer agrees to indemnify, defend and hold harmless the Participating States and First Health, their officers, agents and employees from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Manufacturer in the performance of this Agreement.

9.11 Inasmuch as the State Supplemental Rebates required by this Agreement are for state Medicaid (and other state funded, HHS/CMS approved state pharmaceutical assistance programs) program

beneficiaries, it is agreed, in accordance with Medicaid Drug Rebate Program Release #102 for State Medicaid Directors and other applicable law, that the State Supplemental Rebates do not establish a new 'Best Price' for purposes of participating Manufacturer's CMS Agreement.

9.12 In the event that Participating State(s) require(s) prior authorization of Manufacturer's Supplemental Covered Product(s) as part of a Product Category prior authorization under Section 5.1, State Supplemental Rebates shall nevertheless be payable hereunder.

9.13 If First Health or a Participating State makes changes to a Product Category that are considered to be a material change in the structure of the supplemental rebates program, Manufacturer may be allowed to re-submit bids for the Product Category/Categories affected.

9.14 As evidence of their Agreement to the foregoing terms and conditions, the parties have signed below.

STATE OF MICHIGAN, DEPARTMENT OF COMMUNITY HEALTH:

By: \_\_\_\_\_ Date: \_\_\_\_\_  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_

MANUFACTURER

By: \_\_\_\_\_ Date: \_\_\_\_\_  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_

FIRST HEALTH SERVICES CORPORATON

By: \_\_\_\_\_ Date: \_\_\_\_\_  
Name: James G. Council  
Title: VP & Corporate Counsel

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## EXHIBIT A

**New Participating State Amendment to Supplemental  
Drug-Rebate Agreement Between  
The States of Michigan, New Hampshire, Alaska, Nevada, Hawaii,  
Minnesota, Montana, Kentucky, Tennessee, New York, and  
District of Columbia; First Health Services Corporation  
And  
(Manufacturer Name ("Manufacturer"))**

WHEREAS, the State of Michigan, First Health Services Corporation ("First Health"), and Manufacturer have entered into a Supplemental Drug-Rebate Agreement (the "Agreement"), effective as of <<DATE>>; and

WHEREAS, the participating States as named in Section 8 below have become parties to the Agreement as Participating States by previous amendment or addenda; and

WHEREAS, additional states have indicated their willingness to become a new Participating State, as defined in Section 3.14 of the Agreement, and thereby participate in the State Supplemental Rebates (as defined in Section 3.19 of the Agreement) available under the Agreement.

Now, therefore, in consideration of the mutual covenants, promises, and conditions contained herein and in the Agreement, the parties agree as follows:

1. The State of Georgia is hereby added as a party to the Agreement as a new Participating State, as defined in Section 3.14 of the Agreement.
2. This Amendment shall become effective upon the date determined in accordance with Section 3.16 of the Agreement; provided that this Amendment shall not become effective until the effective date of the state plan amendment submitted to CMS on June 6, 2006.
3. An executed copy of this Amendment shall be sent via certified mail, return receipt requested to Manufacturer's address of record as set forth in the Agreement within five (5) business days of its execution by the parties. Any notice to Participating State shall be sent to the names and address in section 9 of this Exhibit:
4. This Addendum adds a new Participating State to the Agreement and does not otherwise change or alter the Agreement. The new Participating State(s) understand(s) and agrees to be bound by the terms of the Agreement.

**EXHIBIT A**

- 5. The undersigned State acknowledges that manufacturer rebate pricing information is confidential information under applicable Federal law and shall be exempt from public disclosure pursuant to State Code Section O.C.G.A. 50-18-70, et seq.
- 6. The undersigned State represents that it has not requested authorization from CMS to include any state pharmaceutical assistance program within the rebate provisions of the Agreement. The above representation shall not prohibit the undersigned State from requesting CMS authorization to include (other) pharmaceutical assistance programs within the Agreement at a later date. Upon receipt of CMS authorization, State shall give written notice to Manufacturer of the date Manufacturer's Supplemental Covered Product is effectively placed on the preferred drug list of the undersigned State's non-Medicaid programs approved by CMS in the Medicaid state plan(s) by completing the attached Exhibit A1.
- 7. The approximate enrollment in the undersigned State's Medicaid program at the time of execution of this Amendment is 364,000.
- 8. As of the effective date of this Amendment, the following are all of the Participating States under the Agreement:

<u>Michigan</u>	<u>Alaska</u>
<u>New York</u>	<u>Nevada</u>
<u>New Hampshire</u>	<u>Hawaii</u>
<u>Minnesota</u>	<u>Montana</u>
<u>Kentucky</u>	<u>Tennessee</u>
<u>District of Columbia</u>	

- 9. The contact information for each of the Participating States listed above in section 8 and new states shall be as follows:

State of Michigan      Department of Community Health  
Medical Services Administration  
Attn: Dave McLaury  
400 S. Pine Street  
Lansing, MI 48933

State of Nevada      Division of Health Care Financing and Policy



## EXHIBIT A

	Nevada Department of Human Resources Mark Willden, Director 1100 East Williams Street Carson City, Nevada 89701
State of New Hampshire	State of New Hampshire Department of Health and Human Services Commissioner John Stephen 129 Pleasant Street Concord, NH 03301
State of Alaska	Dwayne Peoples Director of Health Care Services State of Alaska Health & Social Services Department Health Care Services Division 4501 Business Park Boulevard, Ste. 24 Anchorage, AK 99503
State of Hawaii	Lillian B. Koller, ESQ., Director Department of Human Services P. O. Box 339 Honolulu, HI 96809
State of Minnesota	Brian Osberg Deputy Secretary Minnesota Department of Human Services 444 Lafayette Road North Saint Paul, Minnesota 55155
State of Montana	John Chapuis State Medicaid Director Montana Department of Public Health and Human Services P.O. Box 4210 Helena, Montana 59604
State of Kentucky	Rebecca Cecil Deputy Undersecretary Commonwealth of Kentucky Cabinet for Health and Family Services 275 East Main Street, 4W-A Frankfort, Kentucky 40621
State of Tennessee	State of Tennessee Department of Finance & Administration TennCare Bureau

**EXHIBIT A**

State of New York

Attn; David Beshara, Chief Pharmacy Officer  
310 Great Circle Drive  
Nashville, TN 37243  
PDP Program Manager  
Bureau of Program Guidance  
Office of Medicaid Management  
NYSDOH  
99 Washington Ave, Suite 720  
Albany, NY 12210-2806

STATE OF GEORGIA  
DEPARTMENT OF COMMUNITY  
HEALTH

FIRST HEALTH SERVICES CORP

By: \_\_\_\_\_  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_

By: \_\_\_\_\_  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_

**EXHIBIT A1**

**Participating State's Non-Medicaid Programs Approved by CMS in the  
Medicaid State Plan(s)**

Participating State: Georgia

Non-Medicaid programs approved by CMS in the Medicaid State Plan(s)- Date of Approval

1. **None**

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

**SUPPLEMENTAL DRUG-REBATE AGREEMENT**  
**CONTRACT # NMPI- \_\_\_\_\_**

**PARTIES/PERIOD**

1.1 This Supplemental Drug-Rebate Agreement ("Agreement") is made and entered into this <<DATE>>, by and between the State of Michigan ("State"), represented by the Department of Community Health ("State"), First Health Services Corporation ("First Health"), \_\_\_\_\_ ("Manufacturer"), Labeler Code \_\_\_\_\_, and such other states that subsequently join into this Agreement upon the terms hereafter set forth ("Participating State(s)") The parties, in consideration of the covenants, conditions, agreements, and stipulations expressed in this Agreement, do agree as follows:

**PURPOSE**

2.1 It is the intent of this Agreement that (i) states that have entered into agreements for First Health to provide pharmacy benefit administration services ("PBA Services") to the state Medicaid and other non-Medicaid programs approved by CMS in the Medicaid state plan(s) that do not affect Best Price ("FH Clients"), including the States, ("Participating States"), will receive State Supplemental Rebates, in addition to the rebates received under the CMS Rebate Agreement, pursuant to Section 1927 of the Social Security Act (42 U.S.C. § 1396r-8), for the Manufacturer's Supplemental Covered Product(s) quarterly utilization in the Participating States' Medicaid Programs in which there is Medicaid federal financial participation. It is also the intent of this Agreement that State Supplemental Rebates will be paid for utilization of the Manufacturer's Supplemental Covered Product(s) in other state funded programs that have been approved for inclusion by the Secretary of Health and Human Services ("HHS"). The parties also intend for this Agreement to meet the requirements of federal law at Section 1927 of the Social Security Act (42 U.S.C. § 1396r-8).

**DEFINITIONS**

3.1 'Average Manufacturer Price' (AMP) means Manufacturer's price for the Covered Product(s). AMP will be calculated accordance with 42 U.S.C. 1396r-8(k)(1) and as specified in Manufacturer's CMS Agreement.

3.2 'Best Price' means, in accordance with 42 U.S.C. §13961-8(c)(1)(C), with respect to a Single Source Drug or Innovator Multiple Source Drug of a Manufacturer, the lowest price available from the Manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance

organization, nonprofit entity, or government entity within the United States, excluding: (a) any price charged on or after October 1, 1992, to the Indian Health Services, the Department of Veterans Affairs, a State home receiving funds under Section 1741 of Title 38, United States Code, the Department of Defense, the Public Health Service, or a covered entity described in subsection (a)(5)(B) of Section 1927 of the Social Security Act; (b) any prices charged under the Federal Supply Schedule of the General Services Administration; (c) any prices used under a State Pharmaceutical Assistance Program; and (d) any depot prices and single award contract prices, as defined by the Secretary of any agency of the Federal Government. "Best Price" shall: (a) be inclusive of cash discounts, free goods that are contingent on any purchase requirement, volume discounts, and rebates (other than rebates under this section); (b) be determined without regard to special packaging, labeling, or identifiers on the dosage form or product or package; and (c) not take into account prices that are merely nominal in amount.

3.3 [Reserved]

3.4 'Covered Product(s)' means the pharmaceutical product(s) of the Manufacturer pursuant to Section 1927 of the Social Security Act (42 U.S.C. § 1396r-8).

3.5 'CMS Agreement' means, the Manufacturer's drug rebate contract with the Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration, entered pursuant to Section 1927 of the Social Security Act (42 U.S.C. § 13961-8).

3.6 'CMS Basic Rebate' means, with respect to the Covered Product(s), the quarterly payment by Manufacturer pursuant to Manufacturer's CMS Agreement, made in accordance with Section 1927(c)(1) or Section 1927(c)(3) of the Social Security Act [42 U.S.C. § 1396r-8(c)(1) and 42 U.S.C. § 1396r8(c)(3)].

3.7 'CMS CPI Rebate' means, with respect to the Covered Product(s), the quarterly payment by Manufacturer pursuant to Manufacturer's CMS Agreement, made in accordance with Section 1927(c)(2) of the Social Security Act [42 U.S.C. § 1396r-8(c)(2)].

3.8 'CMS Rebate' means, with respect to the Covered Product(s), the quarterly payment by Manufacturer pursuant to Sections 4.1 of this Agreement.

3.9 'CMS Unit Rebate Amount' means, the unit amount computed by CMS to which the Medicaid utilization information may be applied by States in invoicing the Manufacturer for the rebate payment due.

3.10 'Drug Reimbursement Amount' means the total amount per unit allowable as calculated by the Participating States, specific to each drug, that the Participating States reimburse pharmacy providers per unit of drug under their Medicaid (and other state funded, HHS approved) programs, in accordance with applicable state and federal laws and regulations.

3.11 'First Health Client(s)' or 'FH Clients' means those states (including the State) that have entered or subsequently enter into agreements with First Health for the provision of PBA Services to the states' Medicaid and other non-Medicaid programs approved by CMS in the Medicaid state plan(s), subject to the supervision and oversight of such States.

3.12 [Reserved]

3.13 'Manufacturer' means, for purposes of this Agreement, the party identified as such in Section 1.1 of this Agreement, which may be a pharmaceutical manufacturer, labeler or other entity not prohibited by law from entering into this Agreement.

3.14 'Participating State(s)' means the (i) States named in Section 1.1 hereof, and (ii) other states that, subsequent to the execution of this Agreement by the States, elect to participate under this Agreement and have all necessary authorizations and approvals from CMS to do so. Unless otherwise authorized by CMS on a state by state basis, Participating States shall be limited to ones that have a CMS authorized contract under which First Health has been engaged to provide PBA services to that State. For each new Participating State, a unilateral amendment ("New Participating State Amendment") to this Agreement shall be executed by the new Participating State and First Health and sent to the Manufacturer prior to the Participation Commencement Date. A copy of the New Participating State Amendment is attached hereto as Exhibit A.

3.15 'Participating States' Net Price Per Unit' or 'Net Price' means the amount(s) agreed upon by the parties to this Agreement in the attached "Supplemental Rebate Matrix, Schedule 2". 'Net Price' will vary in accordance with Schedule 2 and is dependent upon the factors detailed therein, which includes, but may not be limited to, the number of Medicaid (and other state funded, HHS approved) eligible recipient lives and the number of products in a Preferred Drug List's product category. Per the attached "Supplemental Rebate Matrix, Schedule 2", Net Price will be a factor in the equation that is determinative of the Supplemental Rebate Amount.

3.16 'Participation Commencement Date' is the latter of the date (i) a Manufacturer's Supplemental Covered Product is effectively placed in a Participating State's Preferred Drug List by distribution of the Preferred Drug List (via website or otherwise) to providers and prescribers or (ii) the New Participating State Amendment is fully executed and returned to the Manufacturer, or (iii) the effective date of CMS approval of the Participating State's applicable state plan amendment. It is the date when the Participating State(s)' entitlement to the State Supplemental Rebate(s) from the Manufacturer accrues.

3.17 'Pharmacy Provider' means an entity licensed or permitted by law to dispense legend drugs, and enrolled as a State Medicaid Provider.

3.18 'Rebate Summary' means the individual Participating States' reports itemizing the State Utilization Data supporting each Participating State's invoice for Rebates. The Rebate Summary will comply in all respects with requirements for Medicaid Utilization Information in the CMS Agreement.

3.19 'State Supplemental Rebate' means, with respect to the Supplemental Covered Product(s), the quarterly payment by Manufacturer pursuant to Section 4.2 of this Agreement.

3.20 'State Utilization Data' means the data used by Participating States to reimburse pharmacy providers under Participating States' Medicaid Program (and other non-Medicaid programs approved by CMS in the state plan(s) as provided in Section 2.1 hereof). State Utilization Data excludes data from covered entities identified in Title 42 U.S.C. §256b(a)(4) in accordance with Title 42 V.S.C. §256b(a)(5)(A) and 1396r-8(a)(5)(C).

3.21 'Supplemental Covered Product' means the pharmaceutical product(s) of the Manufacturer, as detailed in the attached Supplemental Rebate Matrix, Schedule 2, upon which a State Supplemental Rebate will be paid pursuant to this Agreement.

3.22 'Supplemental Covered Product Category' or 'Product Category' means a defined group of pharmaceutical products considered to compete with one another in the market and that are also thought to be therapeutic alternatives in many situations. First Health Services has determined and defined the Product Categories in which manufacturers will bid. The Product Categories, set forth on the "Product Categories, Schedule I" hereto, may be changed as deemed appropriate by Participating States.

3.23 'Supplemental Rebate Amount' means, with respect to the Supplemental Covered Product(s), the amount(s) specified in the attached Supplemental Bid Matrix, Schedule 2 and Supplemental Rebate Calculation, Schedule 3 that the Manufacturer has agreed to reimburse Participating States per unit of drug in accordance with the formula detailed in the above Schedules.

3.24 'Wholesale Acquisition Cost' or 'WAC' means the Manufacturer's U.S. Dollar wholesale acquisition price in effect on the last day of a quarter on a unit basis as published by a third party source, such as First Databank, for each product and represents the Manufacturer's published price for a drug product to wholesalers.

#### **MANUFACTURER'S RESPONSIBILITIES**

4.1 Manufacturer will calculate and provide each Participating State a CMS Rebate for the Covered Product(s), which includes the CMS Basic Rebate and CMS CPI Rebate, as appropriate. The CMS Rebate represents the discount obtained by multiplying the units of the Covered Product(s) reimbursed by each Participating State in the preceding quarter by the per unit rebate amount provided to each Participating State by CMS. CMS will calculate the CMS Rebate amount in accordance with Manufacturer's CMS Agreement. Manufacturer's obligation for CMS Rebates will continue for the duration of the Manufacturer's CMS Agreement.

4.2 In addition to the CMS Rebates described in Section 4.1 of this Agreement, Manufacturer will remit to each Participating State a State Supplemental Rebate for the Supplemental Covered Product(s) that are in each Participating States Preferred Drug List Program. The State Supplemental Rebates will be calculated on a calendar quarter basis and provided via invoices to the Manufacturer's CMS financial contact. The State Supplemental Rebates for the quarter will be determined by multiplying the number of units of the Supplemental Covered Product(s) reimbursed by each Participating State in the preceding quarter by its Supplemental Rebate Amount. The Manufacturer's obligation for State Supplemental Rebates will continue for the duration of this Agreement. The Supplemental Rebate calculation is described in "Supplemental Rebate Calculation, Schedule 3".

4.3 The Manufacturer's obligation for State Supplemental Rebates will begin with the Rebate Billing Period for the second calendar quarter 2006, which begins April 1, 2006 (even if this Agreement is not fully executed by such date) and will continue through the Rebate Billing Period that ends March 31, 2009, subject to each Participating States' actual Participation Commencement Date as described in Section 3.16, *supra*. Notwithstanding the above, the Participating States reserve the right to solicit



annually more favorable State Supplemental Rebates from Manufacturer by giving written notice thereof no less than ninety (90) days prior to the yearly anniversary of the effective date of this Agreement.

4.4 The quarters to be used for calculating the Rebates in Section 4.2 of this Agreement will be those ending on March 31, June 30, September 30, and December 31 of each calendar year during the term of this Agreement.

4.5 The participating Manufacturer will be required to submit each Participating State's State Supplemental Rebate payment within 38 days of the Manufacturer's receipt of the Participating State's Rebate Summary.

4.6 Manufacturer will pay the State Supplemental Rebates, including any applicable interest in accordance with Section 1903 (d)(5) of the Act. Interest on the Rebates payable under Section 4.2 of this Agreement begins accruing 38 calendar days from the postmark date of each Participating State's invoice and supporting Rebate Summary sent to the Manufacturer and interest will continue to accrue until the postmark date of the Manufacturer's payment. For the rebate programs invoiced under this Agreement, if the date of mailing of a Rebate payable under Section 4.2 of this Agreement is 69 days or more from the date of mailing of the invoice, the interest rate will be calculated as required under federal guidelines for rebates described in Section 4.1 but will be increased by ten percentage points or the maximum allowed by that Participating State's state law. If a Participating State has not received the Rebates payable under Section 4.2 of this Agreement, including interest, within 180 days of the postmark date of said Participating State's invoice and supporting Rebate Summary sent to the Manufacturer, such Participating State may deem the Manufacturer to be in default and Participating State may terminate its participation in this Agreement by giving Manufacturer and First Health ninety (90) days advance written notice.

4.7 Manufacturer agrees to continue to pay State Supplemental Rebates on the Supplemental Covered Product(s) for as long as this Agreement or any of its Addenda are in force, and State Utilization Data shows that payment was made for that drug, regardless of whether the Manufacturer continues to market that drug. Manufacturer's obligation to pay State Supplemental Rebates on the Supplemental Covered Product(s) shall terminate twelve (12) months following the last expiration date of the last lot of Supplemental Covered Product sold by the Manufacturer. Notwithstanding the above, in the event Manufacturer's Supplemental Covered Product(s) is/are sold to another manufacturer, the original Manufacturer shall have no liability for rebates on utilization beyond those required by the Medicaid

program. Manufacturer shall provide the State and First Health with notice of the sale of said Supplemental Covered Product(s) concurrent with Manufacturer's notice to CMS.

4.8 Unless notified otherwise, Manufacturer will send Rebate payments by certified mail, return receipt requested, to the address provided to Manufacturer in each individual Participating State's Addendum.

#### **PARTICIPATING STATE(S)' RESPONSIBILITIES**

5.1 Each Participating State will consider the Manufacturer's Supplemental Covered Product(s) for inclusion in the Participating State's Preferred Drug List Program. Each individual Participating State reserves the right to select the products that will be in its Preferred Drug List Program and will only receive State Supplemental Rebates for Manufacturer's Supplemental Covered Products that are actually included in its Preferred Drug List Program. Manufacturer shall pay Participating States State Supplemental Rebates based upon Participating State(s)' utilization of Manufacturer's Supplemental Covered Product(s) that did not require prior authorization. Participating States shall not be entitled to State Supplemental Rebates for utilization of Manufacturer's Supplemental Covered Product(s) that occurred only subsequent to the obtaining of prior authorization unless the Supplemental Covered Product(s) have been assigned to a Product Category and all products in the Product Category are subject to prior authorization requirements. Each individual Participating State also reserves the right to determine, as a result of a Product Category review, that prior authorization is required for all preferred drugs in a Product Category. If a Participating State determines that prior authorization is required for any Supplemental Covered Product, then the Participating State will comply with all provisions of Section 1927( d) of the Social Security Act applicable to Prior Authorization programs. Each Participating State will notify Manufacturer and First Health, within ten (10) business days of adoption and publication of a new or revised Preferred Drug List, when Manufacturer's Supplemental Covered Product is added to the Participating State's Preferred Drug List by providing Manufacturer and First Health a copy of the Preferred Drug List in accordance with the notice provisions of Section 9.2 hereof.

5.2 The State and/or First Health shall notify the Manufacturer whenever a Participating State adds one of Manufacturer's Supplemental Covered Products to its Preferred Drug List or when one of Manufacturer's Supplemental Covered Products is moved to a prior authorization status.

5.3 Each Participating State will provide aggregate State Utilization Data to the Manufacturer on a quarterly basis. This data will be based on paid claims data (data used to reimburse pharmacy providers)

under each Participating State's Medicaid (and other state funded, HHS approved) Program(s), will be consistent with any applicable Federal or State guidelines, regulations and standards for such data, and will be the basis for the Participating State's calculation of the State Supplemental Rebate.

5.4 Each Participating State will maintain those data systems used to calculate the State Supplemental Rebates. In the event material discrepancies are discovered, the Participating State will promptly justify its data or make an appropriate adjustment, which may include a credit as to the amount of the State Supplemental Rebates, or a refund to Manufacturer as the parties may agree.

5.5 Each Participating State shall maintain electronic claims records for the most recent four quarters that will permit Manufacturer to verify through an audit process the Rebate Summaries provided by the Participating State.

5.6 Upon implementation of this Agreement, and from time to time thereafter, Participating States and Manufacturer will meet to discuss any data or data system improvements which are necessary or desirable to ensure that the data and any information provided by the Participating States to Manufacturer are adequate for the purposes of this Agreement.

5.7 First Health, as the pharmacy benefit administrator, may assist the Participating States in fulfilling its responsibilities hereunder and is a party to this Agreement solely in its capacity as agent for, and subject to the supervision and oversight of the Participating State(s).

5.8 The State and each Participating State shall obtain CMS approval of its state Medicaid plan of which this Agreement forms a part. Manufacturer shall not be obligated to remit any Supplemental Rebates that have accrued and are due under this Agreement until after the affected State or Participating State has obtained CMS approval of its Supplemental Rebate Program of which this Agreement forms a part.

## **DISPUTE RESOLUTION**

6.1 In the event that in any quarter a discrepancy in a Participating State's State Utilization Data is questioned by the Manufacturer, which the Manufacturer and the Participating State in good faith are unable to resolve, the Manufacturer will provide written notice of the discrepancy to the Participating State and First Health.

6.2 If the Manufacturer in good faith believes the Participating State's State Utilization Data is erroneous, the Manufacturer shall pay the Participating State that portion of the rebate claimed, that is not in dispute by the required date. The balance in dispute, if any, will be paid by the Manufacturer to the Participating State by the due date of the next quarterly payment after resolution of the dispute.

6.3 The Participating State and the Manufacturer will use their best efforts to resolve the discrepancy within 60 days of receipt of written notification. Should additional information be required to resolve disputes, the Participating State and First Health will cooperate with the Manufacturer in obtaining the additional information.

6.4 In the event that the Participating State and the Manufacturer are not able to resolve a discrepancy regarding State Utilization Data as provided for in Sections 6.1 through 6.3, the Manufacturer may request a reconsideration of the Participating State's determination within 30 days after the end of the 60 day period identified in Section 6.3. The Manufacturer shall submit with its written request its argument in writing, along with any other materials, supporting its position to the Participating State and First Health. The Participating State shall review the written argument and materials and issue a decision in the matter.

## **CONFIDENTIALITY PROVISIONS**

7.1 The parties agree that confidential information will not be released to any person or entity not a party to this contract. Confidential information, including trade secrets, will not be disclosed, or used except in connection with this Agreement or as may be required by law or judicial order.

7.2 The Manufacturer will hold Participating State' State Utilization Data confidential. If the Manufacturer audits this information or receives further information on such data from First Health or a Participating State, that information shall also be held confidential. The Manufacturer shall have the right to disclose Participating State(s)'s State Utilization Data to auditors who agree to keep such information confidential.

7.3 Pursuant to 42 USC 1396r-8(b)(3)(D), and other applicable state or federal laws, the parties agree that this Agreement and all information provided pursuant to this Agreement will not be disclosed and that the parties will not duplicate or use the information, except in connection with this Agreement or as may be required by law or judicial order. The parties further agree that any information provided by

Manufacturer to the State, First Health, or the Participating State(s) pursuant to this Agreement and this Agreement itself constitute trade secrets and/or confidential or proprietary commercial and financial information not subject to public disclosure. Furthermore, the parties agree that any Manufacturer information received by First Health pursuant to this Agreement and distributed by First Health to the State and/or Participating States shall constitute trade secrets and/or confidential or proprietary commercial and financial information of the Manufacturer not subject to public disclosure, except as otherwise provided for herein. If the services of a third party are used to administer any portion of this Agreement, Sections 7.1 through 7.4 of this Agreement shall apply to the third party. In the event a Participating State cannot give satisfactory assurance that rebate pricing data provided under this Agreement will be exempt from public disclosure under applicable state law, then First Health (without assuming responsibility for any wrongful disclosure by a Participating State) shall limit the amount of such data made available to the Participating State by not disclosing to the Participating State any NDC-level pricing information. For purposes hereof "satisfactory assurance" shall be deemed given when the Participating State enters the statutory cite of the applicable exemption on its Participating State Addendum. In the event that either party is required by law to disclose any provision of this Agreement or pricing information to any person, such party shall provide advance written notice to the other party sufficiently in advance of the proposed disclosure to allow the other party to seek a protective order or other relief.

7.4 Notwithstanding the non-renewal or termination of this Supplemental Rebate Agreement for any reason, these confidentiality provisions will remain in full force and effect.

#### **NON-RENEWAL or TERMINATION**

8.1 This Agreement shall be effective as of April 1, 2006 and shall have the term indicated in Section 4.3, *supra*.

8.2 Any Participating State may terminate its participation in this Agreement by giving Manufacturer and First Health written notice at least (90) days prior to the anniversary date of this Agreement, in which case termination shall become effective on the anniversary date of the date of execution of this Agreement. The termination of this Agreement by one or more Participating States shall not affect the Manufacturer's, First Health's or the other Participating States' obligations under this Agreement, other than any effect the reduction in the number of lives covered by the Agreement may have on the Supplemental Rebate payable hereunder. Manufacturer may terminate this Agreement and all Addenda by

giving all Participating States and First Health written notice at least ninety (90) days prior to the anniversary date of this Agreement, in which case termination shall become effective on the anniversary date of the date of execution of this Agreement. Manufacturer's right of termination is limited to the right to terminate the entire Agreement. Manufacturer may not terminate specific Addendum/Addenda of less than all Participating State(s).

8.3 Termination by a FH Client of its PBA Services Agreement with First Health shall, as of the same termination effective date, terminate this Agreement as to that Participating State.

8.4 Notwithstanding any non-renewal or termination of this Agreement, State Supplemental Rebates will still be due and payable from the Manufacturer under Section 4.2 for any Supplemental Covered Products for which Participating State(s)' obligation to reimburse arose prior to the effective date of termination of this Agreement.

8.5 On at least an annual basis or as mutually agreed upon by Manufacturer and First Health, Manufacturer shall have the opportunity to decrease the Net Price of its Covered Products to increase the likelihood of product(s) utilization and/or inclusion in the Participating States Preferred Drug List Programs.

#### GENERAL PROVISIONS

9.1 This Agreement will be governed and construed in accordance with 42 U.S.C. § 1396r-8 and all other applicable federal and state law and regulations.

9.2 Any notice required to be given pursuant to the terms and provisions of this Agreement will be in writing and will be sent by certified mail, return receipt requested. Notice will be mailed to the addressees specified in each individual Participating State's Addendum to this Agreement.

Notice to the State shall be sent to:

State of Michigan  
Department of Community Health Medical Services Administration  
Attn: Dave McLaury  
400 S. Pine Street  
Lansing, MI 48933

Notice to First Health shall be sent to:

First Health Services Corporation  
Attn: James McGarry, President  
With a copy to: Legal Department  
4300 Cox Road  
Glen Allen, Virginia 23060

Notice to Manufacturer will be sent to:

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9.3 The Manufacturer agrees to be bound by the laws of the United States of America and with respect to each Participating State, the law of that Participating State. Proper venue in any legal action shall be the venue of the Participating State that is party to the proceeding. Any action brought by Manufacturer must be brought separately against individual Participating States or First Health, unless all affected Participating States and First Health consent to joinder of the actions.

9.4 Nothing herein shall be construed or interpreted as limiting or otherwise affecting First Health or Participating State( s) ability to pursue its rights arising out of the terms and conditions of the Agreement in the event that a dispute between the parties is not otherwise resolved.

9.5 Manufacturer and the agents and employees of Manufacturer in the performance of this Agreement, will act in an independent capacity and not as officers, employees or agents of First Health or any Participating State.

9.6 Manufacturer may not assign this Agreement, either in whole or in part, without the written consent of the Participating States and First Health. However, in the event of a transfer in ownership of the Manufacturer, the Agreement is automatically assigned to the new owner subject to the conditions in this Agreement. If the Agreement is assigned pursuant to this Section, Manufacturer shall provide First Health and the Participating States with an update of the information contained in Section 9.2, *supra*.

9.7 Nothing in this Agreement will be construed so as to require the commission of any act contrary to law. If any provision of this Agreement is found to be invalid or illegal by a court of law, or inconsistent with federal requirements, this Agreement will be construed in all respects as if any invalid, unenforceable, or inconsistent provision were eliminated, and without any effect on any other provision.

9.8 First Health, Participating State(s) and Manufacturer declare that this Agreement, including attachments, schedules and addenda, contains a total integration of all rights and obligations of the parties. There are no extrinsic conditions, collateral agreements or undertakings of any kind. In regarding this Agreement as the full and final expression of their contract, it is the express intention of the parties that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period of time governed by this Agreement which are not expressly set forth herein are to have no force, effect, or legal consequences of any kind.

9.9 This Agreement will not be altered except by (i) an amendment in writing signed by all the parties, other than (ii) in the case of the addition of a new Participating State(s), by its execution of the New Participating State Amendment. It is acknowledged that the intent of the previous sentence is that the addition of a new Participating State(s) by amendment shall only require the consent of First Health and the approval of CMS, not Manufacturer. Manufacturer agrees that any Participating State may be added to this Agreement by amendment and that said Participating State's covered Medicaid (and other non-Medicaid programs approved by CMS in the Medicaid state plan(s)) lives shall apply to the provisions of Schedules 2 and 3 and will affect the rebates to all Participating States in accordance with Schedules 2 and 3. The New Participating State Amendment shall be executed by First Health and the new Participating State with a copy provided to Manufacturer for its records. Other than as stated herein, no individual is authorized to alter or vary the terms or make any representation or inducement relative to it, unless the alteration appears by way of a written amendment, signed by duly appointed representatives of the Participating State(s), First Health, and the Manufacturer. Any modification or amendment must be authorized by CMS.

9.10 The parties do not contemplate any circumstances under which indemnification of the other parties would arise. Nevertheless, should such circumstances arise, Manufacturer agrees to indemnify, defend and hold harmless the Participating States and First Health, their officers, agents and employees from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Manufacturer in the performance of this Agreement.



9.11 Inasmuch as the State Supplemental Rebates required by this Agreement are for state Medicaid (and non-Medicaid programs approved by CMS in the Medicaid state plan(s)) program beneficiaries, it is agreed, in accordance with Medicaid Drug Rebate Program Release #102 for State Medicaid Directors and other applicable law, that the State Supplemental Rebates do not establish a new 'Best Price' for purposes of participating Manufacturer's CMS Agreement.

9.12 In the event that Participating State(s) require(s) prior authorization of Manufacturer's Supplemental Covered Product(s) as part of a Product Category prior authorization under Section 5.1, State Supplemental Rebates shall nevertheless be payable hereunder.

9.13 If First Health or a Participating State makes changes to a Product Category that are considered to be a material change in the structure of the supplemental rebates program, Manufacturer may be allowed to re-submit bids for the Product Category/Categories affected.

9.14 As evidence of their Agreement to the foregoing terms and conditions, the parties have signed below.

STATE OF MICHIGAN, DEPARTMENT OF COMMUNITY HEALTH:

By: \_\_\_\_\_ Date: \_\_\_\_\_  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_

MANUFACTURER

By: \_\_\_\_\_ Date: \_\_\_\_\_  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_

FIRST HEALTH SERVICES CORPORATON

By: \_\_\_\_\_ Date: \_\_\_\_\_  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_

## EXHIBIT A

**New Participating State Amendment to Supplemental  
Drug-Rebate Agreement Between  
Participating States; First Health Services Corporation  
And  
(Manufacturer Name ("Manufacturer'))**

WHEREAS, the State of Michigan, First Health Services Corporation ("First Health"), and Manufacturer have entered into a Supplemental Drug-Rebate Agreement (the "Agreement"), effective as of <<DATE>>; and

WHEREAS, the participating States as named in Section 8 below have become parties to the Agreement as Participating States by previous amendment or addenda; and

Now, therefore, in consideration of the mutual covenants, promises, and conditions contained herein and in the Agreement, the parties agree as follows:

1. The State of Georgia is hereby added as a party to the Agreement as a new Participating State, as defined in Section 3.14 of the Agreement.
2. This Amendment shall become effective upon the date determined in accordance with Section 3.16 of the Agreement; provided that this Amendment shall not become effective until the effective date of the state plan amendment submitted to CMS on June 6, 2006.
3. An executed copy of this Amendment shall be sent via certified mail, return receipt requested to Manufacturer's address of record as set forth in the Agreement within five (5) business days of its execution by the parties.
4. This Addendum adds a new Participating State to the Agreement and does not otherwise change or alter the Agreement. The new Participating State(s) understand(s) and agrees to be bound by the terms of the Agreement.
5. The undersigned State acknowledges that manufacturer rebate pricing information is confidential information under applicable Federal law and shall be exempt from public disclosure pursuant to State Code Section O.C.G.A. 50-18-70, et seq.
6. The undersigned State represents that it has not requested authorization from CMS to include any state pharmaceutical assistance program within the rebate provisions of the Agreement.

**EXHIBIT A**

The above representation shall not prohibit the undersigned State from requesting CMS authorization to include (other) pharmaceutical assistance programs within the Agreement at a later date. Upon receipt of CMS authorization, State shall give written notice to Manufacturer of the date Manufacturer's Supplemental Covered Product is effectively placed on the preferred drug list of the undersigned State's non-Medicaid programs approved by CMS in the Medicaid state plan(s) by completing the attached Exhibit A1.

- 7. The approximate enrollment in the undersigned State's Medicaid program at the time of execution of this Amendment is 364,000.
- 8. As of the effective date of this Amendment, the following are all of the Participating States under the Agreement:

<u>Michigan</u>	<u>Alaska</u>
<u>New York</u>	<u>Nevada</u>
<u>New Hampshire</u>	<u>Hawaii</u>
<u>Minnesota</u>	<u>Montana</u>
<u>Kentucky</u>	<u>Tennessee</u>
<u>District of Columbia</u>	

**EXHIBIT A**

STATE OF GEORGIA  
DEPARTMENT OF COMMUNITY  
HEALTH

By: \_\_\_\_\_  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_

FIRST HEALTH SERVICES CORP

By: \_\_\_\_\_  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_

**EXHIBIT A1**

**Participating State's Non-Medicaid Programs Approved by CMS in the Medicaid State Plan(s)**

Participating State: Georgia

Non-Medicaid programs approved by CMS in the Medicaid State Plan(s) - Date of Approval

1. **None**

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

12.c. PROSTHETIC SERVICES

Prosthetic devices, including hearing aids, that are prescribed by a physician and are medically necessary for recipients under the age of 21 years are covered. For recipients 21 and over, prosthetic devices must be ordered or prescribed by a physician. Measurement and fitting must be performed by a practitioner who is certified in prosthetics.

Hearing aids for recipients under the age of 21 years are provided once every three years unless medically necessary and prior approved.

Non-Covered Services

Items which are not within the scope of definition of prosthetic devices.

Orthopedic shoes and supportive devices for the feet which are not an integral part of a leg brace are not covered for recipients 21 years of age and over.

Hearing aids and Accessories are not covered for recipients over 21 years of age.

d. EYEGLASSES

Eyeglasses and other optical devices are available to EPSDT eligible recipients. The amount, duration and scope of services are described in Optometric Services, Section 6.b. of this Attachment.

**AMOUNT, DURATION AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY**

13.

b. Screening services

Provided                       No limitations                       With limitations\*  
 Not provided

c. Preventive services

Provided                       No limitations                       With limitations\*  
 Not provided

d. Rehabilitative services

Provided                       No limitations                       With limitations\*  
 Not provided

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services

Provided                       No limitations                       With limitations\*  
 Not provided

b. Nursing facility services

Provided                       No limitations                       With limitations\*  
 Not provided

\* Description provided on attachment.



13. a) **DIAGNOSTIC, b) SCREENING, c) PREVENTIVE SERVICES**

**Diagnostic, screening and preventive services provided by a physician or other licensed practitioner of the healing arts, within scope of their practice under State law, are provided by qualified providers to all eligible recipients to promote physical and mental health and efficiency.**

1.) **Diagnostic** services include medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts within the scope of his/her practice that enables him/her to identify the existence, nature or extent of illness, injury or other health deviation.

2.) **Screening** services include standardized tests performed under medical direction of qualified healthcare professionals to a designated population to detect the existence of one or more particular diseases.

3.) **Preventive** services include services provided by a physician or other licensed practitioner of the healing arts within the scope of practice under State law to:

- a) prevent disease, disability and other health conditions or their progression;
- b) prolong life; and
- c) promote physical and mental health and efficiency,

**Qualified providers must meet the standards approved by the Department and contained in Sections 106 and Chapter 600 of the Diagnostic, Screening and Preventive Services program policy manual.**

**Non-Covered Services**

Adjunctive services provided in a nursing facility or institutional setting

Experimental services or procedures or those that are not recognized by the professions or the U. S. Public Health Services as universally accepted treatment

Nursing Home visits

Day Care Center visits

Hospital visits

13. a) DIAGNOSTIC, b) SCREENING, C) PREVENTIVE SERVICES (continued).

Non-Covered Services (continued).

**Family Planning Services.**

Drugs used or dispensed in the clinic except those injectables authorized by the Department.

Health Check screening services.

Laboratory services.

**Experimental Services.**

Educational supplies, medical testimony, special response, travel by the nurse, no-show or canceled appointments, additional allowances for services provided after clinic hours or between 10:00 p.m. and 8:00 a.m. or on weekends or holidays.

Services or procedures performed without regard to the policies contained in the manual.

Services performed outside protocol or licensure of the specific practitioner.

The first two nutrition education contracts for WIC-eligible recipients.

Speech, language and hearing services for recipients 21 years of age and older.

The initial basic audiometer screening (Initial screening must be done under Health Check).

Investigation items and experimental services; drugs or procedures or those not Recognized by the Federal Drug Administration, the United States Public Health Service; Medicare and the Department's contracted peer review organization as universally accepted treatment, including but not limited to, position emission topography, dual photon, absorptiometry, etc.

Lead investigations done at sites other than a child's primary place of residence.

Services not covered in the physician program except where determined medically necessary for EPSDT eligible children.

**Autism Spectrum Disorder Services.** Services to treat Autism Spectrum Disorders (ASD), as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, include assessment and treatment services provided to Medicaid beneficiaries in accordance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards and according to medical necessity. Pursuant to 42 CFR 440.130(c), services must be recommended by a licensed physician or other licensed practitioner of the healing arts acting within their scope of practice under state law to prevent the progression of ASD, prolong life, and promote the physical and mental health and efficiency of the individual.

Prior Authorization is required for all services. Services are authorized in two parts, 1) Assessment, and 2) Treatment Plan and Services. An Assessment is the administration of an industry standard assessment tool, and is required to substantiate services. A Treatment Plan is a plan of care required to coordinate treatment.

Georgia Medicaid will enroll Board Certified Behavioral Analysts (BCBA) to provide ASD treatment services. The BCBA must have a graduate-level certification in behavior analysis. Providers who are certified at the BCBA level are independent practitioners who provide behavior-analytic services. In addition, BCBA's supervise the work of Board Certified Assistant Behavior Analysts (BCBA), Registered Behavior Technicians (RBT), and others who implement behavior-analytic interventions.

The following providers are authorized to provide ASD services:

- BCBA-D: Board Certified Behavior Analyst: Doctoral Level. A doctoral level practitioner qualified to diagnose and provide direct services and supervise BCBA's.
- BCBA: Board Certified Behavior Analyst. Masters/graduate level independent practitioners who provide behavior-analytic services. May supervise the work of Board Certified Assistant Behavior Analysts, Registered Behavior Technicians, and others who implement behavior-analytic interventions.
- BCaBA: Board Certified Assistant Behavior Analyst. Bachelor's level practitioner must be supervised by BCBA/BCBA-D; can supervise Registered Behavior Technicians.
- RBT: Registered Behavior Technicians. Paraprofessional who implements the service plan under supervision of a Certified Behavior Analyst or Certified Assistant Behavior Analyst.

### Assessment Descriptions.

Service	Description	Authorized Provider Type
Behavior Identification Assessment	Behavior identification assessment, by the Physician or other Authorized Provider Type, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report for plan of care.	Physicians Psychologists BCBA-D BCBA

Observational Behavioral Follow-up Assessment	Observational Behavioral Follow-up Assessment is designed by the practitioner to identify and evaluate factors that many impede the expression of adaptive behaviors. The assessment utilizes structured observation and/or standardized and non-standardized tests to determine the levels of adaptive behavior. It enables the practitioner to evaluate a member's social behavior to determine if the patient has a particular set of social skills, as well as the contexts in which social responses are either likely or unlikely to occur. Practitioners may assess cooperation, motivation, visual understanding, receptive and expressive language, imitation, request, labeling, play and leisure, and social interactions. Observational Behavioral Follow-up assessment, includes, Physician or other Authorized Provider Type direction with interpretation and report, administered by one of the Authorized Provider Type; first thirty (30) minutes of the Authorized Provider Type's time, face-to-face with the patient. Additional (30) minute increments are authorized in accordance with medical necessity.	Physicians Psychologists BCBA-D BCBA BCaBA RBT who meets the minimum one year of required experience
Exposure Behavioral Follow-up Assessment	Exposure behavioral follow-up assessments is designed by the practitioner to manipulate or stage environmental or social contexts to examine triggers, events, cues, responses, and consequences associated with maladaptive destructive behavior(s). This service requires the practitioner to provide on-site direction to technicians providing direct service. Exposure behavioral follow-up assessment often requires the use of protective gear and/or padded room to avoid injuries to patient and others. Exposure Behavioral Follow-up assessment, includes Physicians or other Authorized Provider Type, direction with interpretation and report, administered by Physician or Authorized Provider Type with the assistance of one or more Authorized Provider Type; first thirty (30) minutes of the Authorized Provider Type's, face-to-face with the patient. Additional (30) minute increments are authorized in accordance with medical necessity.	Physicians Psychologists BCBA-D BCBA BCaBA RBT who meets the minimum one year of required experience

**Treatment Descriptions and Authorized Providers.**

Code	Description	Authorized Provider Type
Adaptive Behavior Treatment	Adaptive behavior treatment addresses the patient's specific target problems and treatment goals as defined in assessments. Adaptive behavior treatment is based on principles including analysis and alternation of contextual events and motivating factors, stimulus-consequence strategies and replacement behavior, and monitoring of outcome metrics. Goals of adaptive behavior treatment may include reduction of repetitive and aberrant behavior, and improved communication and social functioning. Adaptive behavior skills tasks are often broken down into small, measurable units, and each skill is practiced repeatedly until the member masters it. Adaptive Behavior Treatment by protocol, administered by Authorized Provider Type, face-to-face with one patient; first thirty (30) minutes of the Authorized Provider Type's time. Additional (30) minute increments are authorized in accordance with medical necessity. Adaptive Behavior Treatment can be provided on in an individual, group, family or multi-family setting.	Physicians Psychologists BCBA-D BCBA BCaBA RBT who meets the minimum one year of required experience
Adaptive Behavior Treatment with Protocol Modification	Adaptive Behavior Treatment with Protocol Modification includes skills training delivered to a patient who has poor emotional responses and/or deviation in rigid routines. The practitioner introduces small, incremental changes to the patients expected routine along one or more stimulus areas. More intrusive changes in routines are faded into preferred daily activities until the member appropriately tolerates typical variation in daily activities without poor emotional responses. The service may include demonstration of new or modified protocol for a technician, guardian, and/or caregiver. The practitioner modifies the past protocol targeted for desired results to incorporate changes in the context and environment. Adaptive Behavior Treatment with protocol modification administered by Physician or other Authorized	Physicians Psychologists BCBA-D BCBA BCaBA RBT who meets the minimum one year of required experience

	Provider Type with one patient; first thirty (30) minutes of patient face-to-face time. Additional (30) minute increments are authorized in accordance with medical necessity.	
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Adaptive Behavior Treatment Social Skills Group	Adaptive Behavior Treatment Social Skills Group is administered by a practitioner in a social skills group. The practitioner monitors the needs of the individual and adjusts therapeutic techniques in real-time to address targeted social deficits and problem behaviors using modeling, rehearsing, and corrective feedback. The practitioner develops group activities in which each patient has an opportunity to practice encounters. Adaptive Behavior Treatment Social Skills Group, administered by Physician or other Authorized Provider Type, face-to-face with multiple patients.	Physicians Psychologists BCBA-D BCBA BCaBA RBT who meets the minimum one year of required experience
Exposure Adaptive Behavior Treatment with Protocol Modification	Exposure adaptive behavior treatment with protocol modification requires staged environmental conditions to train appropriate alternative responses under the environmental contexts that typically evoke problem behavior. Exposure adaptive behavior treatment addresses one or more specific destructive behaviors. Practitioners directs the sequence of events utilizing real time observation. Exposure Adaptive Behavior Treatment with protocol modification requiring two (2) or more Authorized Provider Type for severe maladaptive behavior(s); first sixty (60) minutes of the Authorized Provider Type's time, face to face with patient. Additional (30) minute increments are authorized in accordance with medical necessity.	Physicians Psychologists BCBA-D BCBA BCaBA RBT who meets the minimum one year of required experience

**13d. EPSDT-Related Rehabilitative Services - Community Based**

The covered rehabilitative services for the Children's Intervention Services program are audiology, nursing, occupational therapy, physical therapy, nutrition, counseling and speech-language pathology which include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under State law, and are provided by a licensed practitioner of the healing arts to EPSDT eligible recipients (ages 0-20) to promote the maximum reduction of physical disability or developmental delay and/or restoration of a recipient to his/her best possible functional level. These services may be provided in practitioners offices, community centers, and in the recipient's home.

The services are defined as follows:

- **Audiology Services**  
Audiological testing; fitting and evaluation of hearing aids. Providers' qualifications are in accordance with 42 CFR 440.110.
- **Nursing Services**  
Skilled intermittent nursing care to administer medications or treatments. The care provided is necessary for the maximum reduction of the beneficiaries' physical and/or mental disability and restoration to the best possible functional level. Skilled intermittent nursing care is provided by licensed nurses (registered or licensed practical nurses under the supervision of a registered nurse, licensed to practice in the state of Georgia).
- **Occupational Therapy Services**  
Occupational therapy evaluation of gross and fine motor development and clinical services related to activities of daily living and adaptive equipment needs. Providers' qualifications are in accordance with 42 CFR 440.110.
- **Physical Therapy Services**  
Physical therapy evaluation of neuromotor development and clinical services related to improvement of gait, balance and coordination skills. Providers' qualifications are in accordance with 42 CFR 440.110.
- **Counseling Services**  
Evaluation to determine the nature of barriers (social, mental, cognitive, emotional, behavioral problems, etc.) to effective treatment, that impacts the child's medical condition, physical disability and/or developmental delay and the child's family. The provision of counseling and intervention services to resolve those barriers relating to effective treatment of the child's medical condition and which threaten the health status of the child. Services are provided by Licensed Clinical Social Workers in accordance with standards of applicable state licensure and certification requirements, must hold a current license, and adhere to the scope of practice as defined by the applicable licensure board.



**13d. EPSDT Related Rehabilitative Services - Community Based** (continued)

- **Speech-Language Pathology Services**  
Speech-language evaluation of auditory processing, expressive and receptive language and language therapy. Providers' qualifications are in accordance with 42 CFR 440.110, and adhere to the scope of practice as defined by the applicable state licensure board.
- **Nutrition Services**  
Nutritional assessment, management and counseling to children on special diets due to genetic metabolic or deficiency disorders or other complicated medical problems. Nutritional evaluation and monitoring of their nutritional and dietary status, history and any teaching related to the child's dietary regimen (including the child's feeding behavior, food habits and in meal preparation), biomedical and clinical variables and anthropometric measurements). Development of a written plan to address the feeding deficiencies of the child that is incorporated into the child's treatment program. Providers' qualifications must meet the applicable State licensure and certification requirements, hold a current state license, and adhere to the scope of practice as defined by the applicable licensure board.

**Limitations**

The covered services are available only to the EPSDT eligible recipients (ages 0-20) with a written service plan (an IEP/IFSP) which contains medically necessary services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under State law.

Provider enrollment is open only to individual practitioners, who are licensed in Georgia under their respective licensing board such as a licensed audiologist, registered nurse, occupational therapist, physical therapist, licensed clinical social worker, licensed counselor, licensed dietician or speech language pathologist. For annual re-enrollment beginning July 1, 1996, all providers must obtain a minimum of one (1) continuing education credit annually in pediatrics in their area of professional practice. Where applicable, providers will be in compliance with federal requirements defined in 42 CFR 440.110.

**Prior Approval**

Services which exceed the limitations as listed in the policies and procedures manual must be approved prior to service delivery.

**13d. EPSDT related Rehabilitative Services - Community-Based (continued)**

The following services are not provided through the EPSDT-Related Rehabilitative Services - Community Based program:

1. Habilitative services that assist in acquiring, retaining and improving the self-help, socialization, and adaptive skills of the child.
2. Services provided to children who do not have a written service plan.
3. Services provided in excess of those indicated in the written service plan.
4. Services provided to a child who has been admitted to a hospital or other institutional setting as an inpatient.
5. Service of an experimental or research nature.
6. Services in excess of those deemed medically necessary by the Department, its agents or the federal government, or for services not directly related to the child's diagnosis, symptoms or medical history.
7. Failed appointments or attempts to provide a home visit when the child is not at home.
8. Services normally provided free of charge to all patients.
9. Services provided by individuals other than the enrolled licensed practitioner of the healing arts.
10. Services provided for temporary disabilities that would reasonably be expected to improve spontaneously as the patient gradually resumes normal activities.
11. Audiology services that are a part of the HealthCheck (formerly EPSDT) Services.
12. Billing for more than one travel fee per location when more than one patient is treated.

13d Rehabilitative Services (continued).

**EPSDT-Related Rehabilitative Services - School Based Health Services**

The Children's Intervention School Services (CISS) program includes covered rehabilitative services provided by or through Georgia State Department of Education (DOE) or a Local Education Agency (LEA) to children with or suspected of having disabilities, who attend school in Georgia, recommended by a physician or other licensed practitioners of the healing arts to EPSDT eligible special education students (from ages 0-20) to promote the maximum reduction of physical disability or developmental delay and/or restoration of a recipient to his/her best possible functional level. These services are provided pursuant to an Individual Education Program (IEP) or Individual Family Service Plan (IFSP).

The services are defined as follows:

- Evaluation

Evaluations for children determined to have disabilities, requiring physical therapy, speech pathology, occupational therapy, psychological, audiological, medical and nutritional evaluations, performed by appropriately licensed individuals, and meet criteria in 42 CFR 440.110 when applicable, that result in an IEP or IFSP.

- Audiology Services

Audiological testing; fitting and evaluation for hearing aids. Providers' qualifications are in accordance with the requirements of federal regulations 42 CFR 440.110.

- Nursing Services

Skilled intermittent nursing care to administer medications or treatments. The care provided is necessary for the maximum reduction of the beneficiaries' physical and/or mental disability and restoration to the best possible functional level. Skilled intermittent nursing care is provided by licensed nurses (registered or licensed practical nurses under the supervision of a registered nurse, licensed in the state of Georgia).

13d. Rehabilitative Services

**EPSDT-Related Rehabilitative Services - School Based Health Services** (continued)

- Occupational Therapy Services

Occupational therapy evaluation of gross and fine motor development and clinical services related to activities of daily living and adaptive equipment needs. Providers' qualifications are in accordance with the federal requirements in 42 CFR 440.110.

- Physical Therapy Services

Physical therapy evaluation of neuromotor development and clinical services related to improvement of gait, balance and coordination skills. Providers' qualifications are in accordance with the federal requirements in 42 CFR 440.110.

- Counseling Services

Evaluation to determine the nature of barriers (social, mental, cognitive, emotional, behavioral problems, etc.) to effective treatment that impacts the child's medical condition, physical disability and/or developmental delay and the child's family. The provision of counseling and intervention services to resolve those barriers relating to effective treatment of the child's medical condition and which threaten the health status of the child. Services are provided by licensed professionals practicing within the scope of their applicable state licensure requirements.

- Speech-Language Pathology Services

Speech language evaluation of auditory processing, expressive and receptive language and language therapy. Providers' qualifications are in accordance with the federal requirements in 42 CFR 440.110 and adhere to the scope of practice as defined by the applicable board.

- Nutrition Services

Nutritional assessment, management and counseling to children on special diets due to genetic, metabolic or deficiency disorders or other complicated medical problems. Nutritional evaluation and monitoring of their nutritional and dietary status, history and any teaching related to the child's dietary regimen (including the child's feeding behavior, food habits and in meal preparation), biochemical and clinical variables and anthropometrics measurements).

13d. Rehabilitative Services

**EPSDT-Related Rehabilitative Services - School Based Health Services** (cont'd.)

- Nutrition Services (continued)

Development of a written plan to address the feeding deficiencies of the child. Providers' qualifications must meet the applicable state licensure requirements, hold a current state license, and adhere to the scope of practice as defined by the applicable licensure board.

**Requirements**

The medically necessary rehabilitative services must be documented in the Individual Education Program (IEP) or Individualized Family Service Plan (IFSP).

Schools will still need to obtain prior approval for medical necessity if the service limits are exceeded and additional services are necessary by either the schools or community providers. Services that exceed the limitations listed in the policies and procedures manual must be approved prior to service delivery.

**Limitations**

The covered services are available only to the EPSDT eligible recipients (ages 0-20) only at the school setting with a written service plan (an IEP/IFSP) which contains medically necessary services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under State law.

Provider enrollment is open only to individual practitioners who are licensed in Georgia under their respective licensing board as a licensed audiologist, registered nurse, occupational therapist, physical therapist, licensed clinical social worker, licensed counselor, licensed dietician or speech-language pathologist. For annual re-enrollment beginning July 1, 1996, all providers must obtain a minimum of one (1) continuing education credit annually in pediatrics in their area of professional practice. Where applicable, providers will be in compliance with federal requirements defined in 42 CFR 440.110.

13d. Rehabilitative Services

**EPSDT-Related Rehabilitative Services - School Based Health Services (continued)**

**Limitations** (continued)

The following services are not provided through the EPSDT-Related Rehabilitative Services-School Based program:

1. Habilitative services that assist in acquiring, retaining and improving the self-help, socialization, and adaptive skills.
2. Services provided to children who do not have a written service plan.
3. Services provided in excess of those indicated in the written service plan.
4. Services provided to a child who has been admitted to a hospital or other institutional setting as an inpatient.
5. Services of an experimental or research nature (investigational) which are not generally recognized by the professions, the Food and Drug Administration, the U.S. Public Health Service, Medicare and the Department's contracted Peer Review Organization, as universally accepted treatment.
6. Services in excess of those deemed medically necessary by the Department, its agents or the federal government, or for services not directly related to the child's diagnosis, symptoms or medical history.
7. Failed appointments or attempts to provide a home visit when the child is not at home.
8. Services normally provided free of charge to all patients.
9. Services provided by individuals other than the enrolled licensed practitioner of the healing arts.

13d. Rehabilitative Services

**EPSDT-Related Rehabilitative Services - School Based Health Services** (continued)

**Limitations** (continued)

The following services are also not provided through the EPSDT-Related Rehabilitative Services School Based program:

10. Services provided for temporary disabilities, which would reasonably be expected to improve spontaneously as the patient gradually resumes normal activities.
11. Audiology services that are a part of the Health Check (formerly EPSDT) Services.
12. Billing for more than one travel fee per location when more than one patient is treated.

13.d.1 - Community Behavioral Health Rehabilitation Services in accordance with 42 CFR 440.130(d)

The covered Community Behavioral Health Rehabilitation Services will be available to all Medicaid eligible members with mental illness and substance use disorders and who are medically determined to need rehabilitative/prevention services. These services must be ordered by a physician or other licensed practitioner within the scope of his/her practice under state law and furnished by or under the direction of a physician or other licensed/certified practitioners operating within the scope of applicable state law, to:

- promote the maximum reduction of symptoms; and/or
- restore the recipient to his/her best possible functional level; and/or
- prevent the escalation of a condition into a crisis situation or into a chronic/significantly disabling disorder.

When services/supports are provided under the direction of a physician or other practitioners operating within the scope of applicable state law, the practitioner will provide clinical direction by:

- assuming professional responsibility for the services provided under his/her direction and monitors the need for continued services;
- directly overseeing services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensuring that individuals working under his/her direction have contact information to permit them direct access to clinical direction as necessary during the course of treatment; and
- maintaining documentation supporting the oversight of services and ongoing involvement in the treatment.

The covered Community Behavioral Health Rehabilitation Services (CBHRS) are reimbursed when delivered by enrolled agencies meeting the requirements listed herein. The State does not arbitrarily limit Medicaid Provider Agencies. The State enrolls any willing Provider Agency that meets the qualifications required to be a Provider Agency as outlined in the Policies and Procedures Manual that is made available to all interested Provider Agencies. Individual practitioners are not enrolled in this program. NOTE: The term “practitioner” is used to denote an individual who provides direct services/supports under the auspices of a Provider Agency. Provider agency qualifications to provide these services are ensured by Provider Agency compliance with requirements and standards of The Joint Commission (TJC), Commission on Accreditation for Rehabilitation Facilities (CARF), Council on Accreditation of Services for Children and Families, Inc. (COA), Council on Quality Leadership (CCL), and/or State certification. Additionally, where agencies provide services in a qualified residential setting, required state licensure is verified through the provider application and enrollment process.



Individual practitioners working within these provider agencies are required to meet all applicable licensure and certification requirements set forth in Georgia law, the scope of practice definitions of local and national licensure boards, and state agency policy regarding certification. Practitioners are grouped into levels consistent with specific credentials and in consideration of associated ranges of salaries as follows:

- Level 1: Physician, Psychiatrist
- Level 2: Licensed Practitioners of healthcare and behavioral health (highly trained and specialized [or specialty skilled] salary scale): Includes practitioners such as Psychologists, Physician's Assistants, Nurse Practitioners, Clinical Nurse Specialists/PMHs, Pharmacists
- Level 3: Licensed/Certified Practitioners of healthcare and behavioral health (highly trained and skilled salary scale): Includes practitioners such as Registered Nurse, Licensed Dietician, Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Certified/Registered Addictions Counselor-II
- Level 4: Associate Licensed and other Certified Practitioner (significantly trained and skilled salary scale): including Licensed Practical Nurse (LPN); Licensed Associate Professional Counselor (LAPC); Licensed Master's Social Worker (LMSW); Licensed Associate Marriage and Family Therapist (LAMFT); Certified/Registered Addictions Counselor), Certified Peer Specialist, Trained Paraprofessional or Certified Psychiatric Rehabilitation Professional (CPRP) with Bachelor's degree or higher in the social sciences/helping professions
- Level 5: Non-Licensed, Non-degreed and Trained Paraprofessionals (moderately trained and skilled salary scale): including practitioners such as Certified/Registered Addiction Counselor (CAC-I or Registered Alcohol and Drug Technician), Certified Peer Specialist, Certified Psychiatric Rehabilitation Professional, and Qualified Medication Aide

Detailed guidance related to practitioner level classification, licensure or title nomenclature, revisions to Georgia practice standards including any new adjustments made in Georgia law are reflected in the State Medicaid Agency's Part II Policies and Procedures Manual for CBHRS.

Members are given freedom of choice to choose a qualified, enrolled Provider Agency and practitioner within that agency. A toll-free access number and website provides information

regarding the available services and providers to participants and family members seeking behavioral healthcare services. The Department of Behavioral Health & Developmental Disabilities offices are also available to provide information to individuals seeking behavioral healthcare services through this program and participants may also access services by directly contacting providers of their choice.

The state also employs telemedicine strategies to promote access to services, for example, where there are identified barriers due to either behavioral health care professional shortage areas or because of a need for access to a very specialized practice (i.e., an ASL-fluent licensed therapist).

#### Limitations

Rehabilitation services do not include reimbursement for room nor board, and reimbursement will not be provided for services provided to individuals in an Institution for Mental Diseases (IMD) (see page 6c-7, e.). The covered services are available only to Medicaid eligible recipients with a written service plan, which contains medically necessary services ordered by a physician or other licensed practitioners operating within the scope of state law. All treatment, rehabilitative, and prevention services are focused on the Medicaid eligible individual. Any consultation or treatment involving families or other persons is solely for the purpose of addressing the behavioral health needs of the Medicaid recipient.

Service utilization is managed through the use of prior authorizations which set maximum units within an authorization period. Authorization periods vary according to service and may range between one day to 12 months for individuals who experience long-term, intensive, and chronic illness. At the outset of services and again when the authorization period expires or maximum units have been reached, a request must be submitted to the URAC-accredited Administrative Services Organization to justify provision of services based upon medical necessity of the service for the Medicaid recipient.

CBHRS do not include any of the following and FFP is not available for:

- a. room and board services;
- b. educational, vocational and job training services;
- c. habilitation services;
- d. services to inmates in public institutions as defined in 42 CFR §435.1010;
- e. services to individuals residing in institutions for mental diseases as described in 42 CFR §435.1010;
- f. recreational and social activities, and
- g. services that must be covered elsewhere in the state Medicaid plan.

The services are defined as follows:

### **Behavioral Health Assessment**

The behavioral health assessment process consists of a face-to-face (in person or via telemedicine/telehealth) comprehensive clinical assessment with the individual, which must include the individual's perspective/desires, and may also include individual-identified family and/or significant others as well as collateral agencies/treatment providers. The purpose of the assessment process is to gather all information needed to determine the individual's symptoms, strengths, needs, abilities and preferences, to develop a social and medical history, to determine functional capacity and level, and to develop or review collateral assessment information. This service may be provided in a clinic or outside the clinic setting in the community. Levels 2-5 practitioners may provide this service.

### **Recovery Plan Development**

The recovery plan development process results in a written, individualized service (recovery) plan. The plan is formulated through a collaborative process with the individual that includes all necessary treatment and rehabilitative services. With the individual, the individualized planning process includes the development of individualized treatment objectives/outcomes, plans for the expected frequency and duration of each service, identifies the type of practitioner who may best provide recommended services, identifies accessible locations for service delivery, and the identified outcomes which are expected from provision of the planned service. Service plans must be reviewed at least annually or whenever there is a change in the individual's service needs. Each plan and subsequent revisions must be authorized by a physician or other licensed practitioner authorized by state law to recommend a course of treatment. This service may be provided in a clinic or outside the clinic setting in the community. Levels 2-5 practitioners may provide this service.

### **Diagnostic Assessment**

The psychiatric diagnostic examination provides a comprehensive assessment of the medical and psychiatric treatment needs of the individual. The results of nursing assessments and behavioral health assessments are used by the physician as an integral part of the psychiatric assessment process which results in a diagnosis and associated treatment decisions. Diagnostic assessments may involve specific psycho-diagnostic assessments, testing, and evaluation performed by licensed psychologists or certain other licensed practitioners, or their supervisee/trainee in the administration of psychological tests, the results of which assist in the determination of a diagnosis and treatment recommendations. These services may be provided in a clinic or outside the clinic setting in the community. Levels 1-3 practitioners may provide this service.

### **Crisis Intervention Services**

Crisis Intervention Services entail a face-to-face (in person or via telemedicine/telehealth) short-term intervention with individuals in an active state of crisis. Interventions include a brief, situational assessment; verbal interventions to de-escalate the crisis; assistance in

immediate crisis resolution; mobilization of natural and formal support systems, and referral to alternate services at the appropriate level. This service is not duplicative of the comprehensive, in-depth assessments included in Behavioral Health Assessment or Diagnostic Assessment and does not duplicate the comprehensive and proactive planning for crisis management that is included in Recovery Plan development. Crisis intervention services are available 24 hours a day, 7 days a week. Services may be provided in a clinic setting or can occur in a variety of other settings including the individual's home, local emergency departments, or other community settings when the situation is such that it is medically necessary to deliver the services wherever the individual is located outside the clinic. Levels 1-5 practitioners may provide this service.

### **Crisis Stabilization**

Crisis Stabilization is a structured intensive residential alternative to or diversion from psychiatric inpatient hospitalization or inpatient detoxification offering psychiatric stabilization and withdrawal management services. Crisis Stabilization Services are for individuals who are experiencing a period of acute stress that significantly impairs the capacity to cope with normal life circumstances. The program provides medically monitored intensive psychiatric and/or substance abuse services that address the psychiatric, psychological, and behavioral health crisis needs of the individuals. This service may be utilized at various points in an individual's course of treatment and recovery; however, each intervention is intended to be a discrete time-limited service that stabilizes a crisis situation which the individual is experiencing. Levels 1-5 practitioners may provide this service as appropriate under approved scope of practice by practitioner type.

### **Psychiatric Treatment**

Psychiatric treatment encompasses the provision of specialized medical and/or psychiatric interventions that will result in improved levels of functioning or maintaining existing levels of functioning. Psychiatric treatment includes the ongoing care related to the behavioral healthcare needs of the individual as specified in the individualized recovery plan through pharmacological management and individual psychotherapeutic services coupled with medical evaluation and pharmacological management. These services may be provided in a clinic or outside the clinic setting in the community. Levels 1-2 practitioners may provide this service.

### **Psychiatric-Medical Consultation**

This service includes an inter-professional telephone consultation between physicians (or physician extenders) in which the physician with the CBHRS-enrolled agency (the consultant) provides specialty expertise opinion and/or treatment advice to a treating physician or other qualified health care professional regarding an individual about whom the consultant has behavioral health treatment knowledge and familiarity. The treating physician confers with the consultant regarding the diagnosis and/or management of an individual's presenting condition without the need for the individual's face-to-face contact with the

consultant. This service is provided telephonically. Levels 1-3 practitioners may provide this service.

### **Nursing Assessment and Care**

Nursing Assessment and Care services are face-to-face (in person or via telemedicine/telehealth) contacts with an individual to monitor, evaluate, assess, establish nursing goals, and/or carry out physicians' orders regarding treatment and rehabilitation of the physical and/or behavioral health conditions of an individual as specified in the individualized recovery plan. It includes providing special nursing assessments to observe, monitor and care for physical, nutritional and psychological issues or crises manifested in the course of the individual's treatment; to assess and monitor individual's response to medication to determine the need to continue medication and/or for a physician referral for a medication review; assessing and monitoring an individual's medical and other health issues that are either directly related to the mental health or substance related disorder, or to the treatment of the disorder (e.g. diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures, etc.); venipuncture required to monitor and assess mental health, substance disorders or directly related conditions, and to monitor side effects of psychotropic medication; consultation with the individual's family and/or significant others for the benefit of the client about medical and nutritional issues; to determine biological, psychological, and social factors which impact the individual's physical health and to subsequently promote wellness and healthy behavior and provide medication education and medication self-administration training to the individual and family. These services may be provided in a clinic or outside the clinic setting in the community. Levels 2-4 practitioners may provide this service.

### **Detoxification Services**

Detoxification Services are an outpatient set of services designed to achieve safe and comfortable withdrawal from mood altering drugs (including alcohol) and to facilitate an individuals transition into ongoing treatment and recovery, which may be delivered in a licensed office setting, licensed residential setting, or addiction treatment facility by practitioners who specialize in addiction treatment. Service includes supervision, observation, and support for individuals who are intoxicated or experiencing withdrawal. Services are directed toward stabilizing symptoms related to withdrawal, applying basic recovery skills, preventing relapse, engaging in outpatient recovery services/treatment, promoting personal responsibility, and reintegrating the individual into the worlds of work, education and family life.

This service does not include medical care in an Institution for Mental Disease, nor does it encompass social detoxification or inpatient intensive detoxification. Providers are required to meet all applicable state licensure requirements for drug treatment agencies. This service may be provided either in an in-clinic or out-of-clinic setting. Levels 1-5 practitioners may

provide components of this service as applicable and appropriate to the practitioner's scope of practice.

### **Substance Abuse Intensive Outpatient Program**

The Substance Abuse Intensive Outpatient Program is a time limited, treatment service for persons who require structure and support to achieve and sustain recovery. This service provides a set of substance abuse skilled treatment services for relapse prevention. Such services are inclusive of addiction services appropriate to the individual's recovery plan designed to assist individuals to begin recovery and learn skills for recovery maintenance. The following types of services are included in the intensive outpatient program: continuous assessment of current recovery status related to stabilization of symptoms and biomedical issues, confounding behavioral health and/or medical conditions, emerging capacity to self-manage addiction, readiness and motivation related to the addiction condition, and history of use/abuse; broad addiction and recovery skills training, individual and group counseling; family counseling; intensive coordination and brokering of recovery supports, and community/social support system strategies to promote ongoing recovery. These services may be provided in a clinic or outside the clinic setting in the community. Levels 1-5 practitioners may provide components of this service as applicable and appropriate to the practitioner's scope of practice.

### **Individual Outpatient Services**

Individual outpatient services provide face-to-face (in person or via telemedicine/telehealth) counseling and psychotherapy services for symptom/behavior management of mental health conditions and addictive diseases. Interventions are directed toward symptom reduction, promoting self-examination of current and desired psychological status; development and restoration of functional abilities; addressing motivation and behavior change; healing and transformation; problem solving, interpersonal, communication, and coping skills; developing adaptive behaviors; and enhancing strengths to offset challenges as delineated in the individualized recovery plan. These services may be provided in a clinic or outside the clinic setting in the community. Levels 1-5 practitioners may provide components of this service as applicable and appropriate to the practitioner's scope of practice.

### **Family Outpatient Services**

Family outpatient services provide face-to-face (in person or via telemedicine/telehealth) counseling, psychotherapy, and skills training services to the eligible individuals and their identified family for symptom reduction/behavior management of mental health conditions and addictive diseases according to the individualized recovery plan. Services are directed toward the identified individual and the restoration of adaptive behaviors and skills, functional abilities, and the interpersonal skills and functioning of the individual within the family unit. Services include counseling, therapy, and/or education and training for the individual and family members (for the benefit of the individual) regarding mental health and substance abuse disorders; prescribed medication (including adherence to medication regimen); problem solving, interpersonal, communication and coping skills; adaptive

behaviors and skills; and skills and abilities necessary to access community resources and support systems. These services may be provided in a clinic or outside the clinic setting in the community. Levels 1-5 practitioners may provide this service as applicable and appropriate to the practitioner's scope of practice.

### **Group Outpatient Services**

Group outpatient services provide face-to-face counseling, psychotherapy, and skills training services to the eligible individuals for symptom reduction/ behavior management of mental health conditions and addictive diseases according to the individualized service plan. Services are provided to individuals in a group setting. Services may include counseling, therapy, and/or skills training/education for the individuals in the group regarding mental health and substance abuse disorders, problem solving, interpersonal, communication, relapse prevention, and coping skills; adaptive behaviors and skills; and skills and abilities necessary to access and benefit from community resources and natural support systems. These services may be provided in a clinic or outside the clinic setting in the community. Levels 1-5 practitioners may provide components of this service as applicable and appropriate to the practitioner's scope of practice.

### **Medication Administration**

Medication Administration is the giving or administration of an oral or injectable medication. Medication administration includes educating the individual about their medications, assessment of the individual's physical and behavioral status prior to medication administration, and determination of whether to administer the medication or refer the individual to the physician for medication review. Service plans which include these services must be authorized by a physician. These services may be provided in a clinic or outside the clinic setting in the community. Levels 2-5 practitioners may provide components of this service as applicable and appropriate to the practitioner's scope of practice.

### **Intensive Family Intervention**

Intensive Family Intervention is a time-limited, community-based, intensive behavioral health, team-based intervention delivered to children and youth with emotional disturbances or co-occurring emotional disturbances and substance use disorders. Services are directed towards the identified youth and his or her behavioral health needs and goals as identified in the individualized recovery plan. Services include therapeutic and rehabilitative interventions with the individual and family to correct or ameliorate symptoms of mental health and/or substance abuse conditions and to reduce the likelihood of the need for more intensive/restrictive services. These services may be provided in or outside the clinic setting but services are delivered primarily in the family's home and promote a family-based focus in order to evaluate the nature of the difficulties, defuse behavioral health crises, intervene to reduce the likelihood of a recurrence, ensure linkage to needed community services and resources, and improve the individual child's/adolescent's ability to self-recognize and self-manage behavioral health issues, as well as the parents'/responsible caregivers' skills to care for their youth's mental health and addictive disease conditions. Specialized therapeutic and

rehabilitative interventions are available to address special areas such as problem sexual behaviors and the effects of domestic violence. Levels 2-5 practitioners may provide components of this service as applicable and appropriate to the practitioner's scope of practice.

### **Psychosocial Rehabilitation**

A therapeutic, rehabilitative, skill building and recovery-promoting service for individuals to gain the skills necessary to allow them to remain in or return to naturally-occurring community settings and activities. The service is provided in individual and group settings to assist individuals in restoring maximum possible functional level by improving social, interpersonal, problem-solving, coping, and communication skills. Services include, but are not limited to: didactic training, structured skills practice, skills training and coaching techniques focusing on the development of problem-solving abilities, social and communication skills, medication self-management abilities and functional abilities. These services may be provided in a clinic or outside the clinic setting in the community. Levels 1-5 practitioners may provide components of this service as applicable and appropriate to the practitioner's scope of practice.

### **Case Management Support & Services**

Case Management Support & Services consist of mental health rehabilitative services and supports necessary to assist the adult in achieving rehabilitative and recovery goals as identified in the individualized service plan. The focus of the interventions include assisting the individual in identification of service needs, minimizing the negative effects of symptoms of mental health conditions and addictive diseases which interfere with the consumer's daily living skills, independent functioning and personal development; developing strategies and supportive interventions for avoiding out-of-home placement or the need for more intensive services; assisting consumers to increase social support skills that ameliorate life stresses resulting from the consumer's disability and coordinating rehabilitative services as specified in the individualized service plan. These services may be provided in a clinic or outside the clinic setting in the community. Levels 4-5 practitioners may provide components of this service as applicable and appropriate to the practitioner's scope of practice.

### **Intensive Customized Care Coordination**

Intensive Customized Care Coordination is a high-fidelity, recovery and resiliency focused intervention in which coaching and skill building for youth with severe emotional disturbances and the parent/caregiver are provided to empower their self-activation and self-management of their personal and family wellness, stability and independence. The healthcare practitioner rendering Intensive Customized Care Coordination (IC3) utilizes multiple strength-based approaches and interrelated activities to identify how the youth's and their family members' capacity for exercising self-determination, self-activation, and self-actualization can be tapped to restore esteem, hope, and coping skills. The service provides a broad range of rehabilitative supports to restore functioning which has been impacted by the youth's condition. Supports include interventions such as coaching and skills-building to



improve and practice skills regarding accessing behavioral healthcare, communicating health needs, and adopting behaviors for rebuilding relationships with friends, family, communities, etc. The IC3 practitioner's overall approach is to address functional improvement outcomes by identifying, planning, documenting, coordinating, securing, and reviewing the delivery of appropriate services through a wraparound approach that simultaneously infuses and evolves the empowerment and skills of the family to assume greater control and management of the youth's behavioral health condition. As a result of the rehabilitation and skills-building described above, the youth and family begin practicing and ultimately assuming personal authority for self-management of needed services.

These services may be provided in or outside the clinic setting, but services are delivered primarily in the family's home and in community settings natural and conducive to the needs and preferences of the individual and family. Levels 1-5 practitioners may provide components of this service as applicable and appropriate to the practitioner's scope of practice.

### **Community Support Services**

Specific to youth, Community Support Services consist of mental health and substance abuse rehabilitative services and supports necessary to assist the youth in achieving resiliency and recovery goals as identified in the individualized service plan. The service includes skills training in a variety of areas including problem-solving, interpersonal, communication, and community coping skills, including adaptation to home, school and community environments; symptom monitoring and management. The focus of the interventions include assisting the youth in identification of service needs, minimizing the negative effects of symptoms of mental health conditions and addictive diseases which interfere with the individual's daily living skills, independent functioning and personal development; developing strategies and supportive interventions for avoiding out-of-home placement or the need for more intensive services; assisting youth to increase social support skills that ameliorate life stresses resulting from the illness and coordinating rehabilitative services as specified in the individualized service plan. These services may be provided in a clinic or outside the clinic setting in the community. Levels 1-5 practitioners may provide this service as appropriate under approved scope of practice by practitioner type.

### **Addictive Diseases Support Services**

Specific to youth and adults with addictive disease issues, Addictive Diseases Support Services consist of substance abuse recovery services and supports necessary to assist the person in achieving recovery goals as identified in the individualized service plan. The service includes skills training in a variety of areas including identifying risk factors, problem-solving, interpersonal, communication, self-care and coping skills, including adaptation to home, school and work environments; including relapse planning and prevention, and aftercare. The focus of the interventions include engagement, assisting the individual in identification of service needs, minimizing the negative effects of addiction and use which interfere with the individual's daily living skills, motivational enhancement, and

personal development; developing strategies and supportive interventions for avoiding out-of-home placement or the need for more intensive services; practicing personal responsibility, healthy behaviors and choice-making, assisting individuals to practice and increase social support skills that ameliorate life stresses resulting from the individual's use and coordinating recovery services as specified in the individualized service plan. These services may be provided in a clinic or outside the clinic setting in the community. Levels 1- 5 practitioners may provide this service.

### **Peer Support**

Peer Support provides structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills, by Certified Peer Specialists under the direct supervision of a behavioral health professional. Youth and Adults actively participate in decision-making and services operation. Services are directed toward achievement of the specific, individualized, and result-oriented goals defined by the individual and specified in the Individual Recovery Plan. The service is provided under the direct supervision of a Behavioral Health Professional. The Peer Support service actively engages and empowers the participant and his/her identified supports in leading and directing the design of the service plan and thereby ensures that the plan reflects the needs and preferences of the individual with the goal of active participation in this process. Additionally, this service provides support and coaching interventions to individuals to promote recovery and healthy lifestyles and to reduce identifiable behavioral health and physical health risks and increase healthy behaviors intended to prevent the onset of disease or lessen the impact of existing chronic health conditions by teaching more effective management techniques that focus on the individual's self-management and decision making about healthy choices which ultimately extend the members' lifespan. The interpersonal interactions and activities within the program are directed, supervised, guided and facilitated by the Behavioral Health Professional in such a way to create the therapeutic community or therapeutic effect required to achieve individual treatment goals. These services may be provided in a clinic or outside the clinic setting in the community. Peer practitioners include individuals with lived experience with mental health conditions, severe emotional disturbances, substance use disorders, as well as parents providing support to other parents of those with behavioral health conditions. All certified peer specialists are required to hold current certification from the Georgia Department of Behavioral Health and Developmental Disabilities. Levels 4-5 practitioners may provide this service.

### **Community Living Supports**

The Community Living Supports service provides four levels of support and service intensity which are medically required by an adult to remain in a community-based residence. The goals of the service are to restore and develop skills in functional areas which interfere with individual's ability to live in the community, to support the person to live independently, and to support the person to independently participate in social, interpersonal or community activities. Activities that are considered necessary to remain in the community include, but

are not limited to: supporting housing retention (such as crisis coping skills, dispute resolution and peer mentoring); building and maintaining independent living skills (such as meal planning and preparation, household cleaning, shopping, budgeting, community resource access and utilization and wellness, recreational and social activities); providing support to access and attend mental health, medical, dental and substance abuse appointments and treatment; providing support to access and follow-through with medical and non-medical transportation; to develop and support the maintenance of social relationships which provide natural supports to prevent escalation of symptoms into crisis situations; and monitoring and/or directly providing personal care services. All recovery-building activities are intended to support successful community living through utilization of skills training, cuing and/or guided supervision as identified in the person-centered service plan.

This service does not include care or treatment in an Institute for Mental Diseases. Services are provided in the community or in the person's residence which may be his/her own home, personal care home, or another community living situation. Providers are required to meet all applicable licensure requirements, hold a current license and, for practitioners, adhere to scope of practice definitions of licensure/certification boards. Levels 1-5 practitioners may provide elements of this service as appropriate to the model according to scope of practice by practitioner type.

#### **Task-Oriented Rehabilitation Services**

Task-Oriented Rehabilitation Services provide rehabilitative supports with the goals of successfully focusing on tasks and task-completion, promoting recovery/wellness, preventing the escalation of a mental health condition into a crisis situation or into a chronic/significantly disabling disorder, improving community-based functioning, and alleviating symptoms, and decreasing isolation. The goal of the service is to help people with the most severe mental health disabilities be prepared for community-living/activities which may ultimately result in employability. This service includes developing the person's skill-sets in pacing/communicating/accommodating mental illness while working; offering positive role modeling/mentoring specific to a working-individual with a mental illness; motivating the individual to develop meaningful roles while managing a mental illness; mitigating any learned helplessness associated with the individual's chronic mental illness; understanding work stress and its impact on the person's own recovery process, and supporting the individual in developing work-appropriate relationships with coworkers and supervisors. This service may be provided in a clinic or outside the clinic setting in the community. Levels 4-5 practitioners may provide this service.

#### **Assertive Community Treatment (ACT)**

ACT is an intensive behavioral health service for individuals discharged from a hospital after multiple\extended stays, or who, because of their illness, have not previously been successful in engaging in traditional outpatient treatment and rehabilitative supports. Specific interventions provided to participants are included on the individualized recovery plan (IRP)

as medically necessary and include a comprehensive and integrated set of interventions including psychiatric and nursing services; support and assistance in restoration and maintenance of daily living skills (grooming, personal hygiene, nutrition; health and mental health education; medication management and monitoring; self-medication training and support; money management and maintenance of the living environment); relapse prevention skills training and substance abuse counseling; problem-solving, social, interpersonal, and communication skills training; development of appropriate personal support networks; telephone and face-to-face monitoring and counseling/crisis intervention services; and symptom assessment, management and individual supportive therapy; psychosocial rehabilitation and skill development; consultation and psycho-educational support for individuals and their families.

The composition of the team includes the following practitioners: Psychiatrist, Registered Nurse, Certified Addiction Counselor, Certified Peer Specialist, one licensed practitioner who must be either a Psychologist, Licensed Clinical Social Workers, Licensed Professional Counselors, or Licensed Marriage and Family Therapy, and at least two other team members, such as Licensed Associate Marriage and Family Therapists, Licensed Associate Professional Counselors, and Licensed Master's Social Workers and certified paraprofessionals, who must work under the supervision of the licensed staff. The team may also include any additional staff members listed in the practitioner table below. Psychiatrists, physicians, physician's assistants, nurse practitioners, and clinical nurse specialists—psychiatry/mental health will provide medical services including psychiatric diagnosis and treatment including management of pharmacotherapy regimens. Registered nurses, licensed practical nurses and advanced practice nurses will provide necessary nursing care, health evaluation/reevaluation, and medication administration. Licensed professionals, including Psychologists, Licensed Clinical Social Workers, Licensed Professional Counselors, or Licensed Marriage and Family Therapists and their supervisees on the team, including Licensed Associate Marriage and Family Therapists, Licensed Associate Professional Counselors, Licensed Master's Social Workers and certified addictions counselors will provide any needed counseling. These professionals as well as certified peer specialists and trained paraprofessionals will provide skills training and psycho-educational services. These interventions may be provided in a clinic setting but must be primarily provided in non-office settings, such as the participant's home, and are available 24 hours a day/seven days a week. There are two billing models to accommodate a fully-staffed model and a model with staffing variation for areas in which access calls for different team capacity to meet the specialized needs of the population and community at a less-intensive staffing pattern, while maintaining model integrity.

This service may be provided in a clinic or outside the clinic setting in the community. Levels 1-5 practitioners may provide elements of this service as appropriate to the model and under approved scope of practice by practitioner type.

of the client about medical and nutritional issues, and provision of medication education to the consumer and family and training for self-administration of medication. Service plans which include these services must be authorized by a physician. These services may be provided in a clinic or outside the clinic setting in the community.

Distinct Billable Services:

Description Nursing Assessment / Evaluation	Practitioners Practitioner Level 2: Advanced Practice Registered Nurse (APRN)
	Practitioner Level 3: Registered Nurse (RN),
RN Services, up to 15 minutes	Practitioner Level 4: Licensed Practical Nurse (LPN) Practitioner Level 2: Advanced Practice Registered Nurse (APRN)
	Practitioner Level 3: Registered Nurse (RN)
LPN/LVN Services, up to 15 minutes Health and Behavior Assessment (e.g. health-focused clinical interview, behavioral observations, psycho-physiological monitoring, health-oriented questionnaires). each 15 minutes face-to-face with the patient, <u>initial assessment</u>	Practitioner Level 4: Licensed Practical Nurse (LPN) Practitioner Level 2: Advanced Practice Registered Nurse (APRN)
	Practitioner Level 3: Registered Nurse (RN), Licensed Dietician (LD)
Health and Behavior Assessment (e.g. health-focused clinical interview, behavioral observations, psycho-physiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient, <u>re-assessment</u>	Practitioner Level 4: Licensed Practical Nurse (LPN) Practitioner Level 2: Advanced Practice Registered Nurse (APRN)
	Practitioner Level 3: Registered Nurse (RN), Licensed Dietician (LD)
Health and Wellness Supports (Behavioral Health Prevention Education Service (Delivery Of Services With Target Population To Affect Knowledge, Attitude and/or Behavior)	Practitioner Level 4: Licensed Practical Nurse (LPN) Practitioner Level 2: Advanced Practice Registered Nurse (APRN)
	Practitioner Level 3: Registered Nurse (RN), Licensed Dietician (LD)
	Practitioner Level 4: Licensed Practical Nurse (LPN)

Detoxification Services

These are an outpatient set of services designed to achieve safe and comfortable withdrawal from mood altering drugs (including alcohol) and to facilitate patient's transition into ongoing treatment and recovery, which may be delivered in an office setting, health care, licensed residential setting or addiction treatment facility by practitioners who specialize in addiction treatment. Service includes supervision, observation, and support for patients who

are intoxicated or experiencing withdrawal. The intensive level includes medically directed evaluation and withdrawal management. Services are directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual into the worlds of work, education and family life.

This service does not include medical care in an Institute for Mental Diseases. Providers are required to meet all applicable licensure requirements for drug treatment agencies, hold a current license and, for practitioners, adhere to scope of practice definitions of substance treatment licensure/certification boards.

#### Distinct Billable Services:

Description	Practitioners
Alcohol and/or drug services, Ambulatory Detoxification	Practitioner Level 2: PA or Advanced Practice Registered Nurse (APRN)
	Practitioner Level 3: Registered Nurse (RN)
Alcohol and/or drug services; Sub-acute Detoxification (Residential Addiction Program Outpatient)	Practitioner Level 4: Licensed Practical Nurse (LPN). Level 1 (license is not required in State law)
	<ul style="list-style-type: none"> <li>• Practitioner Level 1: Physician/Psychiatrist</li> <li>• Practitioner Level 2: Psychologist, APRN, PA</li> <li>• Practitioner Level 3: LCSW, LPC, LMFT, RN</li> <li>• Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPS, CPRP. CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology</li> <li>• Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above</li> </ul>
	Level II (licensed by the State's Health Facilities Regulation authority as a Drug Treatment and Prevention program)
	<ul style="list-style-type: none"> <li>• Practitioner Level 1: Physician/Psychiatrist</li> </ul>

- Practitioner Level 2: Psychologist, APRN, PA
- Practitioner Level 3: LCSW, LPC, LMFT, RN
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPS, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology
- Practitioner Level 5: CPS, PP, CPRP, CAC-1, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above

Alcohol and/or drug services; Acute Detoxification  
(Residential Addiction Program Outpatient)

Level III ((licensed by the State's Health Facilities Regulation authority as a Drug Treatment and Prevention program and/or the Department of Behavioral Health and Developmental Disabilities as a Crisis Stabilization Unit)

- Practitioner Level 1: Physician/Psychiatrist
- Practitioner Level 2: Psychologist, APRN, PA
- Practitioner Level 3: LCSW, LPC, LMFT, RN
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPS, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology
- Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above

### **Individual Outpatient Services**

Individual outpatient services provide face-to-face counseling and psychotherapy services for symptom/behavior management of mental health problems and addictive diseases. Services are directed toward symptom reduction and restoration of functional abilities as delineated in the individualized service plan. These services may be provided in a clinic or outside the clinic setting in the community.

#### **Distinct Billable Services:**

##### **Description**

Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately 20-30 minutes face-to-face with patient (appropriate license required).

Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately 45-50 minutes face-to-face with patient (appropriate license required).

Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately 75-80 minutes face-to-face with patient (appropriate license required)

individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20-30 minutes face-to-face with patient (appropriate license required)

Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45-50 minutes face-to-face with patient (appropriate license required)

Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75-80 minutes face-to-face with patient (appropriate license required)

##### **Practitioner**

Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 2 rate)

Practitioner Level 2: Psychologist, CNS-PMH

Practitioner Level 3: LCSW, LPC, LMFT, RN

Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addiction counselors may only perform these functions related to treatment of addictive diseases).

Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases and under the supervision of one of the licensed/credentialed professionals above).

### **Family Outpatient Services**

Family outpatient services provide face-to-face counseling, psychotherapy, and skills training services to the eligible individuals and their families for symptom reduction/behavior management of mental health problems and addictive diseases according to the



individualized service plan. Services are directed toward the identified individual and the restoration of adaptive behaviors and skills, functional abilities, and the interpersonal skills and functioning of the individual within the family unit to the maximum extent possible. Services include counseling, therapy, and/or education and training for the individual and family members (for the benefit of the individual) regarding mental health and substance abuse disorders and prescribed medication (including adherence to medication regimen); problem solving, interpersonal, communication and coping skills; adaptive behaviors and skills; and skills and abilities necessary to access community resources and support systems. These services may be provided in a clinic or outside the clinic setting in the community.

Distinct Billable Services:

<p>Description            Family Outpatient Services - Behavioral health counseling and therapy (with client present)            Family Outpatient Services - Behavioral health counseling and therapy (without client present)            Family Psychotherapy without the patient present</p>	<p>Practitioners            Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 2 rate)             Practitioner Level 2: Psychologist, CNS-PMH             Practitioner Level 3: LCSW, LPC, LMFT, RN             Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addiction counselors may only perform these functions related to treatment of addictive diseases).</p>
<p>Conjoint Family Psychotherapy with the patient present</p>	<p>Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases and under the supervision of one of the licensed/credentialed professionals above).            Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)</p>
<p>Family - Skills training and development</p>	<p>Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)             Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)             Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist's supervisee/trainee with at least a</p>

Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology

Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above

### **Group Outpatient Services**

Group outpatient services provide face-to-face counseling, psychotherapy, and skills training services to the eligible individuals for symptom reduction/ behavior management of mental health problems and addictive diseases according to the individualized service plan. Services are provided to individuals in a group setting. Services may include counseling, therapy, and/or skills training/education for the individuals in the group regarding mental health and substance abuse disorders; problem solving, interpersonal, communication, relapse prevention, and coping skills; adaptive behaviors and skills, and skills and abilities necessary to access and benefit from community resources and natural support systems. These services may be provided in a clinic or outside the clinic setting in the community.

#### Distinct Billable Services:

Description	Practitioners
Group Counseling - Behavioral health counseling and therapy	Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 2 rate)
Group Counseling - Behavioral health counseling and therapy	Practitioner Level 2: Psychologist, CNS-PMH
Group Counseling - Behavioral health counseling and therapy	Practitioner Level 3: LCSW, LPC, LMFT, RN
Group Counseling - Behavioral health counseling and therapy	Practitioner Level 4: LMSW; LAPC; LAMFT;

Group Psychotherapy other than of a multiple family group	Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (may only perform these functions related to treatment of addictive diseases).
	Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases and under the supervision of one of the licensed/credentialed professionals above) Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)
	Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)
	Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)
Group Skills training and development	Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, Psychology. Or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, (continued on next page) CADC, CCADC, GCADC (II, III); PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology  Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III). Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above

### **Medication Administration**

Medication Administration is the giving or administration of an oral or injectable medication. Medication administration includes educating the individual about their medications, assessment of the consumer's physical and behavioral status prior to medication administration, and determination of whether to administer the medication or refer the consumer to the physician for medication review. Service plans which include these services must be authorized by a physician. These services may be provided in a clinic or outside the clinic setting in the community.

Distinct Billable Services:

Description	Practitioners
Comprehensive Medication Services	Practitioner Level 2: Advanced Practice Registered Nurse (APRN), PA, Pharmacist
	Practitioner Level 3: Registered Nurse (RN)
	Practitioner Level 4: Licensed Practical Nurse (LPN)
	Practitioner Level 5: Qualified Medication Aide (QMA can do only when working in a community living arrangement)
Therapeutic, prophylactic or diagnostic injection	Practitioner Level 2: Advanced Practice Registered Nurse (APRN), PA, Pharmacist
	Practitioner Level 3: Registered Nurse (RN)
	Practitioner Level 4: Licensed Practical Nurse (LPN)
Alcohol, and/or drug services, methadone administration and/or service (provision of the drug by a licensed program)	Practitioner Level 2: Advanced Practice Registered Nurse (APRN), PA, Pharmacist
	Practitioner Level 3: Registered Nurse (RN)
	Practitioner Level 4; Licensed Practical Nurse (LPN)

**Intensive Family Intervention**

This is a time-limited, community-based, intensive behavioral health intervention delivered to children and youth with emotional disturbances or co-occurring emotional disturbances and substance use disorders. Services are directed towards the identified youth and his or her behavioral health needs and goals as identified in the individualized service plan. Services include therapeutic and rehabilitative interventions with the individual and family to correct or ameliorate symptoms of mental health and/or substance abuse problems and to reduce the likelihood of the need for more intensive/restrictive services. These services may be provided in or outside the clinic setting but services are delivered primarily in the family's home and promote a family-based focus in order to evaluate the nature of the difficulties, defuse behavioral health crises, intervene to reduce the likelihood of a recurrence, ensure linkage to needed community services and resources, and improve the individual child's/adolescent's ability to self-recognize and self-manage behavioral health issues, as well as the parents/responsible caregivers' skills to care for their children's mental health and addictive disease problems. Specialized therapeutic and rehabilitative interventions are available to address special areas such as problem sexual behaviors and the effects of domestic violence.

Distinct Billable Services:

## Description

Intensive Family Intervention

## Practitioners

Practitioner Level 2: Psychologist, CNS-PMH  
(reimbursed at Level 3 rate)

Practitioner Level 3: LCSW, LPC, LMFT, RN

Practitioner Level 4: LMSW; LAPC; LAMFT;  
Psychologist/LCSW/LPC/LMFT's supervisee/trainee  
with at least a Bachelor's degree in one of the helping  
professions such as social work, community counseling,  
counseling, psychology, or criminology, functioning  
within the scope of the practice acts of the state; MAC,  
CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP,  
CAC-I or Addiction Counselor Trainees with at least a  
Bachelor's degree in one of the helping professions such  
as social work, community counseling, counseling,  
psychology, or criminology (addictions counselors may  
only perform counseling functions related to treatment of  
addictive diseases).

Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I,  
II, or III), Addiction Counselor Trainees with high school  
diploma/equivalent under supervision of one of the  
licensed/credentialed professionals above

**Psychosocial Rehabilitation**

A therapeutic rehabilitative social skill building service provided to assist individuals in restoring the individual to the maximum possible functional level by improving social, interpersonal, problem-solving, coping, and communication skills. Services include, but are not limited to: didactic training, structured practice, skills training and coaching techniques focusing on the development of problem-solving abilities, social and communication skills, medication self-management abilities and functional abilities. These services may be provided in a clinic or outside the clinic setting in the community.

Distinct Billable Services:

## Description

Psychosocial Rehabilitation

## Practitioners

Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)

Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)

Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)

Practitioner Level 4: LMSW; LAPC; LAMFT;  
 Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPS, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology

Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above

### **Case Management Support & Services**

Case Management Support & Services consist of mental health rehabilitative services and supports necessary to assist the adult in achieving rehabilitative and recovery goals as identified in the individualized service plan. The focus of the interventions include assisting the individual in identification of service needs, minimizing the negative effects of symptoms of mental health problems and addictive diseases which interfere with the consumer's daily living skills, independent functioning and personal development; developing strategies and supportive interventions for avoiding out-of-home placement or the need for more intensive services, assisting consumers to increase social support skills that ameliorate life stresses resulting from the consumer's disability and coordinating rehabilitative services as specified in the individualized service plan. These services may be provided in a clinic or outside the clinic setting in the community.

#### **Distinct Billable Services:**

Description	Practitioners
Case Management Supports & Services	<p>Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)</p> <p>Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)</p> <p>Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)</p> <p>Practitioner Level 4: LMSW; LAPC; LAMFT;            Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; PP; CPS; CPRP; or, when an individual served is co-occurring diagnosed with a mental illness and addiction issue, a MAC, CAC-II, CADC, CCADC,</p>

GCADC (II, III) or CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology can provide service,

Practitioner Level 5: CPS; PP; CPRP; or, when an individual served is co-occurring diagnosed with a mental illness and addiction issue CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above

### **Community Support Services**

Specific to youth, Community Support Services consist of mental health and substance abuse rehabilitative services and supports necessary to assist the youth in achieving resiliency and recovery goals as identified in the individualized service plan. The service includes skills training in a variety of areas including problem-solving, interpersonal, communication, and community coping skills, including adaptation to home, school and community environments; symptom monitoring and management. The focus of the interventions include assisting the youth in identification of service needs, minimizing the negative effects of symptoms of mental health problems and addictive diseases which interfere with the consumer's daily living skills, independent functioning and personal development; developing strategies and supportive interventions for avoiding out-of-home placement or the need for more intensive services; assisting youth to increase social support skills that ameliorate life stresses resulting from the illness and coordinating rehabilitative services as specified in the individualized service plan. These services may be provided in a clinic or outside the clinic setting in the community.

#### **Distinct Billable Services:**

Description Community Support Services	Practitioners Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)  Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)  Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)  Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, IN); PP, CPS, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community
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counseling, counseling, psychology, or criminology

Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above

### **Addictive Diseases Support Services**

Specific to youth and adults with addictive disease issues, Addictive Diseases Support Services consist of substance abuse recovery services and supports necessary to assist the person in achieving recovery goals as identified in the individualized service plan. The service includes skills training in a variety of areas including identifying risk factors, problem-solving, interpersonal, communication, self-care and coping skills, including adaptation to home, school and work environments, including relapse planning and prevention, and aftercare. The focus of the interventions include engagement, assisting the individual in identification of service needs, minimizing the negative effects of addiction and use which interfere with the consumer's daily living skills, motivational enhancement, and personal development; developing strategies and supportive interventions for avoiding out-of-home placement or the need for more intensive services; practicing personal responsibility, healthy behaviors and choice-making, assisting consumers to practice and increase social support skills that ameliorate life stresses resulting from the consumer's use and coordinating recovery services as specified in the individualized service plan. These services may be provided in a clinic or outside the clinic setting in the community.

#### **Distinct Billable Services:**

Description	Practitioners
Addictive Diseases Support Services	Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)
	Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)
	Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)
	Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPS, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology
	Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above



**Peer Support**

This service provides structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills, by Certified Peer Specialists under the direct supervision of a behavioral health professional. Consumers actively participate in decision-making and services operation. Services are directed toward achievement of the specific, individualized, and result-oriented goals defined by the individual and specified in the Individual Service Plan (ISP), and provided under the direct supervision of a Behavioral Health Professional. The Peer Support service actively engages and empowers the participant and his/her identified supports in leading and directing the design of the service plan and thereby ensures the plan reflects the needs and preferences of the individual. Additionally, this service provides support and coaching interventions to individuals to promote recovery and healthy lifestyles and to reduce identifiable behavioral health & and physical health risks and increase healthy behaviors intended to prevent the onset of disease or lessen the impact of existing chronic health conditions by teaching more effective management techniques that focus on the individual's self-management and decision making about healthy choices which ultimately extend the members' lifespan. The interpersonal interactions and activities within the program are directed, supervised, guided and facilitated by the Behavioral Health Professional in such a way to create the therapeutic community or therapeutic effect required to achieve individual treatment goals. These services may be provided in a clinic or outside the clinic setting in the community, Practitioners are required to hold current certification from the Georgia Certified Peer Support Project

**Distinct Billable Services:**

Description  
Peer Support

**Practitioners**

Practitioner Level 4: LMSW; LAPC; LAMFT;  
Psychologist LCSW/LPC/LMFT's supervisee/trainee;  
and CPSs, PPs with at least a Bachelor's degree in one  
of the helping professions such as social work,  
community counseling, counseling, psychology, or  
criminology, functioning within the scope of the  
practice acts of the state

Practitioner Level 5: CPS, PP under supervision of a  
Physician, Psychologist, LCSW, LPC, LMFT, RN,  
APRN, PA, LMSW, LAPC, or LAMFT

Practitioner Level 4: CPSs with at least a Bachelor's  
degree

Health and Wellness Supports (Behavioral Health  
Prevention Education Service (Delivery Of Services  
With Target Population To Affect Knowledge, Attitude  
and/or Behavior)

Practitioner Level 5: CPS

### Community Living Supports

This service provides four levels of support and service intensity which are medically required by an adult to remain in a community-based residence. The goals of the service are to restore and develop skills in functional areas which interfere with consumer's ability to live in the community, to support the person to live independently, and to support the person to independently participate in social, interpersonal or community activities. Activities that are considered necessary to remain in the community include, but are not limited to: supporting housing retention (such as crisis coping skills, dispute resolution and peer mentoring); building and maintaining independent living skills (such as meal planning and preparation, household cleaning, shopping, budgeting, community resource access and utilization and wellness, recreational and social activities); providing support to access and attend mental health, medical, dental and substance abuse appointments and treatment; providing support to access and follow-through with medical and non-medical transportation; to develop and support the maintenance of social relationships which provide natural supports to prevent escalation of symptoms into crisis situations; and monitoring and/or directly providing personal care services. All recovery-building activities are intended to support successful community living through utilization of skills training, cuing and/or guided supervision as identified in the person-centered service plan.

This service does not include care or treatment in an institute for Mental Diseases. Services are provided in the community or in the person's residence which may be his/her own home, personal care home, or another community living situation. Provider qualifications to provide these services are ensured by provider compliance with requirements and standards of the national accreditation Commission on Accreditation for Rehabilitation Facilities (CARF), which specifically accredits rehabilitative Provider Agencies in the areas of behavioral health community services. Providers are required to meet all applicable licensure requirements, hold a current license and, for practitioners, adhere to scope of practice definitions of licensure/certification boards.

Description	Levels
Community Living Supports	<ul style="list-style-type: none"> <li data-bbox="656 1161 1422 1451">• CLS Level I is intensive and provides 24/7/365 awake staff support generally in a licensed community-living setting (in no case exceeding 16 beds). In order to directly support the individual, there will be a minimum of five hours weekly of skills training, community integration activities, and/or personal services provided to the person if indicated on the individual supports plan. This skills training is provided by one or more Community Living Supports specialists who may be practitioner Level 3, 4 or 5.</li> <li data-bbox="656 1486 1422 1608">• CLS Level II is intensive and provides 24/7/365 staff support generally in a licensed community-living setting in no case exceeding 16 beds). In order to directly support the individual, there will be a minimum of five hours</li> </ul>

weekly of skills training, community integration activities, and/or personal services provided to the person if indicated on the individual supports plan. This skills training is provided by one or more Community Living Supports specialists who may be practitioner Level 3, 4 or 5.

- CLS Level III is semi-independent support which provides 36 hours per week staff support generally in a licensed community-living setting (in no case exceeding 16 beds). In order to directly support the individual, there will be a minimum of three hours per week of skills training, community integration activities, and/or personal services provided to the person if indicated on the individual supports plan. This skills training is provided by one or more Community Living Supports specialists who may be practitioner Level 4 or 5.
- CLS IV is support to provide a minimum of one face-to-face contact and an average of 10 15-minute units per week of skills training, community integration activities, and/or personal services provided to the person as indicated on the individual supports plan. A Community Living Supports specialist is a practitioner Level 5 operating on 65% productivity and is on call and available to consumers 24/7/365. This skills training is provided by one or more Community Living Supports specialists who may be practitioner Level 4 or 5.

### **Task-Oriented Rehabilitation Services**

Task-Oriented Rehabilitation Services provide rehabilitative supports with the goals of successfully focusing on tasks and task-completion, promoting recovery/wellness, preventing the escalation of a mental health problem into a crisis situation or into a chronic/significantly disabling disorder, improving functioning, and alleviating symptoms, and decreasing isolation. The goal of the service is to help people with the most severe mental health disabilities be prepared for community-living/activities, which may ultimately result in employability. This service includes developing the person's skill-sets in pacing/communicating/accommodating mental illness while working; offering positive role modeling/mentoring specific to a working-individual with a mental illness; motivating the individual to develop meaningful roles while managing a mental illness; mitigating any learned helplessness associated with the individual's chronic mental illness; understanding work stress and its impact on the person's own recovery process, and supporting the individual in developing work-appropriate relationships with coworkers and supervisors.

Description	Practitioners
Task-Oriented Rehabilitation Services	Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social

work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP. CPS, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology

Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above

### **Assertive Community Treatment (ACT)**

ACT is an intensive behavioral health service for consumers discharged from a hospital after multiple or extended stays, or who are difficult to engage in treatment. Specific interventions provided to participants are included on the individualized recovery plan (IRP) as medically necessary and include a comprehensive and integrated set of interventions including psychiatric and nursing services; support and assistance in restoration and maintenance of daily living skills (grooming, personal hygiene, nutrition; health and mental health education; medication management and monitoring; self-medication training and support; money management and maintenance of the living environment); relapse prevention skills training and substance abuse counseling; problem-solving, social, interpersonal, and communication skills training; development of appropriate personal support networks; telephone and face-to-face monitoring and counseling/crisis intervention services; and symptom assessment, management and individual supportive therapy; psychosocial rehabilitation and skill development; consultation and psycho-educational support for individuals and their families.

The composition of the team includes the following practitioners: Psychiatrist, Registered Nurse, Certified Addiction Counselor, Certified Peer Specialist, one licensed practitioner who must be either a Psychologist, Licensed Clinical Social Workers, Licensed Professional Counselors, or Licensed Marriage and Family Therapy, and at least two other team members, such as Licensed Associate Marriage and Family Therapists, Licensed Associate Professional Counselors, and Licensed Master's Social Workers and certified paraprofessionals, who must work under the supervision of the licensed staff. The team may also include any additional staff members listed in the practitioner table below. Psychiatrists, physicians, physician's assistants, nurse practitioners, and clinical nurse specialists---psychiatry/mental health will provide medical services including psychiatric diagnosis and treatment including management of pharmacotherapy regimens. Registered nurses, licensed practical nurses and advanced practice nurses will provide necessary nursing care, health evaluation/reevaluation, and medication administration. Licensed professionals, including Psychologists, Licensed Clinical Social Workers, Licensed Professional Counselors, or Licensed Marriage and Family Therapists and their supervisees on the team, including Licensed Associate Marriage and Family Therapists, Licensed Associate Professional Counselors. Licensed Master's

Social Workers and certified addictions counselors will provide any needed counseling. These professionals as well as certified peer specialists and trained paraprofessionals will provide skills training and psycho-educational services. These interventions may be provided in a clinic setting but must be primarily provided in non-office settings, such as the participant's home, and are available 24 hours a day/seven days a week. The model for areas designated as rural (less consumer demand) will have a less-intensive staffing pattern while maintaining model integrity.

Distinct Billable Services:

Description

Assertive Community Treatment

Practitioners

Practitioner Level 1: Physician/Psychiatrist

Practitioner Level 2: Psychologist, APRN, PA

Practitioner Level 3: LCSW, LPC, LMFT, RN

Practitioner Level 4: LMSW; LAPC; LAMFT;  
Psychologist/LCSW/LPC/LMFT's

Supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPS, CPRP, CAC-I or Addiction Counselor Trainees with Master's/Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addictions counselors may only perform counseling functions related to treatment of addictive diseases).

Practitioner Level 5: CPS, PP, CPRP, CAC-I,  
RADT (I, II, or III), Addiction Counselor

Trainees with high school diploma/equivalent under supervision of one of the licensed credentialed professionals above

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**AMOUNT, DURATION AND MORE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED  
TO THE CATEGORICALLY NEEDY**

15. a. Intermediate care facility services (other than such services to an institution for mental disease) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

Provided                              || No limitations  
 With limitations\*                      || Not Provided:

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

Provided                              || No limitations  
 With limitations\*                      || Not Provided:

16. Inpatient psychiatric facility services for individuals under 21 year of age.

Provided                               No limitations  
|| With limitations\*                      || Not Provided:

17. Nurse-midwife services

Provided                              || No limitations  
 With limitations\*                      || Not Provided:

18. Hospice care (in accordance with section 1905(o) of the Act).

|| Provided                              || No limitations                       Provided in accordance with section  
 With limitations\*                      || Not Provided:                      2302 of the Affordable Care Act

\* Description provided on attachment

15. a. NURSING FACILITY SERVICES

Prior to admission to a Nursing Facility, evaluation is provided for each patient. A physician's review is performed periodically to determine:

- the need for continued placement at this level of care.
- the adequacy, appropriateness and quality of services received.
- the feasibility of meeting the recipient's health and rehabilitative needs through alternative arrangements.

15. b. INTERMEDIATE CARE FACILITY SERVICES FOR THE MENTALLY RETARDED (ICFMR)

Prior to admission to an ICFMR, evaluation is provided for each patient. Independent professional review is performed periodically to determine:

- the need for continued placement at this level of care.
- the adequacy, appropriateness and quality of services received.
- the feasibility of meeting the recipient's health and rehabilitative needs through alternative arrangements.
- whether the recipient is receiving active treatment for mental retardation or related mental conditions.

State / Territory: GEORGIA

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16. Inpatient psychiatric facility services for individuals under 21 years of age (Psychiatric Residential Treatment Facility)

The covered Psychiatric Residential Treatment Facility (PRTF) services will be available to all Medicaid eligible individuals through the age of 21 (psych under 21 benefit) with emotional and behavioral issues and any co-occurring disorder.

***PRTF services will not be available to consumers that are involuntarily living in the secure custody of law enforcement, judicial, or penal systems and therefore would be considered inmates of a public institution as defined in Federal regulations.***

The facilities are institutions described as follows:

- 1) with a provider agreement with a State Medicaid Agency to provide the psychiatric inpatient services
- 2) accredited by JCAHO, CARF or COA
- 3) licensed in the state of Georgia as a specialty hospital specializing in intensive residential treatment services for individuals under 22 years of age.
- 4) meeting requirements in 42 CFR part 483, sub-part G, §483.350 through §483.376 and §441.151 through 441.182.

The services are described as and will include the following:

- 1) Short-term, intense, focused treatment programs that will address medical necessity related to the primary behavioral health diagnoses and promote a successful return by the child or adolescent to the community.
- 2) Discharge planning, including the family, significant other/s, community resources the youth will need once returned to their community and the referring organization.
- 3) Outcomes of the resident returning to the family or to another less restrictive community living situation.

A certificate of need is required prior to offering pediatric psychiatric services on an inpatient basis in a residential treatment facility.



**LIMITATIONS:**

17. Nurse-Midwife Services

Nurse-midwife services are provided as specified in the Policies and Procedures Manual for Nurse-Midwife Services.

The scope of service is the management and care of pregnant women and newborns throughout the maternity cycle to include uncomplicated pregnancy, labor, birth, and the sixty day postpartum period as well as services that midwives are authorized to perform under State Law that are outside the maternity cycle.

Providers must be currently licensed as registered professional nurses and be currently certified as nurse-midwives by the America College of Nurse-Midwives.

Non-covered services include:

Any procedure outside the legal scope of nurse-midwife services.

Obstetrical care rendered to recipients who arbitrarily travel to other states to bear children for non-medical reasons.

Assisting physicians during delivery.

Services identified as rural health clinic services are subject to policies and procedures governing the Rural Health clinic Program.

18. Hospice Care

Hospice care services are furnished by Medicare certified hospices enrolled in the Medicaid program. Services are available to eligible individuals who are certified as being terminally ill and having a medical prognosis that his or her life expectancy is six months or less.

An eligible individual must voluntarily elect this service and file an election statement with a Medicaid participating hospice provider,

Hospice coverage is available for an unspecified number of days, subdivided into four election periods as follows: Two periods of 90 days each, subsequent period of 30 days, and subsequent extension period of an unspecified number of days.

A recipient may revoke the election of hospice care at any time during the election period. Medicaid coverage of benefits waived during the election period is resumed.

State/Territory: Georgia

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE  
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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19. Case management services and Tuberculosis related services

- a. Case management services defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A, (in accordance with Section 1905 (a) (19) or Section 1915(g) of the Act).

Provided:  With limitations\*  
 Not provided.

- b. Special tuberculosis (TB) related services under Section 1902(z) (2) of the Act.

Provided:  With limitations\*  
 Not provided.

20. Extended services for pregnant women.

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

Additional coverage++

- b. Services for any other medical conditions that may complicate pregnancy

Additional coverage++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

\*Description provided on attachment.

State/Territory: GEORGIA

AMOUNT, DURATION AND SCOPE OF MEDICAL  
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21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act). Eligible

Provided:  No limitations\*  With limitations\*  
 Not provided.

22. Respiratory care services (in accordance with section 1902(e) (9)(A) through (C) of the Act).

Provided:  No limitations\*  With limitations\*  
 Not provided.

23. Certified Pediatric or family nurse practitioners' services.

Provided:  No limitations\*  With limitations\*

\*Description provided on attachment.

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**23. CERTIFIED PEDIATRIC OR FAMILY NURSE PRATITIONERS' SERVICES.**NURSE PRACTITIONER SERVICES.

## Limitations.

1. The scope of service for certified Pediatric Nurse Practitioners is the management and care of children up to 18 years of age for primary and preventive health care.

The scope of service for certified Family Nurse Practitioners is the management and care of children and adults for primary and preventive health care.

Providers must be currently licensed as registered professional nurses, be currently certified as Pediatric Nurse Practitioners or Family Nurse Practitioners by the appropriate certifying body and be registered with the Georgia Board of Nursing for the specialty.

2. The Medicaid program will not provide reimbursement to a nurse practitioner for the following:
  - a. Office visits which exceed 12 per recipient per calendar year unless medically justified.
  - b. Nursing home visits that exceed 12 per recipient per calendar year unless medically justified.
  - c. More than one hospital visit per patient per day of hospitalization, except when additional visits can be medically justified and approved.
1. Reimbursement for injectable drugs is restricted to those listed in the Physician Administered Drug List.

Prior Approval.

More than twelve medically necessary office or nursing home visits per year (January 1 through December 31) for any one recipient.

Non-Covered Services.

1. Laboratory services furnished by the State or a Public Laboratory.
2. Experimental services, drugs or procedures which are not generally recognized by the Advanced Nursing Profession, the Medical Profession, or the U. S. Public Health Service as acceptable treatment.
3. Any procedure outside the legal scope of Pediatric and Family Health Nurse Practitioner services.
4. Services not covered under the Physicians' Program.

## 19. CASE MANAGEMENT SERVICES

### Limitations

Case management providers must meet the conditions established by the Department of Human Resources (DHR) and contained in the DHR Grants-to-Counties Manual and the Division of Mental Health, Mental Retardation and Substance Abuse (MH/MR/SA) Policy Memorandum 40-01 and Standards Manual. Services are provided to eligible recipients who are emotionally or mentally disturbed, drug or alcohol abusers, and mentally retarded or developmentally disabled. Available service:

Demonstrated medically necessary case management services which are an integral part of aiding the eligible recipients to overcome their health related disabilities and to attain their highest level of independence or self-care.

Medically necessary is a term used to describe a service which is reasonably calculated to prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the recipient receiving the service.

The following criteria must be met prior to admission to service:

1. Physician order as evidenced in the Individualized Service Plan, and,
2. The client meets the Division of Mental Health, Mental Retardation and Substance Abuse criteria for Most-In-Need status, and,
3. One or more of the following:
  - a. the client has been discharged from "inpatient" service two or more times in the previous 12 months, or
  - b. the client is currently residing in a living arrangement financially supported by the Department of Human Resources, or
  - c. the client has a history of severe and disabling mental illness or substance abuse and is "homeless." Homeless is defined as: determination by area mental health, mental retardation and substance abuse service programs, by whatever means, that an individual is undomiciled,

7/1/88

TN No. 88-25      DATE/ RECEIPT 9/28/88  
 SUPERSEDES      DATE/APPROVED 1/18/89  
 TN No. 87-11      DATE/EFFECTIVE 7/1/88

i.e., one who lives with neither family nor in a board and care home, & single room occupancy hotel, a nursing home or in his/her home or apartment; has a history of persistent, continuous or intermittent use of shelter services; and is unable to secure permanent or stable housing, or

- d. the client is on an outpatient court ordered commitment status, or
  - e. the client would be eligible for services under the provisions of Title XIX (Medicaid) 2176 Waivers, or
  - f. the client is receiving Clozaril as a part of a treatment plan formulated by the Area Mental Health, Mental Retardation and Substance Abuse Program, and,
4. The client exhibits one or more of the following:
- a. Repeated, long term use of restrictive intensive care settings.
  - b. Noncompliance with treatment or failure to access needed services.
  - c. Frequent crisis episodes.
  - d. Multiple programs (dual diagnoses, medical fragility).
  - e. Need for multiple services and their coordination.
  - f. Lack or inadequacy of natural supports.

Prior Approval for case management service will be given by the Department of Human Resources to any enrolled provider on Form DMA-80, Prior Authorization Request.

Case Management Services Include:

1. Assessment of prescribed recommended services in the physician plan of care and identification of those services which have not been adequately assessed over time, resulting in client deterioration and the use of unexplained intensive care services such as emergency crisis intervention or hospitalization.
2. Development of specific 24 hour service plan for each client to assure adequate medical, pharmacy and other needed services.
3. Establishment of relationships between patient and medically necessary services.
4. Assisting the patient in attaining or retaining capability for independence or self care. Assistance will be limited

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to management and/or coordination efforts and will not include the direct provision of services by the case manager.

5. Monitoring service delivery to continually evaluate patient status and quality of services provided.
6. Discharge planning coordination to hospital inpatients. This is the only service provided hospital inpatients.

Non-Covered Services

No services provided in nursing homes or prisons will be covered.

No counseling services will be provided by case managers.

No services to enrolled clients in an Institution for Mental Diseases (IMD) Units will be covered, however, clients may remain enrolled in the case management program and services resumed upon discharge from an IMD Unit.

Medicaid will not pay for Case Management services that duplicate case management services provided to eligible recipients through the Early Intervention Case Management Program.

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## CHILDBIRTE EDUCATION PROGRAM

a. +2 Definition of Services:

The Childbirth Education Program is made up of two components. The first component is a series of six (6) childbirth preparation classes. These classes are designed to provide information concerning pregnancy, proper prenatal care, what to expect during labor and delivery and breastfeeding. The second component is comprised of two (2) classes. One class is designed to provide information on newborn feeding, e.g., bottle feeding, breastfeeding and general infant nutrition. The second class provides information on basic newborn care.

Limitations:

Recipients may take individual classes or the entire series. However, the same class may only be taken once every twelve (12) months. Recipients receiving services under the Childbirth Preparation component (six class series) must be pregnant women. Recipients receiving services under the Newborn Care or Newborn Feeding classes must be pregnant women or postpartum women. The postpartum period is defined as thirty days after maternal discharge.

Provider Qualifications:

Enrollment is open to all providers who meet the following requirements:

1. Instructors must be licensed practitioners of the healing arts.
2. Instructors must be certified as a childbirth educator by a national or state recognized certifying association.

b.+ Services for any other medical conditions that may complicate pregnancy are provided, as described in Attachments 3.1-A & B of this plan, to the same extent as for other recipients.



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AMOUNT, DURATION, AND SCOPE OF MEDICAL  
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24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary

a. Transportation.

Provided:  No limitations\*  With limitations\*  
 Not provided.

b. Services of Christian Science nurses.

Provided:  No limitations\*  With limitations\*  
 Not provided.

c. Care and services provided in Christian Science sanatoria.

Provided:  No limitations\*  With limitations\*  
 Not provided.

d. Nursing facility services for patients under 21 years of age.

Provided:  No limitations\*  With limitations\*  
 Not provided.

e. Emergency hospital services.

Provided:  No limitations\*  With limitations\*  
 Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

Provided:  No limitations\*  With limitations\*  
 Not provided.

\*Description provided on attachment.

## 23. a. TRANSPORTATION

### EMERGENCY AMBULANCE

Telemedicine: Emergency Ambulances may serve as Telemedicine Facility sites. Emergency ambulances may serve as a telemedicine origination site and the ambulance may bill a separate origination site fee. Emergency Ambulances may not serve as a distant site. A distant site means the site at which the physician or practitioner delivering the service is located at the time the service is provided via a telecommunications system.

Limitations: Emergency ambulance services are provided only when medically necessary. The recipient's physical condition must prohibit use of any method of transportation except emergency ambulance for a trip to be covered.

Prior Approval is required for:

Emergency ambulance transportation of more than 150 miles one way from an institution to an institution.

Emergency transportation services certified by a physician as medically necessary, but not included as a covered service, may be covered for recipients under twenty one years of age when such services are prior approved by the Department.

All ambulance transportation of more than 50 miles beyond the boundaries of the Georgia state line (out-of-state).

Transportation that is not of an emergency nature, but the recipient requires services of an EMT and the life sustaining equipment provided in the emergency ambulance.

All ambulance transportation by air ambulance except for recipients 0 to twelve months of age who meet certain criteria listed in the policies and procedures manual.

Non-covered services:

Ambulance services are not covered in the following circumstances without medical justification:

The recipient is ambulatory.

The recipient's condition would not ordinarily require movement by stretcher.

The ambulance was used solely because other means of transportation were unavailable.

The recipient was transferred to another facility at his/ her request.

Transportation of a recipient pronounced dead at the scene by a licensed physician before the ambulance was called. If the recipient was pronounced dead after the ambulance was called but before pickup, service to the pickup point is covered.

23. a. **TRANSPORTATION (continued)****Non-Covered Services (continued)**

Transportation for routine obstetrical delivery.

The member requested transportation to a more distant hospital or health care facility to receive the services of a specific physician of the member's choice.

Ambulance service to the physician's office of physician-directed clinic. A stop to a physician's office en route to the hospital necessitated by the patient's need for emergency professional care at a physician's office will be covered if the ambulance immediately continues to the hospital.

Transportation of a member 21 years of age and older by helicopter.

**NON-EMERGENCY TRANSPORTATION EXCEPTIONAL TRAVEL**

The Department assures provision of necessary transportation to and from a health care provider when the member has no other transportation resources. The Department or an authorized representative will make determination of transportation necessity.

Exceptional Transportation Services (ETS) are defined as non-emergent transport necessary under extraordinary medical circumstances, that require traveling out-of-state for health care treatment not normally provided through Georgia's health care providers.

This transportation is limited to out-of-state travel including air and ground travel.

ETS is limited to out of state travel and must be arranged through the county Department of Family and Children Services (DFCS).

Transportation outside of the area customarily used by the member's community can be reimbursed only when the required medical resources are not available within the area or the member's primary care physician is not located in the member's area.

**23. a. TRANSPORTATION (continued)****Limitations** (continued)

Enrolled ETS providers must bill the Department only for medically necessary transportation to the nearest out-of-state provider who can provide the needed service.

A maximum of one (1) passenger round trip ticket may be reimbursed per date of services per member for the ETS.

Reimbursement for escorts is limited to one (1) member, when the same escort escorts two (2) or more members to the same medical facility, on the same date of service.

Reimbursement for meals and lodging is covered for a member and one escort when required in conjunction with in-state or out-of-state travel.

**Prior Approval**

As a condition of reimbursement, the Department requires that ETS rendered through DFCS be approved prior to the time they are rendered. Prior approval pertains to medical necessity only and does not guarantee reimbursement. In order to be reimbursed for prior approved services, the member must be Medicaid eligible at the time the services are rendered.

Prior approval must be obtained before ETS are rendered, and at least forty-eight (48) hours in advance, if possible. When the member receives health care services from more than one (1) out-of-state provider and requires approved transportation to each health care provider, prior approval may be given for the duration of planned treatment as indicated on the medical certification form, but not for more than (1) year.

A county DFCS office must obtain prior approval before authorizing the services listed below.

- A. Out-of-state travel in an automobile, commercial bus or train;
- B. Any local taxi service for members who require this transportation to access commercial bus, train or airplane for transport out-of-state.
- C. Out-of-local service area taxi used in conjunction with out-of-state commercial bus, train or airplane;
- D. Any meals or lodging out-of-state;
- E. Any meals or lodging in-state;
- F. Any out-of-state transportation by commercial airplane; and
- G. Any parking and toll fees.

23. a. **TRANSPORTATION** (continued)

**Non-Covered Services**

- A. Transportation provided by relatives or individuals living in the same household with the Medicaid member;
- B. Transportation provided in the Medicaid member's vehicle, driven by the member or another person;
- C. Any travel when the Medicaid member is not an occupant of the vehicle, except for travel via an automobile driven by volunteer driver up to a total of twenty (20) miles between the driver's home and the member's home and return;
- D. Meals and lodging for volunteer drivers;
- E. Transportation for educational purposes, vocational training, social services or for any other services not covered by Medicaid and transportation services to attend amusement parks, sporting events, and other social functions;
- F. Services for which prior approval is required but was not obtained;
- G. Services which are not medically necessary or which are not provided in compliance with the provisions;
- H. In-state transportation services, including meals and lodging, when not coordinated by the NET broker, or out-of-state travel, including meals and lodging, when not coordinated by DFCS.

**Intentionally Left Blank**

23.d. SKILLED NURSING FACILITY SERVICES FOR PATIENTS UNDER 21 YEARS OF AGE

Skilled nursing facility services are provided to eligible recipients under age 21 to the same extent as for those age 21 and older (see 4.a. of this Attachment).

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 STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

 State/Territory: Georgia


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## NON-EMERGENCY TRANSPORTATION BROKER SYSTEM

 AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE  
 AND SERVICES PROVIDED TO THECA TEGORJCALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

a 1. Transportation

- No limitations  
 With limitations

a 2. Brokered Transportation

- Provided under section 1902(a)(70)

The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(f).

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);

- (1) statewideness (indicate areas of State that are covered)  
 (10)(B) comparability (indicate participating beneficiary groups)  
 (23) freedom of choice (indicate mandatory population groups)

(2) Transportation services provided will include:

- wheelchair van  
 taxi  
 stretcher car  
 bus passes  
 tickets (tokens)  
 secured transportation  
 such other transportation as the Secretary determines appropriate (please describe).  
 Other appropriate modes are volunteer drivers, minibuses, federally funded transportation services (i.e. public transportation), and other forms of passenger vehicles (i.e. sedans).



## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GeorgiaNON-EMERGENCY TRANSPORTATION BROKER SYSTEM  
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE  
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- (3) The State assures that transportation services will be provided under a contract with a broker who:
- (i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;
  - (ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transport personnel are licensed, qualified, competent, and courteous;
  - (iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services;
  - (iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate). The broker shall not itself be a provider of transportation; however the state may require that the broker own/operate and have available vehicles referred to as "shooter vans" in the event the scheduled transportation provider is unavailable for transport or if there are no other qualified providers available to provide the transportation. The state acknowledges that the broker will use shooter vans only as a back-up measure to assure that beneficiaries are able to access medical service and not as a standard means of transportation.
- (4) The broker contract will provide transportation to the following categorically needy mandatory populations:
- Low-income families with children (section 1931)
  - Low-income pregnant women
  - Low-income infants
  - Low-income children 1 through 5
  - Low-income children 6 through 19
  - Qualified pregnant women
  - Qualified children
  - IV-E Federal foster care and adoption assistance children
  - TMA recipients (due to employment)
  - TMA recipients (due to child support)
  - SSI recipients
- (5) The broker contract will provide transportation to the following categorically needy optional populations:
- Optional low-income pregnant women
  - Optional low-income infants
  - Optional targeted low-income children
  - Individuals under 21 who are under State adoption assistance agreements
  - Individuals under age 21 who were in foster care on their 18th birthday
  - Individuals who meet income and resource requirements of AFDC or SSI

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 STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
 

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 State/Territory: Georgia


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## NON-EMERGENCY TRANSPORTATION BROKER SYSTEM

 AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE  
 AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency
- Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law
- Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
- Individuals infected with TB (Transportation for inpatient hospital services for persons in institutions for special disorders such as tuberculosis is not cover).
- Individuals screened for breast or cervical cancer by CDC program
- Individuals receiving COBRA continuation benefits
- Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300 percent of SSI income standard
- Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution
- Individuals terminally ill if in a medical institution and will receive hospice care
- Individuals aged or disable with income not above 100 percent FPL
- Individuals receiving only an optional State supplement in a 209(b) State
- Individuals working disabled who buy into Medicaid (BBA working Disabled group)
- Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group
- Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids)

(6) The State will pay the contracted broker by the following method:

- (i) risk capitation
- (ii) non-risk capitation
- (iii) other

State: Georgia

AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

           provided                        X   not provided

**State/Territory: Georgia**  
**AMOUNT, DURATION AND SCOPE OF SERVICES  
PROVIDED**  
**CATEGORICALLY NEEDY GROUP(S)**

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

\*The state needs to check each assurance below.

Provided:   X  

I. General Assurances:

**Routine Patient Cost – Section 1905(gg)(1)**

  X   Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

**Qualifying Clinical Trial – Section 1905(gg)(2)**

  X   A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

**Coverage Determination – Section 1905(gg)(3)**

  X   A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938- 1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State/Territory: GEORGIA  
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): ALL

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The following ambulatory services are provided.

Outpatient Hospital  
Rural Health Clinic  
Laboratory and X-ray  
EPSDT  
Family Planning  
Physician  
Podiatry  
Optometry  
Other Practitioners  
    a. Psychology for Under 21  
Ambulatory Surgical Center Services  
Home Health (including DME)  
Clinic Services  
    a. Family Planning  
Dental  
Prescribed Drugs  
Dentures for Under 21  
Prosthetics & Orthotics (including Hearing Aids)  
Eyeglasses  
Nurse-Midwife  
Case Management  
    a. Mental Health/Mental Retardation/Substance Abuse  
Extended Services to Pregnant Women  
Transportation  
    a. Emergency Ambulance  
    b. Non-Emergency

\*Description provided on attachment.

TN No: 01-06

Supersedes  
TN No: 89-31  
Supersedes  
TN No: 87-20

Approval Date OCT 15 2001 Effective Date 7/1/2001

State/Territory: GEORGIA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): ALL

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1. Inpatient hospital services other than those provided in an institution for mental diseases.
- X  Provided: \_\_\_\_\_ No limitations  X  With limitations\*
2. a. Outpatient hospital services
- X  Provided: \_\_\_\_\_ No limitations  X  With limitations\*
- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic which are otherwise covered under the plan.
- X  Provided: \_\_\_\_\_ No limitations  X  With limitations\*
- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medical Manual (HCFA-Pub. 45-4).
- X  Provided: \_\_\_\_\_ No limitations  X  With limitations\*
3. Other laboratory and x-ray services.
- X  Provided: \_\_\_\_\_ No limitations  X  With limitations\*
4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
- \_\_\_\_\_ Provided: \_\_\_\_\_ No limitations \_\_\_\_\_ With limitations\*
- b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found \*
- X  Provided:
- c. Family planning services and supplies for individuals of childbearing age.
- X  Provided: \_\_\_\_\_ No limitations  X  With limitations\*
- \* Description provided on attachment 3.1-A, limitations supplement

Supersedes  
TN No: 90-20  
Revision: HCFA-PM- 92-7 (MB)  
October 1992

HCFA ID: 7986E  
ATTACHMENT 3.1-B  
Page 2a  
OMB No.

State/Territory: GEORGIA  
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY' NEEDY GROUP(S): ALL

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5. a. Physicians' services, whether furnished in the office, the Patient's home, a hospital, a nursing facility, or elsewhere.

Provided with limitations\*

- b. Medical and surgical services furnished by a dentist (in accordance with section 1905 (a) (5) (B) of the Act).

Provided:  No limitations  With limitations\*

\*Description provided on attachment.

TN No: 01-06

Approval Date OCT 15 2001 Effective Date 7/1/2001

Supersedes  
TN No: 93-003

State/Territory: GEORGIA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): ALL

- 
6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by state law.
- a. Podiatrists' Services
- |                      |                             |                              |
|----------------------|-----------------------------|------------------------------|
| <u> X </u> Provided: | <u>     </u> No limitations | <u> X </u> With limitations* |
|----------------------|-----------------------------|------------------------------|
- b. Optometrists' Services
- |                      |                             |                              |
|----------------------|-----------------------------|------------------------------|
| <u> X </u> Provided: | <u>     </u> No limitations | <u> X </u> With limitations* |
|----------------------|-----------------------------|------------------------------|
- c. Chiropractors' Services
- |                        |                             |                                |
|------------------------|-----------------------------|--------------------------------|
| <u>     </u> Provided: | <u>     </u> No limitations | <u>     </u> With limitations* |
|------------------------|-----------------------------|--------------------------------|
- d. Other Practitioners
- |                      |                             |                                |
|----------------------|-----------------------------|--------------------------------|
| <u> X </u> Provided: | <u>     </u> No limitations | <u>     </u> With limitations* |
|----------------------|-----------------------------|--------------------------------|
- e. Ambulatory Surgical Center Services
- With limitations\*
7. Home Health Services
- a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.
- |                      |                             |                              |
|----------------------|-----------------------------|------------------------------|
| <u> X </u> Provided: | <u>     </u> No limitations | <u> X </u> With limitations* |
|----------------------|-----------------------------|------------------------------|
- b. Home health aide services provided by a home health agency.
- |                      |                             |                              |
|----------------------|-----------------------------|------------------------------|
| <u> X </u> Provided: | <u>     </u> No limitations | <u> X </u> With limitations* |
|----------------------|-----------------------------|------------------------------|
- c. Medical supplies, equipment, and appliances suitable for use in the home.
- |                      |                             |                              |
|----------------------|-----------------------------|------------------------------|
| <u> X </u> Provided: | <u>     </u> No limitations | <u> X </u> With limitations* |
|----------------------|-----------------------------|------------------------------|
- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.
- |                      |                             |                              |
|----------------------|-----------------------------|------------------------------|
| <u> X </u> Provided: | <u>     </u> No limitations | <u> X </u> With limitations* |
|----------------------|-----------------------------|------------------------------|

\*Description provided on attachment.

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TN No: 01-06

Approval Date OCT 15 2001 Effective Date 7/1/2001

Supersedes  
TN No: 87-20



State/Territory: GEORGIA

**AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED**  
**MEDICALLY NEEDED GROUP(S): ALL**

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8. Private Duty Nursing

Provided       No limitations       With limitations\*

\*Limitations are the same as described in Attachment 3.1-A, Page 3a.001.

9. Clinic Services.

Provided       No limitations       With limitations\*

10. Dental Services.

Provided       No limitations       With limitations\*

11. Physical Therapy and Related Services.

Provided       No limitations       With limitations\*

a. Dental Services

Provided       No limitations       With limitations\*

b. Occupational Therapy.

Provided       No limitations       With limitations\*

c. Services for individuals with speech, hearing and language disorders provided by or under supervision of a speech pathologist or audiologist.

Provided       No limitations       With limitations\*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed Drugs.

Provided       No limitations       With limitations\*

*Prescription Drug scope of services for Medically Needy is identical to the scope of pharmacy services for the Categorically Needy. See Description in Attachment 3.1-A.*

b. Dentures.

Provided       No limitations       With limitations\*

State/Territory: GEORGIA  
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): ALL

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- c. Prosthetic Devices.  
 Provided:       No limitations       With limitations\*
- d. Eyeglasses  
 Provided:       No limitations       With limitations\*
13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.
- a. Diagnostic services.  
 Provided:       No limitations       With limitations\*
- b. Screening services.  
 Provided:       No limitations       With limitations\*
- c. Preventive services.  
 Provided:       No limitations       With limitations\*
- d. Rehabilitative services  
 Provided:       No limitations       With limitations\*
14. Services for individuals 65 or older in institutions for mental disease.
- a. Inpatient hospital service.  
 Provided:       No limitations       With limitations\*
- b. Nursing facility services.  
 Provided:       No limitations       With limitations\*

\*Description provided on attachment.

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TN No: 01-06

Approval Date OCT 15 2001

Effective Date 7/1/2001

State/Territory: Georgia

AMOUNT, DURATION AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED  
TO THE MEDICALLY NEEDY

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- c. Intermediate care facility services
- // Provided: // No limitations // With limitations\*
15. a. Intermediate care facility services (other than such services in an institution For mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.
- /X/ Provided: // No limitations /X/ With limitations\*
- b. Including such services in a public institution (or district part thereof) for the mentally retarded or persons with retarded conditions.
- // Provided: // No limitations // With limitations\*
16. Inpatient psychiatric facility services for individuals under 21 years of age.
- /X/ Provided: /X/ No limitations // With limitations\*
17. Nurse-midwife services.
- /X/ Provided: // No limitations /X/ With limitations\*
18. Hospice care (in accordance with section 1985(o) of the Act).
- // Provided: // No limitations /X/ Provided in accordance with section 2302 of the Affordable Care Act
- /X/ With limitations\*

\*Description provided on attachment-

State/Territory: GEORGIA  
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): ALL

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19. Case management services and Tuberculosis related services

- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A, (in accordance with Section 1905(a) (19) or Section 1915 (g) of the Act).

Provided:                       No limitations                       With limitations\*

Not provided.

- b. Special tuberculosis (TB) related services under Section 1902 (z) (2) of the Act.

Provided:                       No limitations                       With limitations\*

Not provided.

20. Extended services for pregnant women.

- a. Pregnancy related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

Provided:                       Additional coverage

- b. Services for any other medical conditions that may complicate pregnancy.

Provided:                       Additional coverage++                       Not provided

21. Certified pediatric or family nurse practitioners' services.

Provided: No limitations                       With limitations\*

Not Provided

+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

\*Description provided on attachment.

State/Territory: GEORGIA  
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY' NEEDY GROUP(S): ALL

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22. Respiratory care service. (in accordance with section 1902 (e) (9) (A) through (C) of the Act).

Provided:  No limitations  With limitations\*

Not provided.

23. Any other medical care and any other of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

Provided:  No limitations  With limitations\*

b. Service of Christian Science nurses.

Provided:  No limitations  With limitations\*

c. Care and services provided in Christian Science sanatoria.

Provided:  No limitations  With limitations\*

d. Skilled nursing facility services provided for patients under 21 years of age.

Provided:  No limitations  With limitations\*

e. Emergency hospital services.

Provided:  No limitations  With limitations\*

f. Personal care services in recipient's home prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.

Provided:  No limitations  With limitations\*

\*Description provided on attachment 3.1-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia

NON-EMERGENCY TRANSPORTATION BROKER SYSTEM

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE  
AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

23. Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

a. 1. Transportation

No limitations

With limitations

a. 2. Brokered Transportation

Provided under section 1902(a)(70)

The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provide transportation, and can document, upon request from CMS, the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(f).

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);

statewideness (indicate areas of State that are covered)

(10)(B) comparability (indicate participating beneficiary groups)

(23) freedom of choice (indicate mandatory population groups)

- (2) Transportation services provided will include:
- wheelchair van
  - taxi
  - stretcher car
  - bus passes
  - tickets
  - secured transportation
  - such other transportation as the Secretary determines appropriate (please describe)  
Other appropriate modes are volunteer drivers, minibus, and federally funded transportation services.
- (3) The State assures that transportation services will be provided under a contract with a broker who:
- (i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;
  - (ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transport personnel are licensed, qualified, competent, and courteous;
  - (iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services;
  - (iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate);

(4) The broker contract will provide transportation to the following medically needy populations under section 1905(a)(i) - (xiii):

- Under age 21, or under age 21, 19, or 18 as the State may choose
- Relatives specified in section 406(b)(1) with whom a child is living if child is a dependent child under part A of title IV
- Aged (65 years of age or older)
- Blind with respect to States eligible to participate, under title XVI
- Permanently or totally disabled individuals 18 or older, under title XVI
- Persons essential to recipients under title I, X, XIV, or XVI
- Blind or disabled as defined in section 1614 with respect to States not eligible to participate in the State plan program under title XVI
- Pregnant women
- Individuals provided extended benefits under section 1925
- Individuals described in section 1902(u)(1)
- Employed individuals with a medically improved disability (as defined in section V)
- Individuals described in section 1902(aa)
- Individuals screened for breast or cervical cancer by CDC program
- Individuals receiving COBRA continuation benefits.

(5) The State will pay the contracted broker by the following method:

- risk capitation
- non-risk capitation
- other (e.g., brokerage fee and direct payment to providers)

Implementation Date:

Georgia will implement this State plan amendment on 7/1/06.



Supersedes  
TN No: 86-27  
Revision: HCFA-PM-97-7 (MB)  
March 1987

HCFA ID: 1042P/0016P  
ATTACHMENT 3.1-B  
Page 9

State/Territory: GEORGIA  
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY' NEEDED GROUP(S): ALL

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24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to supplement 2 Attachment 3.1-A.

Provided  Not provided

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TN No: 01-06

Approval Date OCT 15 2001

Effective Date 7/1/2001

Supersedes  
TN No: 93-003  
Supersedes  
TN No: New

**State/Territory: Georgia**  
**AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED**  
**CATEGORICALLY NEEDY GROUP(S)**

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

\*The state needs to check each assurance below.

Provided:   X  

I. General Assurances:

**Routine Patient Cost – Section 1905(gg)(1)**

  X   Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

**Qualifying Clinical Trial – Section 1905(gg)(2)**

  X   A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

**Coverage Determination – Section 1905(gg)(3)**

  X   A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938- 1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

TN: 22-002  
 Supersedes TN:   New  

Approval Date 4/15/2022  
 Effective Date 1/1/2022

## METHODS AND STANDARDS TO ENSURE QUALITY OF SERVICES

### Provider Standards

Prior to enrollment, providers must satisfy licensing and certification requirements established by local and Federal laws, regulations, and State agency policies.

### Assessment of Long-Term Care Services

Pre-admission reviews are done to determine the appropriate level of care needed by applicants for long-term care. The physician certifies that alternatives to nursing home care have been considered but are not appropriate. Periodic evaluations are made of the adequacy and appropriateness of services rendered and the patient's need for continued placement in the present facility.

Peer review evaluation are provided under contract per Georgia Health Partnership (GHP) by Registered Nurses and consulting Physicians to ensure that the State's responsibility for pre-admission screening and review of Mentally III and Mentally Retarded (PASRR) services as governed by 42CFR483.100 through 483.138, based on section 1919(e)(7) of the Social Security Act is completed. The contractor utilizes the DMA-613 Level 1 instrument to assess each applicant who seeks admission, into a NF and/or each NF resident who has MI or MR, is medically necessary and appropriate.

The GHP evaluator must assess whether the individual's total needs are such that his or her needs can be met in the NF by prioritizing the physical and mental needs of the individual being evaluated, taking into account the severity of each condition. If the peer review decides that further assessment is necessary, they will notify other State contracted mental health or mental retardation authorities (PASRR Contractor, Level 2) who determine whether an NF level of service is feasible and is the appropriate facility for placement.

Surveillance and Utilization Review (SUR)

SUR reviews are done in all Medicaid services and are primarily concerned with medical necessity; quality, appropriateness and frequency of services; adequate documentation to support services billed; policy violations and incorrect payments. In-house reviews are made from SUR system reports including profiles, weighted and ranked, and submitted claims' detail. Provider medical records are reviewed on-site. Questionable practices involving medical necessity and quality are referred to the peer review agency for review and recommendation.

Home Health Agency Reviews

Authorized representatives of the Department review home health agencies as directed by the Department. Functions included in these utilization reviews are assessments of quality of care and need for services rendered. Records are reviewed in the agencies and patients are assessed in their homes. Visits may be announced or unannounced.

STATE: Georgia

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METHODS TO ASSURE TRANSPORTATION  
42 CFR 431.53

The Department assures that necessary transportation for recipients to and from providers will be provided through the following methods:

Emergency Ambulance

Emergency transportation is provided through the Emergency Ambulance Service. (See item 23.a of Attachment 3.1A) when the recipient's physical condition prohibits use of other methods of transportation

Non-Emergency Transportation

Services are provided through the Non-Emergency Transportation (NET) Program (See item 23.a of Attachment 3.1-A). Methods used are:

Any appropriate means of transportation that can be secured without charge through volunteer organizations; public services such as fire and police; ambulances; or by relatives.

If transportation is not available without charge, payment will be made for the least expensive means of transportation suitable to the member:

Exceptional Transportation Services (ETS) is non-emergency transportation which is necessary under extraordinary medical circumstances that requires travel out-of-state for health care treatment not normally provided through in-state health care providers. Payment will be made when exceptional travel is determined to be necessary and when pre-authorized.

Transportation services other than Exceptional are provided through a broker system wherein a capitated payment for each Medicaid member residing within a region is made each month to a broker responsible for arranging the transportation. The NET broker provides medically necessary transportation for any eligible Medicaid member and companion, if required, who have no other means of transportation available to any Medicaid-reimbursable service for the purpose of receiving treatment, medical evaluation, obtaining prescription drugs or medical equipment. The broker is not responsible for out-of-state NET services, or ambulance services. In addition, the broker is not responsible for providing transportation for PeachCare, Qualified Medicare Beneficiary or Emergency Medical Assistance members.

Assistance in arranging necessary transportation will be given to a member as needed by the Department or an authorized representative.

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Centers for Medicare & Medicaid Services  
601 E. 12th St., Room 355  
Kansas City, Missouri 64106



Medicaid and CHIP Operations Group

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March 11, 2022

Lynnette R. Rhodes, Esq.  
Executive Director, Medical Assistance Plans  
Department of Community Health  
2 Peachtree St., 36<sup>th</sup> Floor  
Atlanta, Georgia 30303

Re: Georgia State Plan Amendment (SPA) 21-0015

Dear Executive Director Rhodes:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 21-0015. This amendment proposes to provide attestation of transportation minimum requirements.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations under the Consolidated Appropriations Act of 2021, Division CC, Title II, Section 209; Section 1902(a)(4) of the Social Security Act. This letter is to inform you that Georgia Medicaid SPA 21-0015 was approved on March 10, 2022 with an effective date of October 1, 2021.

If you have any questions, please contact Etta Hawkins at (404) 562-7429 or via email at [Etta.Hawkins@cms.hhs.gov](mailto:Etta.Hawkins@cms.hhs.gov).

Sincerely,

A handwritten signature in blue ink, appearing to read 'James G. Scott', is positioned above the printed name and title.

Digitally signed by James G.  
Scott-S  
Date: 2022.03.11 08:58:48  
-06'00'

James G. Scott, Director  
Division of Program Operations

cc: Brian Dowd

**STATE: Georgia**

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**METHODS TO ASSURE TRANSPORTATION**  
**42 CFR 431.53**

The division of Medicaid attests all of the minimum requirements outlined in 1902(a)(87) of the Act are met, requiring providers, transportation network companies (TNCs), (such as, UBER and LYFT) and individual drivers of non-emergency medical transportation to medically necessary services receiving payments under such plan (but excluding any public transit authority), meets the following minimum specified requirements:

- (A) Each provider and individual driver is not excluded from participation in any federal health care program (as defined in section 1128B(f) of the Act) and is not listed on the exclusion list of the Inspector General of the Department of Health and Human Services;
- (B) Each such individual driver has a valid driver's license;
- (C) Each such provider has in place a process to address any violation of a state drug law; and
- (D) Each such provider has in place a process to disclose to the state Medicaid program the driving history, including any traffic violations, of each such individual driver employed by such provider, including any traffic violations.

Capitation payments to brokers are sufficient to enlist enough providers so that care and services are available under this state plan at least to the extent that such care and services are available to the general population in the geographic area.

TN No.: 21-0015

Supersedes

TN No.: NEW Approval Date: 03/10/2022 Effective Date: 10/1/2021

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State/Territory: Georgia

**STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES**

1. For recipients 21 years of age and over, the only transplants covered are kidney, liver, bone marrow (except for solid tumors, chronic granulocytic leukemia, sickle cell and acute leukemia in relapse), and cornea as described under Hospital and Physician Services in Attachment 3.1-A if established criteria has been met. Lung, bowel, pancreas and heart-lung transplants are not covered. For recipients under age 21, heart transplants and all other recognized, non-experimental organ transplants will be covered if medical necessity is properly documented and prior approval is obtained.

2. Prior approval is required for liver and bone marrow transplants. All transplants performed out-of-state require prior approval.

The following documentation is required: Recent medical summary, age of recipient, diagnosis, prognosis, other therapies used, facility where the procedure will be performed, the proposed date of transplant surgery. Social history is required for liver transplants.

3. Kidney transplants are covered for recipients with documented end stage renal disease. Liver transplants may be requested for recipients with disorders listed under Hospital and Physician Services in Attachment 3.1-A.

4. Organ Transplant Center Criteria

Restrictive criteria on facilities or practitioners which provide transplant procedures will be consistent with the accessibility of high quality care to individuals eligible for transplants. The following criteria will be applied in selecting centers.

The staff must have experience in organ transplant programs and include a transplant surgeon who has trained at an institution with an established transplant program,

The staff must include experts in hepatology, gastroenterology, immunology, infectious disease, nephrology, cardiopulmonary medicine, pediatrics, pathology, pharmacology, anesthesiology, psychiatry, and psychosocial support.

The center must give assurance that satisfactory arrangements are in place for donor procurement services.

The facility must have an active renal dialysis program and blood bank services which are capable of supplying large quantities of blood on short notice.

The hospital should have experience and expertise in the treatment of all types of diseases associated with irreversible organ failure.

The transplant center administration must have made a commitment to the program and there should be broad-based community support and hospital staff support of the commitment.

TRANSMITTAL 93-006  
APPROVED 11-4-93  
EFFECTIVE 1-1-93  
SUPERSEDES 92-16



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The center must have a consistent, equitable, and practical protocol for selection of patients.

The center should have the capacity and commitment to conduct systematic evaluations of cost and clinical outcomes of cases.

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Citation	Condition or Requirement
1932(a)(1)(A)	<p data-bbox="467 390 1024 422">A. <u>Section 1932(a)(1)(A) of the Social Security Act.</u></p> <p data-bbox="467 453 1409 695">The State of Georgia enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).</p> <p data-bbox="467 726 1414 873">This authority may <i>not</i> be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans-see D.2.ii. below), or who meet certain categories of “special needs” beneficiaries (see D.2.iii. - vii. below)</p> <p data-bbox="467 905 1089 936">B. <u>General Description of the Program and Public Process.</u></p> <p data-bbox="467 968 1414 1146">The Georgia Department of Community Health (DCH) will procure a single statewide vendor to provide a Medical Coordination Program for Medicaid Members who are aged, blind and disabled (ABD) as identified by Members' Categories of Aid. The vendor is expected to achieve DCH's healthcare goals and Member health outcomes, and serve as an administrative agent of the State. The Medical Coordination Program will provide:</p> <ul data-bbox="516 1178 1357 1398" style="list-style-type: none"><li>• Person-centered Medical Coordination for all eligible Members</li><li>• Intensive Medical Coordination services for targeted high-risk, impactable populations</li><li>• A medical home to coordinate and manage care for participants receiving Intensive Medical Coordination services</li><li>• Care Coordinators to assist eligible Members in obtaining needed medical services</li></ul> <p data-bbox="467 1430 1414 1581">With the exception of partial benefit dual eligible Members and those Members enrolled in the Georgia Families program (Medicaid managed care), all other Medicaid Members will be eligible to receive services through the Medical Coordination Program. Thus, the Medical Coordination Program includes individuals who are dually eligible, enrolled in a Home- and Community-Based</p>

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Citation

Condition or Requirement

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Services (HCBS) waiver program or residing in a long-term institutional setting. DCH and its sister agencies will continue to administer State Plan benefits and HCBS waiver programs and to provide non-conflicting case management services.

All Members will receive Core Coordination Services to include Member education, call center services and access to a twenty-four (24) hour nurse line. Members with chronic conditions, behavioral health conditions, co-morbidities or other complex diagnoses deemed "high-risk and impactable" will have the option to receive Intensive Medical Coordination services to include a health risk assessment, establishment of a health care plan, assistance with establishing a medical home and interdisciplinary team care management. The Medical Coordination Program vendor must develop and maintain a Primary Care Case Management (PCCM) network to ensure Members will have adequate access to medical home providers.

The vendor will use a variety of mechanisms to identify Members potentially eligible for Intensive Medical Coordination services including those who currently have or are likely to experience catastrophic or other high-cost or high-risk conditions. These mechanisms must include, at a minimum, predictive modeling and other data analyses. For potential Intensive Medical Coordination participants, the vendor must complete a comprehensive health risk assessment that evaluates the Member's medical condition(s), including physical, behavioral, social and psychological needs. The goals of the health risk assessment are to confirm the Member's need for Intensive Medical Coordination, identify the Member's existing and/or potential health care needs, determine the types of services needed by the Member, and begin to develop the health care Plan and treatment team. Health risk assessments may require on-site visits to a Member's residence, doctor's office, pharmacy, or other locations. Meeting the Members "where they are" will be an important component of interaction and engagement.

Members in the Medical Coordination Program will be advised by DCH and the Medical Coordination Program vendor on the provisions for opting out of Intensive Medical Coordination services. The vendor will inform Members and/or Members' legal guardians, as well as primary care providers, specialists and/or behavioral health providers that the Member has been identified as meeting the criteria for Intensive Medical Coordination services. The notification must provide a description of the Intensive Medical Coordination services, the Intensive Medical Coordinator's contact information and phone number, patient confidentiality and protection information, and the mechanism for opting out should the Member and/or Members' legal guardians prefer not to receive Intensive Medical Coordination services. In addition, the vendor's call center staff will be required to

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Citation

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assist those Members wishing to either opt-out of or opt back into Intensive Medical Coordination services. The vendor's Medical Coordination Program website will also provide information to Members on the provisions for opting out or into Intensive Medical Coordination services.

Members eligible to receive Intensive Medical Coordination services will also be assisted by the vendor in selecting a medical home provider which may be a primary care provider, specialist, behavioral health provider or Patient-Centered Medical Home. If a Member is unable to select a medical home provider, the vendor will assign such a provider based on an algorithm approved by DCH and which heavily weighs the practitioner the Intensive Medical Coordination participant is frequenting the most.

DCH expects the Program and vendor to achieve substantive improvements in service, access, appropriateness, and health and quality outcomes while reducing expenditures over the course of the contract. A significant component of the Program is a Value-Based Purchasing (VBP) approach that recognizes and rewards positive financial, and health and quality outcomes achieved through this Program. To be successful, DCH believes a VBP approach must align payer, Offeror and Provider goals, objectives and incentives. The VBP model performance targets will include transactional and quality measures and indicators. A percentage of the fees paid by DCH to the vendor will be withheld and returned to the vendor if these performance measures are met.

DCH will reimburse the selected Offeror on a Per Member Per Month (PMPM) basis for all Members, regardless of whether the Member is eligible for or is an Intensive Medical Coordination Participant receiving Intensive Medical Coordination services. This PMPM payment to the vendor will include the provision of core services to all Members, Intensive Medical Coordination services for eligible Members and a Case Management fee for medical homes selected or assigned to Members receiving Intensive Medical Coordination services.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)  
1932(a)(1)(B)(ii)  
42 CFR 438.50(b)(1)

1. The State will contract with an
- i. MCO
  - ii. PCCM (including capitated PCCMs that qualify as PAHPs)
  - iii. Both

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Citation	Condition or Requirement
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	2. The payment method to the contracting entity will be:  _____ i. fee for service; _____ ii. capitation; <u>  X  </u> iii. a case management fee; <u>  X  </u> iv. a bonus/incentive payment; _____ v. a supplemental payment, or _____ vi. other. (Please provide a description below).
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.  If applicable to this state plan, place a check mark to affirm the state has met <b>all</b> of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).  <u>  X  </u> i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.  <u>  X  </u> ii. Incentives will be based upon specific activities and targets.  <u>  X  </u> iii. Incentives will be based upon a fixed period of time.  <u>  X  </u> iv. Incentives will not be renewed automatically.  <u>  X  </u> v. Incentives will be made available to both public and private PCCMs.  <u>  X  </u> vi. Incentives will not be conditioned on intergovernmental transfer agreements.  _____ vii. Not applicable to this 1932 state plan amendment.

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Citation	Condition or Requirement
CFR 438.50(b)(4)	<p data-bbox="467 394 1406 527">4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. (<i>Example: public meeting, advisory groups.</i>)</p> <p data-bbox="467 562 1406 961">The procurement for a Medical Coordination Program for eligible Members is the result of extensive public input and program analyses. In August 2011, DCH began an effort to analyze the Medicaid program to identify opportunities to achieve efficiencies and to provide improved outcomes and quality of care for Members. These efforts include a transparent, collaborative process working with stakeholders through focus groups and ongoing taskforces to obtain insights about challenges and opportunities for improvement. Stakeholders with which DCH has collaborated include Medicaid Members, advocates, Providers, legislators and Offerors. DCH formed three task forces that meet regularly to provide input: Provider; Aged, Blind and Disabled; and Children and Families Task Forces. DCH also convened a Mental Health and Substance Abuse Workgroup. Common themes identified by these groups are as follows:</p> <ul data-bbox="516 999 1406 1604" style="list-style-type: none"><li data-bbox="516 999 1406 1131">• Due to the often chronic and serious nature of their health issues, the ABD population –including individuals in long-term care and disability programs -would significantly benefit from intensive care management approaches.</li><li data-bbox="516 1167 1406 1230">• Care coordinators should be used to help all ABD Members obtain timely needed services.</li><li data-bbox="516 1266 1406 1329">• A true focus on quality and outcomes is critical to the success of the Medicaid program.</li><li data-bbox="516 1365 1406 1428">• A person-centered model with a holistic view of an individual's needs is essential to quality outcomes.</li><li data-bbox="516 1463 1406 1604">• The ABD population is not homogenous in terms of their medical needs. Some Members are aged or have a disability, but they are otherwise healthy. Other Members of the ABD population have high acuity levels and intense medical needs.</li></ul>

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Citation	Condition or Requirement
1932(a)(1)(A)	<ul style="list-style-type: none"><li>• Due to the often chronic and serious nature of their health issues, the ABD population – including individuals in long-term care and disability programs --would significantly benefit from intensive Care Management approaches or integrated healthcare coordination.</li><li>• Member linkages to Patient-Centered Medical Homes are strongly encouraged for those who have the highest level of needs.</li><li>• Improved care coordination for Medicaid/Medicare dually-eligible Members is needed.</li></ul> <p>Examples of additional methods that DCH will employ to continue collecting public input during and after implementation are as follows:</p> <ul style="list-style-type: none"><li>• Inclusion of stakeholders such as established Task Forces, providers, members and advocates on an as needed basis</li><li>• Requirement for the vendor to identify and work with DCH to resolve issues pertaining to access to health care services, to communicate and educate members, providers and caregivers and to regularly report findings to the Medicaid Agency</li><li>• Inclusion of related topics in the agenda for the Medical Care Advisory Committee on an as needed basis</li></ul> <p>5. The state plan program will _____ /will not <input checked="" type="checkbox"/> implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory _____ / voluntary <input checked="" type="checkbox"/> enrollment will be implemented in the following county/area(s):</p> <ul style="list-style-type: none"><li>i. county/counties (mandatory) _____</li><li>ii. county/counties (voluntary) Statewide _____ <input checked="" type="checkbox"/> _____</li><li>iii. area/areas (mandatory) _____</li><li>iv. area/areas (voluntary) Statewide _____</li></ul>

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Citation	Condition or Requirement
<u>C. State Assurances and Compliance with the Statute and Regulations.</u>	
If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.	
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. <input type="checkbox"/> The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met. Not applicable.
1932(a)(1)(A)(i) (1) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. <input checked="" type="checkbox"/> The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. <input type="checkbox"/> The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.  Not applicable.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C)	4. <input checked="" type="checkbox"/> The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. <input checked="" type="checkbox"/> The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. <input type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.  Not applicable.
1932(a)(1)(A) for 42 CFR 447.362 42 CFR 438.50(c)(6)	7. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 447.362 payments under any non-risk contracts will be met.



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Citation	Condition or Requirement
45 CFR 74.40	8. <u>  X  </u> The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D. <u>Eligible groups</u>
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis.  There will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.  2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.  Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.
1932(a)(2)(B) 42 CFR 438(d)(1)	i. <u>  X  </u> Recipients who are also eligible for Medicare.  There will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.  If enrollment is voluntary, describe the circumstances of enrollment. <i>(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)</i>
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. _____ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. <u>  X  </u> Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.

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Citation	Condition or Requirement
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. <u>  X  </u> Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 438.50(3)(iii)	v. <u>      </u> Children under the age of 19 years who are in foster care or 42 CFR other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. <u>      </u> Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. <u>  X  </u> Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

1932(a)(2)  
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. (*Examples: children receiving services at a specific clinic or enrolled in a particular program.*)

Children receiving services funded by Title V are enrolled in the Children's Medical Services Program administered by the Georgia Division of Public Health. This program provides comprehensive, coordinated, community-based, Title V services for children birth to age 21 with chronic medical conditions. Medical eligibility includes but is not limited to:

- a. Burns
- b. Cardiac conditions
- c. Cystic fibrosis
- d. Hearing disorders
- e. Spina bifida
- f. Cerebral palsy
- g. Diabetes mellitus
- h. Vision disorders
- i. Craniofacial anomalies (including cleft lip/palate)
- j. Gastrointestinal disorders
- k. Neurological and neurosurgical conditions including epilepsy and

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Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	<p>hydrocephalus l. Orthopedic and/or neuromuscular disorders (scoliosis) m. Congenital or traumatic amputations of limbs</p> <p>2. Place a check mark to affirm if the state's definition of title V children is determined by:</p> <p><input type="checkbox"/> i. program participation, <input type="checkbox"/> ii. special health care needs, or <input checked="" type="checkbox"/> iii. both</p>
1932(a)(2) 42 CFR 438.50(d)	<p>3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.</p> <p><input checked="" type="checkbox"/> i. yes <input type="checkbox"/> ii. no</p>
1932(a)(2) 42 CFR 438.50 (d)	<p>4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: (<i>Examples: eligibility database, self-identification</i>)</p> <p>Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.</p> <p>i. Children under 19 years of age who are eligible for SSI under title XVI;</p> <p>Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.</p> <p>ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;</p> <p>Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive</p>

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Citation	Condition or Requirement
	<p>intensive medical coordination may decline to receive, or opt out, of services.</p> <p>iii. Children under 19 years of age who are in foster care or other out-of-home placement;</p> <p>Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.</p> <p>iv. Children under 19 years of age who are receiving foster care or adoption assistance.</p> <p>Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.</p>
1932(a)(2) 42 CFR 438.50(d)	<p>5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. (<i>Example: self-identification</i>)</p> <p>Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.</p>
1932(a)(2) 42 CFR 438.50(d)	<p>6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: (<i>Examples: usage of aid codes in the eligibility system, self-identification</i>)</p> <p>Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.</p> <p>i. Recipients who are also eligible for Medicare.</p> <p>Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive</p>

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Citation	Condition or Requirement
	<p>intensive medical coordination may decline to receive, or opt out, of services.</p> <p>ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.</p> <p>Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.</p>
42 CFR 438.50	<p data-bbox="464 873 1377 930">F. <u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u></p> <p data-bbox="464 968 1398 1058">Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.</p>
42 CFR 438.50	<p data-bbox="464 1096 1398 1123">G. <u>List all other eligible groups who will be permitted to enroll on a voluntary basis</u></p> <ul data-bbox="513 1161 1360 1392" style="list-style-type: none"><li>• SSI</li><li>• Public Laws</li><li>• Institutionalized (Nursing facility, inpatient hospice, long-term hospital, etc.)</li><li>• Home and Community Based Waiver</li><li>• Deeming Waiver</li><li>• Medically Needy</li></ul> <p data-bbox="464 1430 721 1457">H. <u>Enrollment process.</u></p>
1932(a)(4) 42 CFR 438.50	<p data-bbox="513 1495 683 1522">1. Definitions</p> <p data-bbox="570 1526 1398 1614">i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state</p>

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Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	<p>records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.</p> <p>ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.</p> <p>2. State process for enrollment by default.</p> <p>Describe how the state's default enrollment process will preserve:</p> <p>i. the existing provider-recipient relationship (as defined in H. 1.i).</p> <p>All members will receive provider services through the fee-for-service delivery system and so existing provider-recipient relationships may continue at the member's option.</p> <p>Members identified to receive intensive medical coordination services will be formally assigned to a medical home. Members may voluntarily select or the vendor may assign members to a medical home. The vendor will determine if the member has a primary source of care that is participating in the Medical Coordination Program, and if so, assign the member to that provider.</p> <p>ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).</p> <p>The provider networks for Medicaid members are limited to Medicaid-participating providers.</p> <p>iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). (<i>Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.</i>)</p> <p>DCH is contracting with one vendor to provide services to eligible populations. All members will have access to a minimum set of general coordination services and be subject to predictive modeling</p>

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Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	<p>and other analyses by the vendor to identify the need for intensive medical coordination services. Members identified by the vendor as high-risk and impactable will be eligible to receive intensive medical coordination services. The vendor must have a process for individuals to decline to receive, or opt out of, Intensive Medical Coordination services.</p> <p>3. As part of the state's discussion on the default enrollment process, include the following information:</p> <ul style="list-style-type: none"><li>i. The state will _____ /will not <u> X </u> use a lock-in for managed care.</li><li>ii. The time frame for recipients to choose a health plan before being auto-assigned will be _____.</li></ul> <p>Medical Coordination program services will be available to Medicaid members in the fee-for-service delivery system at the time that they are determined eligible under an aged, blind and disabled eligibility category. The vendor will conduct regular analyses to identify eligible members who may be in need of intensive medical coordination services, and contact those members to enroll in those services. The vendor must have a process for individuals to decline to receive, or opt out of, Intensive Medical Coordination services.</p> <ul style="list-style-type: none"><li>iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. (<i>Example: state generated correspondence.</i>)</li></ul> <p>DCH has a process in place to mail notification to the member of the availability of services the vendor will provide.</p> <ul style="list-style-type: none"><li>iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. (<i>Examples: state generated correspondence, HMO enrollment packets etc.</i>)</li></ul> <p>Not applicable.</p> <ul style="list-style-type: none"><li>v. Describe the default assignment algorithm used for auto-assignment. (<i>Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.</i>)</li></ul>

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Citation	Condition or Requirement
	<p data-bbox="607 453 777 480">Not applicable.</p> <p data-bbox="560 518 1395 611">vi. Describe how the state will monitor any changes in the rate of default assignment. (<i>Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker</i>)</p> <p data-bbox="607 646 777 674">Not applicable.</p>
1932(a)(4) 42 CFR 438.50	<p data-bbox="464 709 1390 802">I. <u>State assurances on the enrollment process</u> Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.</p> <p data-bbox="513 837 1390 961">1. <u> X </u> The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program</p> <p data-bbox="513 997 1390 1121">2. <u> </u> The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).</p> <p data-bbox="560 1157 730 1184">Not applicable.</p> <p data-bbox="513 1220 1305 1281">3. <u> </u> The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.</p> <p data-bbox="656 1316 1349 1377"><u> X </u> This provision is not applicable to this 1932 State Plan Amendment.</p> <p data-bbox="513 1413 1382 1537">4. <u> </u> The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)</p> <p data-bbox="656 1572 1349 1633"><u> X </u> This provision is not applicable to this 1932 State Plan Amendment.</p> <p data-bbox="513 1669 1279 1730">5. <u> X </u> The state applies the automatic reenrollment provision in accordance</p>

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Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.  ___ This provision is not applicable to this 1932 State Plan Amendment.  <u>J. Disenrollment</u>  1. The state will ___/will not <u>X</u> use lock-in for managed care.  2. The lock-in will apply for months (up to 12 months).  Not applicable.  3. Place a check mark to affirm state compliance. <u>X</u> The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).  4. Describe any additional circumstances of "cause" for disenrollment (if any).  Members may opt out of receiving intensive care management services at any time for any  <u>K. Information requirements for beneficiaries</u>  Place a check mark to affirm state compliance.  <u>X</u> The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	
1932(a)(5)(D) 1905(t)	<u>L. List all services that are excluded for each model (MCO &amp; PCCM)</u>  Services will continue to be provided through the fee-for-service delivery system.
1932 (a)(1)(A)(ii)	<u>M. Selective contracting under a 1932 state plan option</u>  To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

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Citation	Condition or Requirement
	<ol style="list-style-type: none"><li data-bbox="513 394 1390 457">1. The state will <u> X </u> / will not _____ intentionally limit the number of entities it contracts under a 1932 state plan option.</li><li data-bbox="513 495 1390 590">2. <u> X </u> The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.</li><li data-bbox="513 630 1406 724">3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. (<i>Example: a limited number of providers and/or enrollees.</i>)  DCH has elected to contract with a single vendor that has targeted expertise to effectively provide intensive medical coordination for members who are aged, blind and disabled and have unique and complex health care needs. This program is meant to provide additional coordination to meet the needs of eligible members who remain in the fee-for-service delivery system, and DCH believes that one vendor is sufficient to meet the requirements of the contract and the population being served.</li><li data-bbox="513 1066 1390 1129">4. _____ The selective contracting provision in not applicable to this state plan.</li></ol>

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

CMS-10120 (exp. 3/31/2014)

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Citation	Condition or Requirement
1932(a)(1)(A)	<p>A. <u>Section 1932(a)(1)(A) of the Social Security Act.</u></p> <p>The State of Georgia enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).</p> <p>This authority may <i>not</i> be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPS), Prepaid Ambulatory Health Plans (PAHPS), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans-see D.2.ii. below), or who meet certain categories of “special needs” beneficiaries (see D.2.iii. - vii. below)</p>
1932(a)(1)(B)(i) 1932(a)(1)(B)(ii) 42 CFR 438.50(b)(1)	<p>B. <u>General Description of the Program and Public Process.</u></p> <p>For B.1 and B.2, place a check mark on any or all that apply.</p> <p>1. The State will contract with an</p> <p><input checked="" type="checkbox"/> i. MCO (<i>Care Management Organization, CMOs</i>) <input type="checkbox"/> ii. PCCM (including capitated PCCMs that qualify as PAHPS) <input type="checkbox"/> iii. Both</p>
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	<p>2. The payment method to the contracting entity will be:</p> <p><input type="checkbox"/> i. fee for service; <input checked="" type="checkbox"/> ii. capitation; <input type="checkbox"/> iii. a case management fee; <input checked="" type="checkbox"/> iv. a bonus/incentive payment; <input type="checkbox"/> v. a supplemental payment, or <input type="checkbox"/> vi. other. (Please provide a description below).</p>
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	<p>3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.</p>

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Citation	Condition or Requirement
	<p>If applicable to this state plan, place a check mark to affirm the state has met <i>all</i> of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).</p> <p><input type="checkbox"/> i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.</p> <p><input type="checkbox"/> ii. Incentives will be based upon specific activities and targets.</p> <p><input type="checkbox"/> iii. Incentives will be based upon a fixed period of time.</p> <p><input type="checkbox"/> iv. Incentives will not be renewed automatically.</p> <p><input type="checkbox"/> v. Incentives will be made available to both public and private PCCMs.</p> <p><input type="checkbox"/> vi. Incentives will not be conditioned on intergovernmental transfer agreements.</p> <p><input checked="" type="checkbox"/> vii. Not applicable to this 1932 state plan amendment.</p>
CFR 438.50(b)(4)	<p>4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. (<i>Example: public meeting, advisory groups.</i>)</p> <p><i>In February 2003, the State issued a request for information seeking comprehensive proposals to redesign the Medicaid program to improve quality and provider accountability while achieving budget predictability and cost containment. Over 42 responses were received. For the next several months, meetings were held with providers, consumer groups, insurance representatives and other stakeholders to design a new program.</i></p> <p><i>In October 2003, a diverse team of stakeholders, including senior executives from healthcare provider organizations and advocacy groups assembled for several days to discuss state strategies to promote quality healthcare, enhanced access, shared member and provider responsibility, improved efficiency, and better cost management.</i></p> <p><i>In August 2004, the State announced that it would implement a mandatory managed care program using Care Management Organizations. From</i></p>

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Citation

Condition or Requirement

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*September 2004 through October 2004, the State held stakeholder sessions with physician and hospital providers, senior associations, children and family coalitions and others to ensure participation and input from all group affected by the new mandatory managed care program.*

*Upon implementation of the program, the State will continue to utilize providers from the various medical advisor committees, recipients involved in NET advisory committees, staff liaisons to advisory groups that include both providers and recipients, and member satisfaction surveys.*

*Beginning in 2011, DCH conducted a very inclusive and transparent process in analyzing redesign options and designing the program specific to youth in foster care, juvenile justice and adoption assistance. DCH and its Agent facilitated public input through statewide stakeholder focus groups, two public hearings an online survey and task forces. DCH also allowed for submission of comments through a "MyOpinion" Mailbox.*

*Beginning in February 2012, DCH convened three external task forces (Provider, Children and Families and "ABD" task forces) and a Mental Health and Substance Abuse Workgroup to provide ongoing input into program design which will continue through and after implementation as needed. The Children and Families Task Force has served in a key role in helping to define the program design and will be very involved in implementation and transition. This task force includes parents of members, advocacy organizations and provider groups.*

*Additionally, DCH formed an internal Foster Care and Adoption Assistance Joint Task Force which is an interagency team that includes representatives from DCH and the following agencies:*

- Department of Behavioral Health and Developmental Disabilities (DBHDD)*
- Department of Juvenile Justice (DJJ)*
- Department of Human Services (DHS)*
- Department of Public Health (DPH)*
- Department of Education (DOE)*
- Department of Early Care and Learning (DECAL)*

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Citation	Condition or Requirement
1932(a)(1)(A)	<p data-bbox="464 365 1398 495"><i>The Joint Task Force is advisory in nature and its goal is to provide guidance regarding the transition of youth in foster care and adoption assistance into the Georgia Families program. This guidance has and will help to ensure a program that is child-centric and focused on coordination of care.</i></p> <p data-bbox="464 531 1365 594"><i>Examples of additional methods that DCH will employ to continue collecting public input during and after implementation are as follows:</i></p> <ul data-bbox="516 632 1406 1031" style="list-style-type: none"><li data-bbox="516 632 1406 695">• <i>Inclusion of stakeholders such as foster and adoptive parents, members and advocates on an as needed basis</i></li><li data-bbox="516 737 1406 926">• <i>Requirement for the CMO to employ Ombudsmen staff who will be responsible for identifying and resolving issues, identifying and resolving issues pertaining to access to health care services, and communicating and educating members, providers, caregivers, foster and adoptive parents, state agencies and residential placement facilities and report findings to the Medicaid Agency</i></li><li data-bbox="516 968 1406 1031">• <i>Inclusion of related topics in the agenda for the Medical Care Advisory Committee on an as needed basis</i></li></ul> <p data-bbox="558 1073 1360 1203">5. The state plan program will <input checked="" type="checkbox"/> / will not _____ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory _____ / voluntary _____ enrollment will be implemented in the following county/area(s):</p> <ul data-bbox="558 1241 1406 1478" style="list-style-type: none"><li data-bbox="558 1241 1406 1268">i. county/counties (mandatory) _____</li><li data-bbox="558 1310 1406 1337">ii. county/counties (voluntary) _____</li><li data-bbox="558 1379 1406 1407">iii. area/areas (mandatory). _____</li><li data-bbox="558 1449 1406 1476">iv. area/areas (voluntary) _____</li></ul>
1932(a)(1)(A)(i)(I) 1903(m)	<p data-bbox="464 1520 1292 1547"><u>C. State Assurances and Compliance with the Statute and Regulations.</u></p> <p data-bbox="464 1583 1406 1646">If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.</p> <ul data-bbox="516 1682 1406 1745" style="list-style-type: none"><li data-bbox="516 1682 1406 1745">1. <input checked="" type="checkbox"/> The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.</li></ul>

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Citation	Condition or Requirement
42 CFR 438.50(c)(1)	
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. <u>  N/A  </u> The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. <u>  X  </u> The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C)	4. <u>  X  </u> The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. <u>  X  </u> The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. <u>  X  </u> The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) for 42 CFR 447.362 42 CFR 438.50(c)(6)	7. <u>  N/A  </u> The state assures that all applicable requirements of 42 CFR 447.362 payments under any nonrisk contracts will be met.
45 CFR 74.40	8. <u>  X  </u> The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

- 1932(a)(1)(A)(i) 1. List all eligible groups that will be enrolled on a mandatory basis.

**Low Income Families** - Section 1931 adults and children who meet the standards of the old AFDC (Aid to Families with Dependent Children) program.

**Transitional Medicaid** – Former Low-Income Medicaid (LIM) families who are no longer eligible for LIM because their earned income exceeds the

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Citation	Condition or Requirement
	<p><i>income limit pursuant to Section 1925.</i></p> <p><b><u>Pregnant Women (Right from the Start Medicaid – RSM)</u></b> - Pregnant women with family income at or below 200 percent of the federal poverty level who receive Medicaid through the RSM program. Pursuant to section 1902(a)(10)(A)(i)(iv) and 1902(1)(1)(A) and 1902(e)(5).</p> <p><b><u>Children (Right from the Start Medicaid RSM)</u></b> - Children under age nineteen (19) whose family income is at or below the appropriate percentage of the federal poverty level for their age and family, pursuant to section 1902(1)(1)(B) and 1902(1)(1)(C) and 1902(1)(1)(D).</p> <p><b><u>Children (newborn)</u></b> - Pursuant to section 1902(e)(4), a child born to a woman who is eligible Medicaid on the day the child is born.</p> <p><b><u>Breast and Cervical Cancer</u></b> – Pursuant to section 1902(1)(10)(ii)(xviii) women under 65 who have been screened through Title XV CDC screening and have been diagnosed with breast or cervical cancer.</p> <p><b><u>Refugees</u></b> - Those individuals who have the required INS documentation showing they meet a status in one of these groups: refugees, asylees, Cuban parolees/Haitian entrants, Amerasians or human trafficking victims.</p>
	<p>2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.</p> <p>Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.</p>
1932(a)(2)(B) 42 CFR 438(d)(1)	i. _____ Recipients who are also eligible for Medicare.  If enrollment is voluntary, describe the circumstances of enrollment. (Example: Recipients who become Medicare eligible during mid-enrollment remain eligible for managed care and are not disenrolled into fee-for- service.)
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. _____ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with

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Citation	Condition or Requirement
	the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. _____ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. _____ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. _____ Children under the age of 19 years who are in foster care or other out-of- the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. <u> X </u> Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. _____ Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

1932(a)(2)  
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. (*Examples: children receiving services at a specific clinic or enrolled in a particular program.*)

*Children receiving services funded by Title V are enrolled in the Children's Medical Services Program administered by the Georgia Division of Public Health. This program provides comprehensive, coordinated, community-based, Title V services for children birth to age 21 with chronic medical conditions. Medical eligibility includes but is not limited to:*

- *Burns*
- *Cardiac conditions*
- *Cystic fibrosis*
- *Hearing disorders*
- *Spina bifida*
- *Cerebral palsy*
- *Diabetes mellitus*
- *Vision disorders*
- *Craniofacial anomalies (including cleft lip/palate)*

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Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	<ul style="list-style-type: none"><li>• <i>Gastrointestinal disorders</i></li><li>• <i>Neurological and neurosurgical conditions including epilepsy and hydrocephalus</i></li><li>• <i>Orthopedic and/or neuromuscular disorders (scoliosis)</i></li><li>• <i>Congenital or traumatic amputations of limbs</i></li></ul> <p>2. Place a check mark to affirm if the state's definition of title V children a is determined by:</p> <p><input type="checkbox"/> i. program participation, <input type="checkbox"/> ii. special health care needs, or <input checked="" type="checkbox"/> iii. both</p>
1932(a)(2) 42 CFR 438.50(d)	<p>3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.</p> <p><input checked="" type="checkbox"/> i. yes <input type="checkbox"/> ii. no</p>
1932(a)(2) 42 CFR 438.50 (d)	<p>4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: (<i>Examples: eligibility database, self-identification</i>)</p> <p>The State identifies the eligibility groups through the MMIS.</p> <p>i. Children under 19 years of age who are eligible for SSI under title XVI;</p> <p><i>Identification for purposes of exemption will be accomplished by reviewing the eligibility database for each aid category. Exempted aid categories have an identifying edit. For enrollees who should be exempt but are inadvertently enrolled in managed care, notification by the enrollee, provider or other state agency of the exempt status will be processed by the State and the child will be disenrolled.</i></p> <p>ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;</p> <p><i>Identification for purposes of exemption will be accomplished by reviewing the eligibility database for each aid category. Exempted aid categories have an identifying edit. For enrollees who should be exempt but are inadvertently enrolled in managed care, notification by the enrollee, provider or other state agency of the exempt status</i></p>

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Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	<p><i>will be processed by the State and the child will be disenrolled.</i></p> <p>iii. Children under 19 years of age who are in foster care or other out-of-home placement;</p> <p><i>Identification for purposes of exemption will be accomplished by reviewing the eligibility database for each aid category. Exempted aid categories have an identifying edit. For enrollees who should be exempt but are inadvertently enrolled in managed care, notification by the enrollee, provider or other state agency of the exempt status will be processed by the State and the child will be disenrolled.</i></p> <p>iv. Children under 19 years of age who are receiving foster care or adoption assistance.</p> <p><i>Identification for purposes of exemption will be accomplished by reviewing the eligibility database for each aid category. Exempted aid categories have an identifying edit. For enrollees who should be exempt but are inadvertently enrolled in managed care, notification by the enrollee, provider or other state agency of the exempt status will be processed by the State and the child will be disenrolled.</i></p>
1932(a)(2) 42 CFR 438.50(d)	<p>5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. <i>(Example: self-identification)</i></p> <p><i>If the eligibility match does not initially identify those enrollees exempt from enrollment in managed care, the enrollee, or their provider or another state agency may notify the State of the error and the child will be exempted from mandatory enrollment.</i></p>
1932(a)(2) 42 CFR 438.50(d)	<p>6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: <i>(Examples: usage of aid codes in the eligibility system, self-identification)</i></p> <p>i. Recipients who are also eligible for Medicare.</p> <p><i>Identification for purposes of exemption will be accomplished by reviewing the eligibility database for each aid category. Exempted aid categories have an identifying edit. For enrollees who should be exempt but are inadvertently enrolled in managed care, notification by the enrollee, provider or other state agency of the</i></p>

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Citation	Condition or Requirement
	<p data-bbox="641 426 1177 453"><i>exempt status will be processed by the State.</i></p> <p data-bbox="544 499 1404 772">ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.</p> <p data-bbox="641 819 1339 846"><i>There are no Federally recognized Indian Tribes in Georgia.</i></p>
42 CFR 438.50	<p data-bbox="446 884 1364 947">F. <u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u></p> <p data-bbox="495 993 1388 1161"><i>1. Children enrolled in the Georgia Pediatric Program (GA PP) who are eligible under another aid category in addition to section 1902(e)(3) will be exempted from enrollment. In the case of the inadvertent enrollment into managed care, the enrollee, provider or another state agency may request disenrollment based upon the enrollee's participation in GAPP.</i></p> <p data-bbox="495 1207 1356 1304"><i>2. Recipients enrolled under group health plans for which DCH provides payment for premiums, deductibles, coinsurance and other cost sharing, pursuant to Section 1906 of the Social Security Act.</i></p> <p data-bbox="495 1350 1096 1377"><i>3. Individuals enrolled in a Hospice category of aid.</i></p> <p data-bbox="495 1423 1177 1451"><i>4. Individuals enrolled in a Nursing Home category of aid.</i></p>

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Citation                                  Condition or Requirement

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42 CFR 438.50                  G. List all other eligible groups who will be permitted to enroll on a voluntary basis

Eligibility Group Name	Social Security Act and CFR Citations
Youth less than 26 years of age who are receiving foster care or who are less than 21 years of age who are receiving other adoption assistance under Title IV-E or Title IV-B of the Social Security Act	1902(a)(10)(A)(i)(I) 473(b)(3) 42 CFR 435.145
Youth less than 26 years of age who are receiving foster care under Title IV- E or Title IV-B of the Social Security Act and are eligible for Supplemental Security Income	1902(a)(10)(A)(i)(I) 473(b)(3) 42 CFR 435.145 1902(a)(10)(A)(i)(II)(aa) 42 CFR 435.120
Youth less than 26 years of age who are receiving foster care or who are less than 21 years of age and are receiving other adoption assistance under Title IV-E or Title IV-B of the Social Security Act and are enrolled in SCHIP, PeachCare for Kids®	1902(a)(10)(A)(i)(I) 473(b)(3) 42 CFR 435.145
Youth less than 18 years of age eligible for Right from the Start Medicaid in the juvenile justice system and who are placed in community residential care	1902(a)(10)(A)(i)(III) <sup>1</sup> 1902(a)(10)(A)(i)(IV) 1902(a)(10)(A)(i)(VI) 1902(a)(10)(A)(i)(VII) 1902(a)(10)(A)(ii)(IX) 42 CFR 435.118 Section 1931 (<18) 42 CFR 435.110

H. Enrollment process.

1932(a)(4)  
42 CFR 438.50

1. Definitions

- i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state

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<sup>1</sup> 1902(a)(10)(A)(i)(III) is RSM covers pregnant women and newborns. The assumption is that newborns would not be in juvenile justice, so this reference applies specifically to pregnant women.

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Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	<p>records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.</p> <p>ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.</p> <p>2. State process for enrollment by default.</p> <p>Describe how the state's default enrollment process will preserve:</p> <p>i. the existing provider-recipient relationship (as defined in H.1.i).</p> <p><i>The State assures that default enrollment will be based on maintaining existing, as well as historical, provider/enrollee relationships to the extent possible. At the time of plan selection, enrollees will also choose a primary care provider (PCP). In the event of auto assignment of an enrollee to a CMO, the CMO will assign a primary care provider (PCP). Assignment will be made to a PCP based on prior enrollee and family history. If no enrollee or family history with a PCP exists, enrollees will be assigned to a PCP using an algorithm based on age, sex, and geographic proximity.</i></p> <p><b>Youth in Foster Care and Youth in Juvenile Justice</b></p> <p><i>The CMO will honor the member's guardian's PCP and dental home selection. Should a voluntary selection not be made, the CMO will auto-assign the member to a PCP and dental home using a formula that includes analysis of prior claims history if available or PCP or dentist selection of other CMO members with the same address. Members may request changes to their PCP and dental home at any point in time.</i></p> <p><i>Additionally, the CMO has three avenues through which it must coordinate to try to obtain information about a member's existing provider relationships for use in auto-assigning members when necessary to a PCP and dental home and in providing care management services.</i></p> <p><i>1. Coordinate with Division of Family and Children Services or Division of Juvenile Justice case workers who are charged with determining the current relationships</i></p>

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Citation	Condition or Requirement
	<ol style="list-style-type: none"><li data-bbox="548 426 1323 455">2. <i>Contact the member's prior insurer to request the information</i></li><li data-bbox="548 493 1393 590">3. <i>For members who were enrolled in Medicaid prior to enrollment with the CMO, review claims data to identify providers to whom the member has had regular visits</i></li></ol>
	<p data-bbox="505 625 857 655"><b><i>Youth in Adoption Assistance</i></b></p> <p data-bbox="505 693 1393 894"><i>The CMO will honor the member's guardian's PCP and dental home selection. Should a voluntary selection not be made, the CMO will auto-assign the member to a PCP and dental home using a formula that includes analysis of prior claims history if available or PCP or dentist selection of other CMO members with the same address. Members may request changes to their PCP and dental home at any point in time.</i></p> <p data-bbox="505 930 1404 1060"><i>Additionally, the CMO has three avenues through which it must coordinate to try to obtain information about a member's existing provider relationships for use in auto-assigning members when necessary to a PCP and dental home and in providing care management services:</i></p> <ol style="list-style-type: none"><li data-bbox="548 1096 1344 1192">1. <i>Coordinate with Division of Family and Children Services or Division of Juvenile Justice case workers who are charged with determining the current relationships</i></li><li data-bbox="548 1230 1323 1260">2. <i>Contact the member's prior insurer to request the information</i></li><li data-bbox="548 1297 1393 1394">3. <i>For members who were enrolled in Medicaid prior to enrollment with the CMO, review claims data to identify providers to whom the member has had regular visits</i></li></ol>
	<ol style="list-style-type: none"><li data-bbox="446 1430 1365 1497">ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).</li></ol> <p data-bbox="537 1533 1404 1797"><i>All CMOs will be contractually required to include significant traditional providers in their provider networks. Significant traditional providers are defined as those providers that provided the top 80 percent of Medicaid beneficiary encounters for the enrolled population in the base year of 2004. CMOs will also be required to contract with all FQHCS, RHCs and critical access hospitals in their service region. These contract requirements ensure that the default enrollment to any of the CMOs will maintain relationships with</i></p>

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Citation

Condition or Requirement

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*traditional Medicaid providers.*

***Youth in Foster Care and Youth in Juvenile Justice***

*CMO provider networks for Medicaid members are limited to Medicaid-participating providers. Additionally, the CMO is required to contract with significant traditional Medicaid, Division of Family and Child Services and Department of Juvenile Justice providers.*

***Youth in Adoption Assistance***

*CMO provider networks for Medicaid members are limited to Medicaid-participating providers.*

- iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2).  
*(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

*If there is no historical usage by the enrollee or family, then the enrollee assigned to the plan with the highest Auto Assignment score in the service region. See Section 3.v below which describes how the Auto Assignment process promotes equitable distribution among qualified CMOS.*

***Youth in Foster Care and Youth in Juvenile Justice***

*DCH is contracting with one CMO to provide services to eligible members in foster care and juvenile justice. The contract with the CMO outlines requirements for allowing members or their guardians to request disenrollment for cause in accordance with 42 CFR 438.56. The contract also requires the CMO to assist members with the disenrollment process by providing required forms to members and referring members to DCH or its Agent who will make disenrollment determinations*

***Youth in Adoption Assistance***

*DCH is contracting with one CMO to provide services to eligible members in adoption assistance who do not opt out of the CMO.*



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Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	<p data-bbox="581 390 1520 621"><i>Members who opt out of the single statewide CMO will be served through the fee-for-service delivery system. The contract with the CMO outlines requirements for allowing members or their guardians to request disenrollment for cause in accordance with 42 CFR 438.56. The contract also requires the CMO to assist members with the disenrollment process by providing required forms to members and referring members to DCH or its Agent who will make disenrollment determinations.</i></p> <p data-bbox="488 659 1425 720">3. As part of the state's discussion on the default enrollment process, include the following information:</p> <p data-bbox="537 758 1438 819">i. The state will <u> X </u> / will not <u> </u> use a lock-in for managed care managed care.</p> <p data-bbox="631 858 1520 1192"><i>Youth in adoption assistance may elect to opt out of the CMO without cause within the first 90 calendar days following the date of the member's initial enrollment with the CMO or the date DCH sends the member notice of the enrollment, whichever is later (Open Enrollment Period). Members who opt out will return to the Medicaid fee-for- service delivery system. Members in adoption assistance who do not opt out within the first 90 calendar days of enrollment in the CMO will remain with the CMO until the member's next enrollment period, subject to eligibility. These members may request to opt out of the CMO without cause every 12 months thereafter. The members may request to opt out of the CMO for cause at any time.</i></p> <p data-bbox="537 1230 1471 1291">ii. The time frame for recipients to choose a health plan before being auto-assigned will be <u> 30 days </u>.</p> <p data-bbox="631 1331 1255 1358"><b><i>Youth in Foster Care and Youth in Juvenile Justice</i></b></p> <p data-bbox="631 1398 1520 1459"><i>All youth in foster care and youth in juvenile justice will be assigned to one CMO; therefore, an auto-assignment process will not be used.</i></p> <p data-bbox="631 1499 992 1526"><b><i>Youth in Adoption Assistance</i></b></p> <p data-bbox="631 1566 1520 1627"><i>All youth in adoption assistance will be assigned to one CMO; therefore, an auto-assignment process will not be used.</i></p>

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Citation	Condition or Requirement
iii.	<p>Describe the state's process for notifying Medicaid recipients of their auto-assignment. (<i>Example: state generated correspondence.</i>)</p> <p><i>All enrollees will have 30 days from the date of eligibility notification to choose a CMO. After 30 days, enrollees are notified in writing of the auto-assignment. The auto-assignment notice will contain:</i></p> <ul style="list-style-type: none"><li>• <i>The name of the enrollee automatically assigned;</i></li><li>• <i>The name of the CMO to which the enrollee was assigned;</i></li><li>• <i>An explanation of why the auto-assignment was performed i.e., failure to select a CMO within the required time;</i></li><li>• <i>The CMO member services telephone number;</i></li><li>• <i>The effective date of enrollment in the CMO; and</i></li><li>• <i>The process and timeframe for changing the CMO selection, including a description of the 90 day choice period, lock-in policy and a list of providers in the enrollee's service region</i></li></ul> <p><b><i>Youth in Foster Care and Youth in Juvenile Justice</i></b></p> <p><i>While an auto-assignment process is not required, DCH has a process in place to mail notification of the member's enrollment with the CMO.</i></p> <p><b><i>Youth in Adoption Assistance</i></b></p> <p><i>While an auto-assignment process is not required, DCH has a process in place to mail notification of the member's enrollment with the CMO. The packet will also include explanation about disenrollment procedures for members in adoption assistance who want to opt out of the CMO.</i></p>
iv.	<p>Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. (<i>Examples: state generated correspondence, HMO enrollment packets etc.</i>)</p> <p><i>Enrollees will be notified in writing of their right to disenroll without cause within the first 90 day period of the CMO plan enrollment or the date the notice of enrollment is sent, whichever is later. After the 90 day period, the enrollee may change CMO plans only for cause in</i></p>

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Citation	Condition or Requirement
	<p><i>accordance with 42 CFR 438.56(d)(2) and as determined by the State until the annual anniversary date of the enrollee's enrollment.</i></p> <p><b><i>Youth in Adoption Assistance</i></b></p> <p><i>Youth in adoption assistance may elect to opt out of the assigned CMO without cause within the first 90 calendar days following the date of the member's initial enrollment with the CMO or the date DCH sends the member notice of the enrollment, whichever is later (Open Enrollment Period). Members who opt out will return to the Medicaid fee-for-service delivery system. Members in adoption assistance who do not opt out within the first 90 calendar days of enrollment in the CMO will remain with the CMO until the member's next enrollment period, subject to eligibility. These members may request to opt out of the CMO without cause every 12 months thereafter. Members who opt out are permitted to re-enter the CMO.</i></p> <p><i>The Member Handbook will detail information about enrollment and disenrollment processes, including information about disenrollment options within the first 90 days of enrollment. The Member Handbook is included in the information packet that the CMO must provide to new members</i></p> <p>v. Describe the default assignment algorithm used for auto-assignment. (Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)</p> <p><i>If a CMO selection is not made, the enrollee is auto assigned to the CMO as follows:</i></p> <ul style="list-style-type: none"><li><i>• If a family member of the enrollee is already enrolled in one CMO, the enrollee shall be assigned to that CMO. (Note: the use of family enrollment as a first step was chosen because often the enrollee history consists of only one encounter, and it is a goal of the State to keep families together in the same CMO whenever possible);</i></li><li><i>• If there are no family members already enrolled and the enrollee has a prior or existing provider relationship then the enrollee will be assigned to the CMO of which that provider is a member;</i></li><li><i>• If there is no prior or existing provider relationship the enrollee will be assigned to the CMO that previously enrolled</i></li></ul>

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Citation	Condition or Requirement
	<p><i>other family members,</i></p> <ul style="list-style-type: none"><li>• <i>If the enrollee does not have a traditional provider in either plan, or the provider is in both plans, the Member shall be auto assigned to the CMO which has the highest Auto Assignment score in the region; the Auto Assignment score will be a composite score comprised of a Quality component weighted at 70% as well as a Cost component weighted at 30%. The State will review the overall scores periodically and may prospectively change the weighting of the Quality and cost scores.</i></li></ul> <p><b><i>Youth in Foster Care and Youth in Juvenile Justice</i></b></p> <p><i>Not applicable as all members will be assigned to one CMO.</i></p> <p><b><i>Youth in Adoption Assistance</i></b></p> <p><i>Not applicable as all members will be assigned to one CMO.</i></p> <p>vi. Describe how the state will monitor any changes in the rate of default assignment. <i>(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)</i></p> <p><i>The State will obtain monthly reports from MMIS data.</i></p> <p><b><i>Youth in Foster Care and Youth in Juvenile Justice</i></b></p> <p><i>Not applicable as all members will be assigned to one CMO.</i></p> <p><b><i>Youth in Adoption Assistance</i></b></p> <p><i>Not applicable as all members will be assigned to one CMO.</i></p>
1932(a)(4) 42 CFR 438.50	<p><b><u>I. State assurances on the enrollment process</u></b></p> <p>Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.</p> <p>1. <u>  X  </u> The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.</p>

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Citation	Condition or Requirement
	<p data-bbox="565 394 1127 420"><b><i>Youth in Foster Care and Youth in Juvenile Justice</i></b></p> <p data-bbox="565 453 1208 478"><i>Not applicable as all members will be assigned to one CMO.</i></p> <p data-bbox="565 516 886 541"><b><i>Youth in Adoption Assistance</i></b></p> <p data-bbox="565 575 1208 600"><i>Not applicable as all members will be assigned to one CMO.</i></p> <p data-bbox="513 634 1414 751">2. <u>  X  </u> The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).</p> <p data-bbox="513 785 1279 844">3. <u>  X  </u> The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.</p> <p data-bbox="565 886 1414 1155"><i>This provision will be applicable only if the State is not successful in procuring more than one CMO plan in rural areas. Additionally, DCH has elected to contract with a single CMO that has targeted expertise to effectively handle the unique and complex health care needs of youth in foster care and youth in juvenile justice. Enrollees will be given a choice between at least two (2) PCPs within the CMO. Any limitation imposed on the freedom to change PCPs will be no more restrictive than the limitations on disenrollment from a CMO. In addition, beneficiaries will have the ability to choose between two physicians or case managers.</i></p> <p data-bbox="565 1188 1127 1213"><b><i>Youth in Foster Care and Youth in Juvenile Justice</i></b></p> <p data-bbox="565 1247 1409 1306"><i>Youth in foster care and eligible youth in juvenile justice will be assigned to the one CMO contracted to provide services to this population.</i></p> <p data-bbox="565 1339 886 1365"><b><i>Youth in Adoption Assistance</i></b></p> <p data-bbox="565 1398 1409 1457"><i>Youth in adoption assistance will be assigned to one CMO, but may elect to opt out to receive services through the fee-for-service delivery system.</i></p> <p data-bbox="659 1491 1312 1549"><u>        </u> This provision is not applicable to this 1932 State Plan Amendment.</p> <p data-bbox="513 1583 1377 1675">4. <u>        </u> The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of</p>

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Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)  <u> X </u> This provision is not applicable to this 1932 State Plan Amendment.  5. <u> X </u> The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.  <i>The State will apply this provision to enrollees who have a temporary loss of Medicaid which the State has defined as 2 months (62 days or less).</i>  <u> </u> This provision is not applicable to this 1932 State Plan Amendment.  <b>J. Disenrollment</b>  1. The state will <u> X </u> /will not <u> </u> use lock-in for managed care.  2. The lock-in will apply for <u> 12 </u> months (up to 12 months).  3. Place a check mark to affirm state compliance.  <u> X </u> The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).  4. Describe any additional circumstances of “cause” for disenrollment (if any).  <i>Enrollee requests to be assigned to the same CMO as other family members.</i>  <i>Members in adoption assistance may opt out of the CMO for cause at any time and return to the Medicaid fee-for-service delivery system. The following constitutes cause for disenrollment by these members:</i> <ul style="list-style-type: none"><li><i>The CMO does not, because of moral or religious objections, provide the covered service the member seeks.</i></li><li><i>The member needs related services to be performed at the same time and not all related services are available within the network. The member's provider or another provider have determined that receiving service separately would subject the member to unnecessary risk.</i></li></ul>

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Citation	Condition or Requirement
	<ul style="list-style-type: none"><li><i>Other reasons, per 42 CFR 438.56(d)(2), include, but are not limited to, poor quality of care, lack of access to services covered under the contract, or lack of providers experienced in dealing with the member's health care needs. (DCH or its Agent shall make determination of these reasons.)</i></li></ul>
	<p><b>K. <u>Information requirements for beneficiaries</u></b></p> <p>Place a check mark to affirm state compliance.</p>
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	<p><u>X</u> The state assures that its state plan program is in compliance with 42 CFR 38.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)</p>
1932(a)(5)(D) 1905(t)	<p><b>L. <u>List all services that are excluded for each model (MCO &amp; PCCM)</u></b></p> <ul style="list-style-type: none"><li><i>The CMO is only responsible for providing primary and acute care; all long term care services are excluded. Institutional care beyond the duration of 30 days is excluded. All care in an ICF/MR is excluded.</i></li><li><i>Experimental, Investigational, or Cosmetic procedures are excluded. Reconstructive procedures may be covered when there is documentation that the procedure is both medically necessary and primarily to restore or improve function or to correct deformity resulting from congenital or developmental anomaly, disease, trauma, or previous therapeutic or surgical process.</i></li></ul>
1932 (a)(1)(A)(ii)	<p><b>M. <u>Selective contracting under a 1932 state plan option</u></b> To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.</p> <ol style="list-style-type: none"><li>The state will <u>X</u> / will not _____ intentionally limit the number of entities it contracts under a 1932 state plan option.  <i>The State will limit the number entities to four (4) plans in the Atlanta region and two (2) entities in other regions.</i></li><li><u>X</u> The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.</li></ol>

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Citation

Condition or Requirement

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3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. (Example: a limited number of providers and/or enrollees.)

*The State will competitively procure CMO plans for participation in the program. Each plan will be evaluated and scored according to a well-defined set of financial and technical criteria. In the Atlanta region, the four plans receiving the highest acceptable scores will be selected to participate. In the other less urban regions, the two plans receiving the highest acceptable scores will be selected to participate.*

*Additionally, DCH has elected to contract with a single CMO that has targeted expertise to effectively handle the unique and complex health care needs of youth in foster care and youth in juvenile justice. DCH believes a single CMO will provide the best opportunity to achieve improvements in continuity of care, services and coordination which will in turn improve outcomes. Dividing such a small population (approximately 27,000 members including youth in adoption assistance) over multiple plans would create a barrier to the development of the necessary infrastructure and processes that are needed to properly serve the child. Additionally, there is significant overlap in the Medicaid providers contracted with each CMO; therefore, contracting with only one CMO will not impede provider choice. The single CMO, in fact, is required to contract with significant traditional Medicaid, Division of Family and Ch Services and Department of Juvenile Justice providers.*

*Additionally, DCH believes the CMO's expertise will also effectively handle the unique and complex health care needs of youth in adoption assistance. Therefore, DCH will contract with the CMO to also serve this population. However, youth in adoption assistance may elect to opt out of the assigned CMO and be served through the fee-for-service delivery system.*

4. \_\_\_\_\_ The selective contracting provision is not applicable to this state plan.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850



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Citation

Condition or Requirement

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CMS-10120 (exp. 3/31/2014)

Telehealth and Telemedicine services.

(a) Definitions. For the purposes of this section the following definitions apply:

(1) Asynchronous store and forward technologies means the transmission of a patient's medical information from an originating site to the physician or practitioner at the distant site. The physician or practitioner at the distant site can review the medical case without the patient being present. An asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines and text messages without visualization of the patient (electronic mail). Photographs visualized by a telecommunications system must be specific to the patient's medical condition and adequate for furnishing or confirming a diagnosis and or treatment plan.

(2) Distant site means the site at which the physician or practitioner delivering the service is located at the time the service is provided via a telecommunications system.

(3) Interactive telecommunications system means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.

(4) Originating site means the location of an eligible Medicaid beneficiary at the time the service being furnished via a telecommunications system occurs. Georgia Medicaid does not reimburse for asynchronous store and forward telecommunications technologies.

(b) General rules. Georgia Medicaid pays for covered telehealth services included on the telehealth list when furnished by an interactive telecommunications system if the following conditions are met:

(1) The physician or practitioner at the distant site must be licensed to furnish the service under State law. The physician or practitioner at the distant site who is licensed under State law to furnish a covered telehealth service described in this section may bill, and receive payment for, the service when it is delivered via a telecommunications system and identified in specific policy as a covered service or practitioner.

(2) The services are furnished to a beneficiary at an originating site, which is any Georgia Medicaid enrolled provider with the technological capacity to provide HIPAA compliant telemedicine services.

(3) Originating sites must not be an entity participating in a Federal telemedicine demonstration project that has been approved by, or receive funding from, the

Secretary as of December 31, 2000, regardless of its geographic location.

(4) The medical examination of the patient is under the control of the physician or practitioner at the distant site.

(5) A telepresenter is not required as a condition of payment unless a telepresenter is medically necessary as determined by the physician or practitioner at the distant site.

(6) Medicaid payment is not permitted for telehealth when asynchronous store and forward technologies, in single or multimedia formats, are used as a substitute for an interactive telecommunications system.

(c) Limitations.

(1) A clinical psychologist and a clinical social worker may bill and receive payment for individual psychotherapy via a telecommunications system, but may not seek payment for medical evaluation and management services per § 42 CFR 410.78.

(2) The physician visits required under § 42 CFR 483.40(c) may not be furnished as telehealth services.

(d) Process for adding or deleting services. Changes to the list of Medicaid telehealth services are made through the policy manuals available on the Georgia MMIS website.

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Pages 1 - 4, Part NN	<b>TCM The Attendance Zones of Walker County Schools and Chickamauga City Schools</b>
Pages 1 - 4, Part OO	<b>TCM Gordon County</b>
Pages 1 - 4, Part PP	<b>TCM Floyd County</b>
Pages 1 - 4, Part QQ	<b>TCM Early County</b>
Pages 1 - 3, Part RR	<b>TCM Grady County</b>
Pages 1 - 4. Part SS	<b>TCM Tattnall County</b>
Pages 1 - 3. Part TT	<b>TCM Meriwether County</b>
Pages 1 - 4, Part UU	<b>TCM Seminole County</b>
Pages 1 - 4. Part VV	<b>TCM Worth County</b>
Pages 1 - 3, Part WW	<b>TCM Spalding County</b>
Pages 1 - 4, Part XX	<b>TCM Dougherty County</b>
Pages 1 - 4, Part YY	<b>TCM Jefferson County</b>
Pages 1 - 4, Part ZZ	<b>TCM Lumpkin County</b>
Pages 1-4, Part AAA	<b>TCM Decatur County</b>
Pages 1-4, Part BBB	<b>TCM Terrell County</b>
Pages 1-4. Part CCC	<b>TCM Chariton County</b>
Pages 1-4. Part DDD	<b>TCM Jeff Davis County</b>
Pages 1-4, Part EEE	<b>TCM Brantley County</b>
Pages 1-4, Part FFF	<b>TCM Lowndes County</b>
Pages 1-4. Part GGG	<b>TCM Fannin County</b>

**Supplement 1 to Attachment 3.1-A**

Pages 1-4, Part HHH	TCM <b>Wilkes County</b>
Pages 1-4, Part III	TCM Berrien County-
Pages 1-4, Part J.TJ	TCM Glynn County
Pages 1-4, Part KKK	TCM Catoosa County
Pages 1-4, Part LLL	TCM Long County
Pages 1-4, Part MMM	TCM Tift County
Pages 1-4, Part NNN	TCM Ben Hill County**
Pages 1-4, Part 000	TCM Gilmer County***
Pages 1-4, Part PPP	TCM Liberty County***
Pages 1-4, Part QQQ	TCM White County***
Pages 1-4, Part RRR	TCM Wilkinson County***
Pages 1-4, Part SSS	TCM Hall County***
Pages 1-4, Part TTT	TCM Lanier County***

**\*\*\*Not yet approved by HCFA**

### **Attachment 3.1-B**

Page 1	Ambulatory Services Provided:
Page 2	Inpatient hospital services other than those provided in an institution for mental diseases. Outpatient hospital services. Other laboratory and x-ray services. Nursing facility services.
Page 2a	Physician Services.
Page 3	Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. Home health services.
Page 4	Private duty nursing services. Clinic services. Dental services. Physical therapy and related services. Prescribed drugs; dentures, and prosthetics devices; and eyeglasses, prescribed by a physician skilled in diseases of the eye or by an optometrist.
Page 5	Other diagnostic, screening, preventive, and rehabilitative services. Services for individuals age 65 or older in institutions for mental disease.
Page 6	Intermediate care facility services. Inpatient psychiatric facility services. Nurse mid-wife services. Hospice care.
Page 7	Case management services and tuberculosis related services. Extended services for pregnant women. Certified pediatric or family nurse practitioners' services.
Page 8	Respiratory care services. Any other medical care and any other type of remedial care Recognized under State law, specified by the Secretary.
Page 9	Home and Community care for the functionally disabled Elderly individuals, as defined, described and limited in Supplement 2 to Attachment 3.I-A, and Appendices A-G to Supplement 2 to Attachment 3.1-SA.

### **Attachment 3.1-C**

Page I            Provider Standards.  
Peer Review of Long Term Care Services.  
Surveillance and Utilization Review.  
Home Health Agency Reviews.

### **Attachment 3.1-D**

Page I            The Department assures that necessary transportation for recipients to and  
from providers will be provided through the following methods:  
Emergency Ambulance  
Non-Emergency Transportation

### **Attachment 3.1-E**

Page I            Standards for the Coverage of Organ Transplants Services. For recipients 21  
years of age and over, the only transplants covered are kidney, liver, etc.

Page 2            Organ transplant centers continued.

### **Attachment 3.19-G**

Page 1            Telehealth and Telemedicine Services.  
Definitions  
General Rules

Page 2            Limitations  
Process for adding or deleting services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program

because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis but not eligible for special education.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

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TN No. 01-033

Supersedes

Approval JAN 28 2002 Effective Date OCT 01 2001  
Date

TN No. New

B. Areas of State in which services will be provided:

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide):  
Coweta County.

C. Comparability of Services:

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.



3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services ( Health Check, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the: Coweta County Health Department, Coweta County Department of Family and Children Services, Coweta County Public Schools and/or city schools.

- f. Case Management Supervisor must hold a Bachelors Degree and have experience in the human service field: i.e. public and social services, counseling, and have experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis but not eligible for special education.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Crawford County.

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the
  - a. Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (Health Check, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Crawford County Health Department, Crawford County Department of Family and Children Services, Crawford County Public Schools and or city schools, Crawford County Commissioners, City of Roberta, Crawford County Juvenile Court, Crawford County Division of Youth Services.

- f. Case Management Supervisor must hold a Bachelors Degree and have experience in the human service field: i.e. public and social services, counseling, and have experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis but not eligible for special education.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Jasper County.

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.



3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services ( Health Check, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Jasper County Health Department, Jasper County Department of Family and Children Services, Jasper County Public Schools and/r city schools, Jasper County Commissioners, City of Monticello, Jasper County Juvenile Court, and Jasper County Division of Youth Services.

- f. Case Management Supervisor must hold a Bachelors Degree and have experience in the human service field: i.e. public and social services, counseling, and have experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis but not eligible for special education.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Miller County.

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act.

Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services ( Health Check, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Miller County Health Department, Miller County Department of Family and Children Services, Miller County Public Schools and/or city schools, Miller County Commissioners, City of Colquitt, Miller County Juvenile Court, and Miller County Division of Youth Services.

- f. Case Management Supervisor must hold a Bachelors Degree and have experience in the human service field: i.e. public and social services, counseling, and have experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis but not eligible for special education.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Towns County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.



3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act.

Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (Health Check, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Towns County Health Department, Towns County Department of Family and Children Services, Towns County Public Schools and/or city schools, Towns County Commissioners, Cities of Young Harris, and Hiawassee, and Towns County Juvenile Court.

- f. Case Management Supervisor must hold a Bachelors Degree and have experience in the human service field: i.e. public and social services, counseling, and have experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis but not eligible for special education.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

State: Georgia

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B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Union County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services ( Health Check, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the: Union County Health Department, Union County Department of Family and Children Services, Union County Public Schools and/or city schools, Union County Commissioners, City of Blairsville, Union County Juvenile Court, and Union County Division of Youth Services.

- f. Case Management Supervisor must hold a Bachelors Degree and have experience in the human service field: i.e. public and social services, counseling, and have experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis but not eligible for special education.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Banks County.

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.



3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (Health Check, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the: Banks County Health Department, Banks County Department of Family and Children Services, Banks County Public Schools and/or city schools, Banks County Commissioners, City of Homer, and Banks County Juvenile Court.

- f. Case Management Supervisor must hold a Bachelors Degree and have experience in the human service field: i.e. public and social services, counseling, and have experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis but not eligible for special education.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Dade County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services ( Health Check, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the: Dade County Health Department, Dade County Department of Family and Children Services, Dade County Public Schools and or city schools, and Dade County Commissioners.

- f. Case Management Supervisor must hold a Bachelors Degree and have experience in the human service field: i.e. public and social services, counseling, and have experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and I individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis but not eligible for special education.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Greene County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.



3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services ( Health Check, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the: Greene County Health Department, Greene County Department of Family and Children Services, Greene County Public Schools and/ or city schools, Greene County Commissioners, City of Greensboro, and Greene County Juvenile Court.

- f. Case Management Supervisor must hold a Bachelors Degree and have experience in the human service field: i.e. public and social services, counseling, and have experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis but not eligible for special education.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

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TN No. 01-042

Supersedes

TN No. New

Approval Date FEB 08 2002

Effective Date OCT 01 2001

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Walton County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:0

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services ( Health Check, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the: Walton County Health Department, Walton County Department of Family and Children Services, Walton County Public Schools and Social Circle City Schools, Walton County Board of Commissioners, Walton County Juvenile Court, and Walton County Division of Youth Services.

- f. Case Management Supervisor must hold a Bachelors Degree and have experience in the human service field: i.e. public and social services, counseling, and have experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia

Special Education Service Coordination Case Management Services  
(Known as Targeted Case Management [TCM])

A. Target Group:

Children ages 3-20 years old who are Medicaid eligible and whom have disabilities under the Individuals with Disabilities Education Act (IDEA) with coverable conditions as documented in their Individual Education Program (IEP) or IFSP (Individual Family Services Plan). A child is eligible to receive comprehensive Special Education Service Coordination case management services (TCM) under the Georgia Medical Assistance Program when all of the following conditions are met:

- The child has an active IEP with special education service coordination listed as a necessary service; and
- The IEP contains Medicaid coverable medical (health-related) services.

B. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to requirements of Section 1902(a)(10)(B) of the Act.

C. Areas of State in which services will be provided:

- Entire State (180 schools or local education agencies)
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): All 180 school districts in GA.

D. Definition of Services:

Special Education Service Coordination case management means ongoing service coordination activities, carried out to assist children receiving special education, as indicated by the child's IEP or IFSP to assist the recipient in gaining access to the appropriate and needed services. It also involves monitoring the recipients to assure needed medical services are received as listed in the IEP. The special education service coordinator is responsible for:

- 1) Coordinating the process of the IEP development,
- 2) Coordinating the implementation of the IEP, and
- 3) Monitoring and follow up on the targeted recipients to assure that required medical services are received and are adequate in meeting each child's needs.

Special education service coordination focuses on medical services detailed in the child's IEP. However, the clearly defined nature of special education service coordination eliminates duplication of service coordination activities and any overlap of responsibilities.

A single Service Coordinator (case manager) should be named in the child's IEP.

Special Education Service Coordination Case Management activities include, but are not limited to:

1. Coordinating the performance of medical evaluations and assessments that the child needs;
2. Facilitating and participating in the development, review, and evaluation of the IEP;
3. Linking and coordinating medical services across private and public agency lines; and
4. Reassessing and follow-up, as required, to ensure medical needs of the student are met.

The department will only pay for case management activities that are over and above the provider's usual assigned duties and responsibilities.

The Service Coordination case management records for special education must be maintained in the child's record. All contacts with or on behalf of a child must be documented in the same manner as other covered services. (This mean that the health-related services, outlined in the child's IEP, are coverable under the school-based Children's Intervention School Services [CISS] program and must be documented according to the CISS program policies and procedures and as defined in the State Plan.)

Services which exceed the limitations must be approved prior to service delivery.



Required Documentation

Service coordination case management services for special education children with an IEP must be documented with each encounter. The following information must be maintained for each encounter: date of service, name of the student, the name of the individual providing the service, the specialty, discipline or title of the individual providing the service, the nature of the billable activity, the method of service delivery (examples: telephone contact, correspondence, face to face, etc.), the group or individual with whom engaged, and the time span of the activity. Documentation materials, including IEPs, should be maintained for at least five years after service delivery.

E. Qualifications of Providers:Provider Qualifications

The individual must possess the following qualifications:

- An individual who possesses a baccalaureate degree with a major in special education, social services, psychology, or a related field (behavioral health, or social sciences); or
- Registered Nurse.

In addition to meeting at least one of the above criteria, the service coordinator must also possess demonstrated knowledge and understanding of all of the following:

- Medicaid regulations related to the provision of IEP services;
- The nature and scope of services covered under IDEA;
- Provision of direct care services to individuals with special needs; and
- Provision of culturally competent services within the culture of the community being served.

Exclusions

- Medicaid will not reimburse case management services, which duplicate other case management services and are provided to eligible recipients through other Targeted Case Management programs.
  - Service coordination case management services (TCM) as defined in the State Plan will not be eligible for FFP at the administrative rate, for the same types of services furnished to the same recipients.
  - Recipients cannot receive another direct billable services at the same date and time they are receiving TCM.
  - The Service Coordinator (case manager) cannot be the direct therapy provider.
- F. The State assures that the provision of case management services will not restrict the children and their family freedom of choice of providers in violations of Section 1902 (a) (23) of the Act.
1. Eligible recipients will have the free choice of the providers of special education service coordination case management services.
  2. Eligible recipients will have the free choice of providers for other Medicaid services or medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis but not eligible for special education.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): **McDuffie County**

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act.  
Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (Health Check, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the:

**McDuffie** County Health Department, **McDuffie** County Department of Family and Children Services, **McDuffie** County Public Schools and or city schools, and **McDuffie** County Commissioners.

- f. Case Management Supervisor must hold a Bachelors Degree and have experience in the human service field: i.e. public and social services, counseling, and have experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis but not eligible for special education.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): **Polk** County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.



3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (Health Check, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the: **Polk County Health Department, Polk County Department of Family and Children Services, Polk County Public Schools and or city schools, Polk County Juvenile Court, Polk County Division of Youth Services.**

- f. Case Management Supervisor must hold a Bachelors Degree and have experience in the human service field: i.e. public and social services, counseling, and have experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis but not eligible for special education.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Atkinson County.

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (Health Check, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the: **Atkinson** County Health Department, **Atkinson** County Department of Family and Children Services, **Atkinson** County Public Schools and or city schools, Atkinson County Commissioners, City of Pearson and City of Willacoochee, **Atkinson** County Juvenile Court, and **Atkinson** County Department of Juvenile Justice.

- f. Case Management Supervisor must hold a Bachelors Degree and have experience in the human service field: i.e. public and social services, counseling, and have experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

**State of Georgia**

**1905(a)(29) Medication-Assisted Treatment (MAT)**

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy  
(Continued)

1905(a)(29) x MAT as described and limited in Supplement 1 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

**State of Georgia**

**1905(a)(29) Medication-Assisted Treatment (MAT)**

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

i. General Assurance

MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020 and ending September 30, 2025.

ii. Assurances

- a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).
- b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.
- c. The state assures coverage for all formulations of MAT drugs and biologicals for OUD that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

iii. Service Package

For the period of October 1, 2020, through September 30, 2025 Medication Assisted Treatment (MAT) to treat Opioid Use Disorder (OUD) is covered exclusively under section 1905(a)(29).

The state covers the following counseling services and behavioral health therapies as part of MAT.



**State of Georgia**

- a) Please set forth each service and components of each service (if applicable), along with a description of each service and component service.
1. Medication Training and Support: Provides education for members to learn about the medications prescribed to treat OUD and the importance of adherence and compliance
  2. Drug Assessment: Assessment for Opioid Use Disorder that includes an assessment of past and present use, the administration of the Addictions Severity index, current and past functioning in all major life areas as well as members strengths, weaknesses, and treatment preferences. It is performed by a licensed behavioral health professional.
  3. Substance Abuse Services Treatment Plan Development: This service is performed by the licensed behavioral health professional and or other professionals who comprise the treatment team. It must contain individualized goals, objectives, activities, and services that support recovery. It must include a discharge plan.
  4. Substance abuse services, skill development: Skills development for Opioid use disorders are behavioral health remedial services that are necessary to improve the client's ability to function in the community. They promote and teach recovery skills necessary to live independently in the community and prevent relapse. They may be performed in a group or one to one. They may be provided by a licensed behavioral health professional.
    - a. Individual, group and/ or family therapy\*.  
\*Family therapy that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.
  5. Crisis Intervention services: Urgent assessment and history of crisis situation to assess individual with OUD for treatment and supportive services
- b) Please include each practitioner and provider entity that furnishes each service and component service.

State of Georgia

(1) Office-Based Opioid Treatment (OBOT) provider:

(a) physician enrolled in Georgia Medicaid to provide MAT services in OBOT settings, who are licensed and in good standing in the State, maintain a federal waiver to dispense and administer narcotics, and maintain state registration to dispense; or

(b) a physician's assistant (PA) or advanced practice registered nurse (APRN) enrolled in Georgia Medicaid to provide MAT services, licensed and in good standing, and supervised as required by law.

OBOT providers must have capacity to provide directly or by referral all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder, including for maintenance, detoxification, overdose reversal, and relapse prevention. OBOT providers must have capacity to provide directly or by referral appropriate counseling and behavioral therapy. OBOT providers are limited to the drugs allowed by law to be prescribed and/or administered in a setting that is not an Opioid Treatment Program.

(2) Opioid Treatment Program (OTP) - a program or provider registered under federal law, certified as an OTP by the Substance Abuse and Mental Health Services Administration (SAMHSA) engaged in opioid treatment of individuals by use of an opioid agonist treatment medication, including methadone, and contracted with the State. An OTP must have the capacity to provide the full range of services included in the definition of MAT and must document both medication dosing and supporting behavioral health services. OTP programs may include:

(a) OTP MAT Provider - a licensed physician in good standing, maintaining a current federal waiver to prescribe drugs and biological products for the treatment of opioid-use disorder, and maintaining a current State registration to dispense dangerous medications; or

(b) OTP Exempt MAT Provider - a licensed PA or APRN in good standing, supervised, when required, by a physician described in (2)(a) above, and exempt from federal regulatory requirements for OTPs.

(c) OTP Behavioral Health Services Providers - licensed professionals who provide drug assessment, treatment plan development, skills development and individual/group therapy

(d) Medication Unit Affiliated with an OTP Established under 42 CFR. 8.11(i) - a dosing location or medication station that obtains its methadone drug supply from a primary OTP site, which retains all records for the medication unit, except dosing and drug screens, which dispenses MAT drugs for observed intake, and which has on staff an OTP MAT Provider as defined above.

State of **Georgia**

- (3) Registered Nurse (medication training and support)
- (4) Physician Assistant (medication training and support)
- (5) Advanced Practice Registered Nurse (medication training and support)
- (6) Behavioral Health Practitioner (Assessment, treatment plan development, skills development and individual/group therapy)

- c) Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training and supervisory arrangements that the state requires.

Registered Nurse: state licensure

Physician Assistant: state licensure

Advanced Practice Registered Nurse: state licensure

Behavioral Health Practitioner: state licensure

Psychologist:

- A doctoral degree from a recognized educational institution in a program that is primarily counseling in content and requires at least one year of supervised internship in a work setting acceptable to the board; or A specialist degree from a recognized educational institution in a program that is primarily counseling in content with supervised internship or practicum and two years of post-master's directed experience under supervision.
- A master's degree in rehabilitation counseling or in a program that is primarily counseling in content from a recognized educational institution.

Licensed Marriage and Family Therapist

- master's degree from a program in marriage and family therapy, from a program equivalent to a marriage and family therapy degree program, or from any program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE).
- two years of full- (A) A doctoral degree from a recognized educational institution in a program that is primarily counseling in content and requires at least one year of supervised internship in a work setting acceptable to the board; or (B) A specialist degree from a recognized educational institution in a program that is primarily counseling in content with supervised internship or practicum and two years of post-master's directed experience under supervision in a setting acceptable to the board; or (C)(i) A master's degree in rehabilitation counseling or in a program that is primarily counseling in content from a recognized educational institution; (ii) An internship or

State of **Georgia**

- practicum supervised either by a supervisor, as defined in paragraph (16) of time post-master's experience or its equivalent, under direction and supervision.
- Examination in Marital and Family Therapy following Board review of his/her application for licensure as a marriage and family therapist and approval to take the examination. Passage of the exam is a requirement to issue a license.

Certified/registered Addiction Counselor

- Minimum High School diploma or Equivalency (G.E.D.)
- 2 years full-time or 4,000 hours active practice as a chemical dependency/abuse counselor in the past 5 years.
- 180 contact hours of education and training in alcoholism and drug abuse or related counseling subjects, including six hours of ethics training
- Passing score on the NCC AP (national written exam)

Behavioral Health Practitioner includes Psychologist, Licensed Marriage and Family Therapists, and Certified Addiction Counselors.

**State of Georgia \_\_\_\_\_**

**1905(a)(29) Medication-Assisted Treatment (MAT)**

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

iv. Utilization Controls

The state has drug utilization controls in place. (Check each of the following that apply)

- Generic first policy
- Preferred drug lists
- Clinical criteria
- Quantity limits

The state does not have drug utilization controls in place.

v. Limitations

Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

The following services are excluded from coverage:  
The State requires that providers follow the SUPPORT Act with respect to MAT products. The State develops and applies clinical criteria for MAT products based on existing clinical evidence. The State develops and applies quantity limitations consistent with the FDA labeling for MAT products.

**State of Georgia**

**1905(a)(29) Medication-Assisted Treatment (MAT)**

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on October 24, 2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020, and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 60). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

T.N. No.: 21-0003

Supersedes

T.N. No.: NEW

Effective: October 1, 2020

Approved: December 6, 2021

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Children ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening.
3. Free or reduced price lunch.
4. One or more retentions.
5. Iowa Test of Basic Skills (ITBS) Test of Achievement and Proficiency (TAP) reading scores below the 35th percentile.
6. Five or more unexcused absences in any one twenty (20) day attendance period.
7. Two or more suspensions during the most recent school year.
8. Limited English proficiency.
9. Transferred two or more times during the most recent school year.
10. One or more years below grade placement in the reading basal.
11. Few friends or school alienation
12. Little or no extracurricular involvement.
13. Frequent disciplinary referrals.
14. Dysfunctional home situation.
15. Disabled without mental impairment.
16. School-aged parents.
17. Economically or socially deprived.

B. Areas of State in which services will be provided:

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide):

Decatur County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(2) of the Act is invoked to provide services without regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.



E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Decatur County Schools; Decatur County Health Department, Decatur County Family and Children Services, and Juvenile Justice.
- f. Case Management Supervisor must hold a Bachelor's Degree and have experience in the human service field; i.e. public and social services, counseling, and have experience working with at-risk children and their families.
- g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
- h. Both the Case Management Supervisor(s) and Case Manager(s) must complete a pre-service training program and a Family Connection designed and supervised practicum experience.

- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below) on Iowa Test of Basis Skills (ITBS) or Test of Achievement and Proficiency (TAP)..
20. Low grades/failing two (2) or more academic subjects in a grading

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Terrell County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan

D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., Health Check, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Terrell County Health Department Terrell County Department of Family and Children Services, Terrell County Public Schools, Terrell County Mental Health, Terrell County Commissioners, City of Dawson , Southwest Health District 8, Unit 2.

E. Qualification of Providers: (continued)

- f. Case Management Supervisor must hold a Bachelor's Degree in a human services field; i.e., public and social services, counseling, humanities and have three years of experience working with a diverse population of low income children and their families.
  - g. Case Managers must have high school diploma or its equivalency, have a minimum of two years experience working with children and families from various racial and ethnic groups and be familiar with the Paulding community and the services provided.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease,
19. Low achievement test scores (35th percentile and below) on Iowa Test of Basis Skills (ITBS) or Test of Achievement and Proficiency (TAP)..
20. Low grades/failing two (2) or more academic subjects in a grading period.
21. History of sexual or physical abuse or neglect.
22. Two or more out-of-school suspensions the most recent school year.
23. Inadequate health care.
24. Children or children with family members identified with drug and/or alcohol abuse
25. Family members with limited job skills or difficulty finding employment.
26. Pregnancy.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Charlton County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan



D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Charlton County Health Department, Charlton County Department of Family and Children Services, Charlton County Public Schools, Charlton County Mental Health, Charlton County Commissioners, City of Folkston, Southeast Health District 9, Unit 2.

E. Qualification of Providers: (continued)

- f. Case Management Supervisor must hold a Bachelor's Degree in a human services field; i.e., public and social services, counseling, humanities and have three years of experience working with a diverse population of low income children and their families.
  - g. Case Managers must have high school diploma or its equivalency, have a minimum of two years experience working with children and families from various racial and ethnic groups and be familiar with the Paulding community and the services provided.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening or inadequate health care.
3. Free or reduced price lunch.
4. One or more retentions,
5. Iowa Test of Basic Skills (ITBS)/Test of Achievement and Proficiency (TAP) reading scores below the 35th percentile.
6. Five or more unexcused absences in any one twenty (20) day attendance period.
7. Two or more suspensions during the most recent school year.
8. Limited English proficiency.
9. Transferred two or more times during the most recent school year.
10. One or more years below grade placement in the reading basal.
11. Few friends or school alienation,
12. Little or no extracurricular involvement.
13. Frequent disciplinary referrals.
14. Dysfunctional home situation.
15. Disabled without mental impairment.
16. School-aged parents.
17. Economically or socially deprived.
18. Pregnancy.

B. Areas of State in which services will be provided:

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide):

Jeff Davis County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(2) of the Act is invoked to provide services without regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act.

Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Jeff Davis County Schools; Jeff Davis Health Department; Jeff Davis County Department of Family and Children Services; Jeff Davis County Juvenile Court; and Jeff Davis County Division of Youth Services.
- f. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families and two years experience working with at-risk children and their families.
- g. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.

- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. No EPSDT initial screen, no periodic screening or inadequate health care.
2. Few friends or school alienation,
3. Little or no extracurricular involvement.
4. Frequent disciplinary referrals.
5. Dysfunctional home situation.
6. Single parent family.
7. One or more grade retentions.
8. Born to teenage parent(s).
9. Born to a parent who has not completed High School.
10. Five or more unexcused absences in any one twenty (20) day attendance period.
11. One or more years below grade placement in reading or math.
12. Free or reduced price lunch.
13. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
14. Residing in home situation with guardian or caretaker other than natural parent(s).
15. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
16. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills(ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
17. History of exposure to direct or indirect violence.
18. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Brantley County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan



D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Brantley County Health Department, Brantley County Department of Family and Children Services, Brantley County Public Schools, Brantley County Mental Health, Brantley County Commissioners, City of Nahunta, Southwest Health District 9, Unit 2.

- E. Qualification of Providers: (continued)
  - f. Case Management Supervisor must hold a Bachelor's Degree in a human services field; i.e., public and social services, counseling, humanities and have one year relative experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
  - 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate healthcare.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Three or more unexcused absences in any one thirty (30) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basis Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Lowndes County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan

D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., Health Check, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Lowndes County Health Department, Lowndes County Department of Family and Children Services, Lowndes County Public Schools, Valdosta City Schools, Lowndes County Commissioners, City of Valdosta, South Health District 8, Unit 1, and Behavioral Health Services of South Georgia.

- E. Qualification of Providers: (continued)
- f. Case Management Supervisor must hold a Bachelor's Degree in a relevant field; i.e., public and social services, counseling, humanities and have one year experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening.
3. Free or reduced price lunch.
4. One or more retentions.
5. Iowa Test of Basic Skills (ITBS) Test of Achievement and Proficiency (TAP) reading scores below the 35th percentile.
6. Five or more unexcused absences in any one twenty (20) day attendance period.
7. Two or more suspensions during the most recent school year.
8. Limited English proficiency.
9. Transferred two or more times during the most recent school year.
10. One or more years below grade placement in the reading basal.
11. Few friends or school alienation.
12. Little or no extracurricular involvement.
13. Frequent disciplinary referrals.
14. Dysfunctional home situation.
15. Disabled without mental impairment.
16. School-aged parents.
17. Economically or socially deprived.
18. Born to a teenage parent(s).
19. Born to a parent who has not completed high school.
20. Residing in a home situation with guardian or caretaker other than natural parents.
21. Born to a Medicaid eligible mother.
22. Free or reduced lunch program.
23. Single parent family.

B. Areas of State in which services will be provided:

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide):

Fannin County

C. Comparability of Services:

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(2) of the Act is invoked to provide services without regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.



E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Fannin County Schools; Fannin County Health Department; Fannin County Department of Family and Children Services, Fannin County Juvenile Court, and Fannin County Division of Youth Services.
- f. Case Management Supervisors must hold a Bachelor's Degree and have experience in the human services field; i.e., psychology, sociology, social work, humanities, counseling, career services and have experience working with low income indigenous children and their families.
- g. Case managers must hold a High School diploma or its equivalent and have experience working with low income indigenous children and their families.
- h. Both the Case Management Supervisors and Case Managers must complete a pre-service training program and a Family Connection designed and supervised practicum experience.

- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Wilkes County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan

D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Wilkes County Health Department, Wilkes County Department of Family and Children Services, Wilkes County Public Schools, Wilkes County Mental Health, Wilkes County Commissioners, City of Washington, Housing Authority of the City of Washington.

- E. Qualification of Providers: (continued)
  - f. Case Management Supervisor must hold a Bachelor's Degree and have experience in the human service field; i.e., public and social services, counseling, and have experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
  - 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Children in grades Pre-K to K and their Medicaid eligible siblings who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen or no periodic screening.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent.
11. Born to a parent who has not completed high school.
12. Five or more unexcused absences in any one twenty (20) day attendance period,
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch. Disabled without mental impairment.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.).
17. Residing in home situation with guardian or caretaker other than biological parents.
18. History of substance abuse, Juvenile Court involvement, or at risk for socially transmitted disease.
19. Low achievement test scores (35<sup>th</sup> percentile and below) on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP).
20. Low grades/failing two (2) or more academic subjects in a grading period,
21. History of sexual or physical abuse or neglect, or exposure to violence.
22. Two or more out-of-school suspensions during the most recent school year.
23. Inadequate health care,
24. Children or children with family members identified with drug and/or alcohol use or abuse.
25. Family members with limited job skills or difficulty finding employment.
26. Pregnancy.
27. Transferred or moved two (2) or more times during the most recent school year.
28. Two (2) or more bus suspensions during the most recent school year.
29. Served or enrolled in the immigrant education program.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Berrien County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(2) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.



E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Fannin County Schools; Fannin County Health Department; Fannin County Department of Family and Children Services, Fannin County Juvenile Court, and Fannin County Division of Youth Services.
- f. Case Management Supervisor must hold a Bachelor's Degree and have experience in the human service field; i.e., public and social services, counseling, and have experience working with at-risk children and their families.
- g. Case managers must hold a High School diploma or its equivalent and have experience working with low income indigenous children and their families.
- h. Both the Case Management Supervisors and Case Managers must complete a pre-service training program and a Family Connection designed and supervised practicum experience.

F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Glynn County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan

D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Glynn County Health Department, Glynn County Department of Family and Children Services, Glynn County Public Schools and/or city schools, Glynn County Commissioners, City of Brunswick, Glynn County Juvenile Court, Glynn County Division of Youth Services.

- E. Qualification of Providers: (continued)
  - f. Case Management Supervisor must hold a Bachelor's Degree and have experience in the human service field; i.e., public and social services, counseling, and have experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
  - 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program

because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basis Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Catoosa County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan



D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Catoosa County Health Department, Catoosa County Department of Family and Children Services, Catoosa County Public Schools and/or city schools, Catoosa County Commissioners, Catoosa County Juvenile Court, and Catoosa County Division of Juvenile Justice.

- E. Qualification of Providers: (continued)
- f. Case Management Supervisor must hold a Bachelor's Degree in a human services field; i.e., public and social services, counseling, humanities and have three years of experience working with a diverse population of low income children and their families.
  - g. Case Managers must have high school diploma or its equivalency, have a minimum of two years experience working with children and families from various racial and ethnic groups and be familiar with the Paulding community and the services provided.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Long County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan

D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Long County Health Department, Long County Department of Family and Children Services, Long County Public Schools and/or city schools, Long County Commissioners, City of Ludowici, and Long County Juvenile Court.

- E. Qualification of Providers: (continued)
- f. Case Management Supervisor must hold a Bachelor's Degree in a human services field; i.e., public and social services, counseling, humanities and have three years of experience working with a diverse population of low income children and their families.
  - g. Case Managers must have high school diploma or its equivalency, have a minimum of two years experience working with children and families from various racial and ethnic groups and be familiar with the Paulding community and the services provided.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening.
3. Few friends or school alienation.
4. Dysfunctional home situation.
5. Mental health diagnosis.
6. Single parent family.
7. Born to teenage parent(s).
8. Born to a parent who has not completed high school.
9. Limited English proficiency.
10. Free or reduced price lunch.
11. Lack of appropriate physical necessities (clothing, proper hygiene, etc).
12. History of exposure to direct or indirect violence.
13. History of sexual or physical abuse or neglect.
14. Low self-esteem.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Tift County\\

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.



E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Tift County School System, Tift County and Turner County Department of Family and Children Services, Tift County Health Department, Tift General Hospital, Tift County Recreation Department, Cooperative Extension Service of Tift County, Big Brothers/Big Sisters, PLIGHT, Kid's Advocacy Coalition, and YMCA.
- f. Case Management Supervisor must hold a Bachelor's Degree in a human services field; i.e., public and social services, counseling, humanities and have three years of experience working with a diverse population of low income children and their families.
- g. Case Managers must have high school diploma or its equivalency, have a minimum of two years experience working with children and families from various racial and ethnic groups and be familiar with the Paulding community and the services provided.
- h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.

- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Ben Hill County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan

D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Ben Hill County Health Department, Ben Hill County Department of Family and Children Services, Ben Hill County Public Schools, Ben Hill County Mental Health, Ben Hill County Commissioners, City of Fitzgerald, and Ben Hill County Department of Juvenile Justice..

- E. Qualification of Providers: (continued)
- f. Case Management Supervisor must hold a Bachelor's Degree in a human services field; i.e., public and social services, counseling, humanities and have three years of experience working with a diverse population of low income children and their families.
  - g. Case Managers must have high school diploma or its equivalency, have a minimum of two years experience working with children and families from various racial and ethnic groups and be familiar with the Ben Hill community and the services provided.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Gilmer County

C. Comparability of Services:

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan



D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Gilmer County Health Department, Gilmer County Department of Family and Children Services, Gilmer County Public Schools and/or City Schools, Gilmer County Commissioners, City of Elijay, and Gilmer County Juvenile Court.

- E. Qualification of Providers: (continued)
- f. Case Management Supervisor must hold a Bachelor's Degree in a human services field; i.e., public and social services, counseling, humanities and have three years of experience working with a diverse population of low income children and their families.
  - g. Case Managers must have high school diploma or its equivalency, have a minimum of two years experience working with children and families from various racial and ethnic groups and be familiar with the Gilmer community and the services provided.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Liberty County

C. Comparability of Services:

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan

D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act.  
Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Liberty County Health Department, Liberty County Department of Family and Children Services, Liberty County Public Schools and/or City Schools, Liberty County Commissioners, City of Hinesville, and Liberty County Regional Medical Center and Liberty County Department of Juvenile Justice.

- E. Qualification of Providers: (continued)
- f. Case Management Supervisor must hold a Bachelor's Degree in a human services field; i.e., public and social services, counseling, humanities and have three years of experience working with a diverse population of low income children and their families.
  - g. Case Managers must have high school diploma or its equivalency, have a minimum of two years experience working with children and families from various racial and ethnic groups and be familiar with the Liberty community and the services provided.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): White County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan



D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act.  
Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the White County Health Department, White County Department of Family and Children Services, White County Public Schools and/or City Schools, White County Commissioners, and White County Juvenile Court..

- E. Qualification of Providers: (continued)
- f. Case Management Supervisor must hold a Bachelor's Degree in a human services field; i.e., public and social services, counseling, humanities and have three years of experience working with a diverse population of low income children and their families.
  - g. Case Managers must have high school diploma or its equivalency, have a minimum of two years experience working with children and families from various racial and ethnic groups and be familiar with the White County community and the services provided.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. nt for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Wilkinson County

C. Comparability of Services:

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan

D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Wilkinson County Health Department, Wilkinson County Department of Family and Children Services, Wilkinson County Public Schools and/or City Schools.

- E. Qualification of Providers: (continued)
- f. Case Management Supervisor must hold a Bachelor's Degree in a human services field; i.e., public and social services, counseling, humanities and have three years of experience working with a diverse population of low income children and their families.
  - g. Case Managers must have high school diploma or its equivalency, have a minimum of two years experience working with children and families from various racial and ethnic groups and be familiar with the Wilkinson community and the services provided.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
17. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
18. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
19. History of exposure to direct or indirect violence.
20. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Hart County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan



D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Hart County Health Department; Hart County Department of Family and Children Services; Hart County Public Schools and/or City Schools; and Hart County Commissioners.

E. Qualification of Providers: (continued)

- f. Case Management Supervisor must hold a Bachelor's Degree in a human services field; i.e., public and social services, counseling, humanities and have three years of experience working with a diverse population of low income children and their families.
  - g. Case Managers must have high school diploma or its equivalency, have a minimum of two years experience working with children and families from various racial and ethnic groups and be familiar with the Hart community and the services provided.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Lanier County

C. Comparability of Services:

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan

D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Lanier County Health Department; Lanier County Department of Family and Children Services; Lanier County Public Schools; Lanier County, and Lanier County Juvenile Court.

- E. Qualification of Providers: (continued)
- f. Case Management Supervisor must hold a Bachelor's Degree in a human services field; i.e., public and social services, counseling, humanities and have three years of experience working with a diverse population of low income children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Baker County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan



D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Baker County Health Department; Baker County Department of Family and Children Services; Baker County Public Schools; Baker County Commissioners, and Baker County Juvenile Court.

- E. Qualification of Providers: (continued)
- f. Case Management Supervisor must hold a Bachelor's Degree in a human services field; i.e., public and social services, counseling, humanities and have three years of experience working with a diverse population of low income children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Pickens County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan

D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Pickens County Health Department, Pickens County Department of Family and Children Services, Pickens County Public Schools and/or city schools, Pickens County Commissioners and City of Jasper, Pickens County Juvenile Court, Pickens County Division of Youth, and the Pickens County Child Abuse Council.

- E. Qualification of Providers: (continued)
  - f. Case Management Supervisor must hold a Bachelor's Degree in a human services field; i.e., public and social services, counseling, and have experience working with at risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
  - 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis but not eligible for special education.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc).
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Chattooga County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan



D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., Health Check, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Chattooga County Health Department, Chattooga County Department of Family and Children Services, Chattooga County Public Schools and/or city schools, Chattooga County Commissioners and Chattooga County Juvenile Court.

- E. Qualification of Providers: (continued)
- f. Case Management Supervisor must hold a Bachelor's Degree and have experience in the human service field; i.e., public and social services, counseling, and have experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis but not eligible for special education.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.).
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Whitfield County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan

D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., Health Check, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Whitfield County Health Department, Whitfield County Department of Family and Children Services, Whitfield County Public Schools and/or Dalton city schools, Whitfield County Commissioners, City of Dalton, Whitfield County Juvenile Court and Whitfield County Division of Youth Services..

- E. Qualification of Providers: (continued)
  - f. Case Management Supervisor must hold a Bachelor's Degree and have experience in the human service field; i.e. public and social services, counseling, and have experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
  
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
  - 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
  
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis but not eligible for special education.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide):  
Bleckley County

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan



D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

2. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services ( Health Check, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Bleckley County Health Department, Bleckley County Department of Family and Children Services, Bleckley County Public Schools and/or city schools, Bleckley County Commissioners, City of Cochran, Oconee Circuit Juvenile Court, District 6 Division of Youth Services/Department of Juvenile Justice.

- E. Qualification of Providers: (continued)
- f. Case Management Supervisor must hold a Bachelor's Degree in a human services field; i.e., public and social services, counseling, humanities and have three years of experience working with a diverse population of low income children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis but not eligible for special education.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide):

Candler County

C. Comparability of Services:

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without Regard to requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management services is a set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (Health Check, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the: Candler County Health Department, Candler County Department of Family and Children Services, Candler County Public Schools and or city schools, Candler County Commissioners.

- f. Case Management Supervisor must hold a Bachelor's Degree and have experience in the human service field: i.e., public and social services, counseling, and have experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The State assures that the provision of case management services will not restrict and individuals free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for their same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. Transferred two or more times during the most recent school year.
15. One or more years below grade placement in reading or math.
16. Free or reduced price lunch.
17. Lack of appropriate physical necessities (clothing, proper hygiene, etc.
18. Pregnancy.
19. Disabled without mental impairment.
20. Residing in home situation with guardian or caretaker other than natural parent(s).

B. Areas of State in which services will be provided:

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): The Paulding County, Georgia community.

C. Comparability of Services

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.



D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private service providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Paulding Board of Education, Paulding Department of Family and Children Services, Department of Child and Youth Services, Paulding County Health Department, Coosa Valley Center, Paulding Enterprises, Dallas Housing Authority and Paulding County Pre-K.

E. Qualification of Providers: (continued)

- f. Case Management Supervisor must hold a Bachelor's Degree in a human services field; i.e., public and social services, counseling, humanities and have three years of experience working with a diverse population of low income children and their families.
  - g. Case Managers must have high school diploma or its equivalency, have a minimum of two years experience working with children and families from various racial and ethnic groups and be familiar with the Paulding community and the services provided.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Children in grades 7-8 at Appling Middle School, Ballard-Hudson Middle School and grades 6-12 at the Bibb County Alternative School and their Medicaid eligible siblings who are "at risks" of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening.
3. Free or reduced price lunch.
4. One or more retentions.
5. Iowa Test of Basic Skills (ITBS)/Test of Achievement and Proficiency (TAP) reading scores below the 35th percentile and not receiving special education services.
6. Five or more unexcused absences in any one twenty (20) day attendance period.
7. Two or more suspensions during the most recent school year.
8. Limited English proficiency.
9. Transferred two or more times during the most recent school year.
10. One or more years below grade placement in the reading basal.
11. History of sexual activity, sexual or physical abuse or neglect; or

Those displaying two of the above characteristics and at least one of the following factors:

1. Few friends or school alienation.
2. Little or no extracurricular involvement.
3. Frequent disciplinary referrals.
4. Dysfunctional home situation.
5. Disabled without mental impairment.
6. Family members with limited job skills and difficulty finding employment.

B. Areas of State in which services will be provided:

Entire State.

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide):  
The attendance zones of Bibb County Public Schools.

C. Comparability of Services:

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with the providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet with following requirements:

- E. Qualification of Providers: (continued)
- a. Must have the capacity to provide the full range of at-risk case management services.
  - b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
  - c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
  - d. Must have demonstrated the ability to obtain collaboration between public and private service providers.
  - e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Bibb County Health Department, Bibb County Department of Family and Children Services, Bibb County Juvenile Court, Bibb County Division of Children and Youth Services, Bibb County Public Schools, Bibb County Commissioners, and River Edge Behavioral Health Center.
  - f. Case Management Supervisors must hold a Bachelor's Degree in a human services field (i.e., psychology, sociology, social work, humanities, counseling, career services and have two years of experience working with at-risk children and their families.
  - g. Case Managers must have a high school degree or equivalent and a demonstrated ability to work effectively with at-risk children and have three years of experience working with at-risk children and their families.
  - h. Both the case management supervisor(s) and case managers must complete a pre-service training program and a Family Connection designed and supervised practicum experience.
- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Children ages 0 - 21 in Ware County and their Medicaid eligible siblings who are "at-risk" of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check initial screen or no periodic screening.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Two or more out-of-school suspensions during the most recent school year.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage mother.
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. Transferred two or more times during the most recent school year.
15. One or more years below grade placement in reading or math.

A. Target Group: (continued)

16. Free or reduced price lunch.
17. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
18. Iowa Test of Basic Skills (ITBS)/Test of Achievement and Proficiency (TAP) reading scores below the 35th percentile and not receiving special education services.
19. Inadequate health care.
20. Children or children with family members identified as drug and/or alcohol abusers.
21. Pregnancy.
22. Family members with limited job skills and difficulty finding employment.
23. Victim of abuse/neglect.

B. Areas of State in which services will be provided:

- Entire State.
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide):

The attendance zones of the Ware County School System.

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirement of Section 1902(a)(10)(B) of the Act.

D. Definition of Services

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with the providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet with following requirements:



- E. Qualification of Providers: (continued)
- a. Must have the capacity to provide the full range of at-risk case management services.
  - b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
  - c. Must have demonstrated direct experience in the coordination of educational support services (e.g., Health Check, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
  - d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
  - e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Ware County Department of Family and Children Services, Ware County School System, Ware County Department of children and Youth Services, Satilla Community Mental Health/Substance Abuse, and Ware County Health Department.
  - f. Case Managers must hold a Bachelor's Degree in a human services field; i.e., psychology, sociology, social work, humanities, counseling, nursing, career services, and have one year of experience working with at-risk children and their families or a minimum of three years demonstrated experience working with at-risk children and their families.
  - g. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.

- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children ages 0-21 in Sumter County who are "at risk" of not completing a secondary education because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT/Health Check initial screen or no periodic screening.
3. Free or reduced price lunch.
4. One or more retentions.
5. Iowa Test of Basic Skills (ITBS)/Test of Achievement and Proficiency (TAP) reading scores below the 35th percentile and not receiving special education services.
6. Five or more unexcused absences in any one twenty (20) day attendance period.
7. Two or more suspensions during the most recent school year.
8. Limited English proficiency.
9. Transferred two or more times during the most recent school year.
10. One or more years below grade placement in reading or math.
11. Children or other family members identified as drug and/or alcohol abusers.
12. Pregnancy.
13. History of Juvenile Court involvement.
14. History of exposure to direct or indirect violence, sexual or physical abuse or neglect.

Those displaying two of the above characteristics and at least one of the following factors:

1. Few friends or school alienation.
2. Little or no extracurricular involvement.
3. Frequent disciplinary referrals.
4. Dysfunctional home situation.
5. Disabled without mental impairment.
6. Family members with limited job skills and difficulty finding employment.

B. Areas of State in which services will be provided:

Entire State.

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide):

Sumter County.

C. Comparability of Services

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various

community resources through referral to appropriate providers. Case management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) or the Act. Enrollment is open to all providers who can meet with following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.

- c. Must have demonstrated direct experience in the coordination of family support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
  - d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
  - e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with Visions for Sumter: Seeing Through Young Eyes, Inc., the Sumter County Department of Family and Children Services, Sumter County Behavioral Health Care, Sumter County School System, Sumter County Health Department, and Sumter County Department of Children and Youth Services.
  - f. Case Managers must hold a High School degree or equivalent and have a minimum of one (1) year's experience working with at-risk children and their families.
  - g. Case managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
  - h. Both the case management supervisor(s) and case managers must complete a pre-service training program and a Family Connection designed and supervised practicum experience.
- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Individuals 0-21 years of age and their Medicaid eligible siblings or offspring who are "at-risk" of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Within the low socio-economic level as evidenced by participation in the free or reduced lunch program, have parents who are unemployed, or employed but with frequent difficulties in money management.
2. Within a minority population or experiencing difficulties with cultural competencies or language proficiencies.
3. No Health Check initial screening or lack of ongoing medical care/health maintenance.
4. Low achievement test scores, (35th percentile and below on ITBS, TAP), low grades, (failing two or more academic subjects in a grading period), or repeated two or more grades.
5. Frequent absences, tardies or school transfers.
6. Frequent disciplinary referrals or suspensions.
7. Frequent physical complaints, low self-concept, or expresses feelings of lack of control of life.
8. Minimal social interaction with peers, limited extra curricular involvement, alienation from school with a potential to drop out.
9. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease or children with family members identified as substance abusers and/or having involvement with the legal system.

A. Target Group (continued)

10. History of exposure to direct or indirect violence.
11. History of sexual or physical abuse or neglect.
12. Dysfunctional home situation.
13. Born to a teenage mother or single parent.
14. Infants born prematurely and experiencing developmental delays.
15. Infants exhibiting developmental delays as a result of birth related trauma or genetic disorders.
16. Both parents with less than a high school education.
17. Inadequate utilities or household appliances.
18. Parent has a history of incarceration or is currently incarcerated.

B. Areas of State in which services will be provided:

Entire State.

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide):

Hall County



## C. Comparability of Services

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

## D. Definition of Services

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with the providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

## E. Qualification of Providers

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet with following requirements:

- a. Must have qualified case manager(s) and the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Hall County Health Department Health District, Hall County Department of Family and Children Services, Hall County Juvenile Court, Hall County School System, Gainesville City Schools, Mental Health, Hall County Commissioners United Way of Hall County, Division of Children and Youth Services, Ninth District Opportunity, Piedmont Migrant Education Agency, and consumer representatives.
- f. Case Management Supervisors must hold a Bachelor's Degree in a human services field, i.e., psychology, sociology, social work, humanities, counseling, career services and have two years of supervisory experience working with low income indigenous children and their families.
- g. Case Managers must hold a high school diploma or equivalent and have two years of experience working with at risk children and their families.

1. Provider Qualifications (continued)
  - h. Both the Case Management Supervisor(s) and Case Manager(s) must complete a pre-service training program and a Family Connection designed and supervised practicum experience.
- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.
  1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found on Attachment 4.19-B, pages 5d and 5e.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**  
**State/Territory: Georgia**  
**CHILDREN AT-RISK CASE MANAGEMENT SERVICES**

**A. Target Group:**

Medicaid eligible children in grades Pre K through 12 in Randolph County who are "at-risk" of not completing a secondary education because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening.
3. Free or reduced price lunch.
4. One or more retentions.
5. Iowa Test of Basic Skills (ITBS) Test of Achievement and Proficiency (TAP) reading scores below the 35th percentile and not receiving special education services.
6. Five or more unexcused absences in any one twenty (20) day attendance period.
7. Two or more suspensions during the most recent school year.
8. Limited English proficiency.
9. Transferred two or more times during the most recent school year.
10. One or more years below grade placement in reading or math.
11. Children or children with family members identified as drug and/or alcohol abusers.
12. Inadequate health care.
13. Teenaged mother or parents.
14. Pregnancy; or

**A. Target Group: (continued)**

those displaying two of the above characteristics and at least one of the following factors:

1. Few friends or school alienation.
2. Little or no extracurricular involvement.
3. Frequent disciplinary referrals.
4. Dysfunctional home situation.
5. Disabled without mental impairment.
6. Inadequate utilities and household appliances.
7. Family members with limited job skills and difficulty finding employment.

**B. Areas of State in which services will be provided:**

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide):

Randolph County

**C. Comparability of services:**

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with the providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet with following requirements:

- a. Must provide the full range of at-risk case management services.

- E. Qualification of Providers: (continued),
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
  - c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
  - d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
  - e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Randolph County School System, Randolph County Health Department, Randolph County Department of Family and Children Services, New Horizons, and Randolph County Commissioners.
  - f. Case Management Supervisors must hold a Bachelor's Degree in a human services field; i.e., psychology, sociology, social work, humanities, counseling, career services and have a minimum of one (1) year's experience working with low income indigenous children and their families.
  - g. Case managers must have a High School diploma and three years demonstrated experience working with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practicum experience.
- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.

- F. (continued)
2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is reported on Attachment 4.19-B, pages 5d and 5e.



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 STATE PLAN UNDER TITLE XIX OF THE SOCIAL-SECURITY ACT
State/Territory: Georgia

## CHILDREN AT-RISK CASE MANAGEMENT SERVICES

## A. Target Group:

Children aged 0-21, who are at risk of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening.
3. Free or reduced price lunch.
4. One or more retentions.
5. Iowa Test of Basic Skills (ITBS) Test of Achievement and Proficiency (TAP) reading scores below the 35th percentile and not receiving special education services.
6. Five or more unexcused absences in any one twenty (20) day attendance period.
7. Two or more suspensions during the most recent school year.
8. Limited English proficiency.
9. Transferred two or more times during the most recent school year.
10. One or more years below grade placement in reading or math.
11. Few friends or school alienation.
12. Little or no extracurricular involvement.
13. Children or children with family members identified as drug and/or alcohol abusers.
14. Inadequate health care.
15. Teenaged mother of parents.
16. Frequent disciplinary referrals.
17. Dysfunctional home situation.
18. Disabled without mental impairment.
19. Inadequate utilities and household appliances.
20. Family members with limited job skills and difficulty finding employment.
21. Pregnancy.

## B. Areas of State in which services will be provided:

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Troup County.

**C. Comparability of Services:**

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

**D. Definition of Services:**

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

## E. Qualification of Providers

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet with following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private service providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Troup County Health Department, Troup County Department of Family and Children Services, Troup County Juvenile Court Troup County Division of Children and Youth Services, Troup County Public Schools, Troup County Mental Health, Troup County Commissioners, City of LaGrange, United Way, and District 4 Health Services.
- f. Case Management Supervisors must hold a Bachelor's Degree in a human services field (i.e., psychology, sociology, social work, humanities, counseling, career services and have two years of experience working with at-risk children and their families.
- g. Case Managers must have a high school degree or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
- h. Both the case management supervisor(s) and case managers must complete a pre-service training program and a Family Connection designed and supervised practicum experience.

- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Children 0 - 21 and their Medicaid eligible siblings who are "at-risk" of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screening assessments indicate the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening.
3. Few friends or school alienation.
4. Little or no extracurricular involvement
5. Frequent disciplinary referrals.
6. Dysfunctional home situation
7. Physical disability,
8. Single parent family.
9. One or more grade retentions.
10. Born to a teenage mother.
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. Transferred two or more times during the most recent school year.
15. One or more years below grade placement in reading or math.
16. Free or reduced price lunch.
17. Pregnancy, or control of life.
18. Currently homeless or homeless within the past year.
19. Poor personal, social, emotional adjustment skills.
20. Chronic Health problems.

B. Areas of State in which services will be provided:

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide):

The attendance zones of Haralson County and Bremen City Schools.

C. Comparability of Services

Services are provided in accordance with Section 1902(a)(10)(B) of the Act

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements.

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education. and Nutritional Services).

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- E. Qualification of Providers: (continued)
- d. Must have demonstrated the ability to obtain collaboration between public and private service providers.
  - e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Haralson County Health and Mental Health Departments, Haralson County Department of Family and Children Services, Haralson County Juvenile Court, Haralson County Department of Children and Youth Services.
  - f. Case Management Supervisors must hold a Bachelor's Degree in a human services' field; i.e., psychology, sociology, social work, humanities, counseling, career services, or must hold an Associate Degree in Nursing. Both must have two years of supervisory experience working with at-risk children and their families.
  - g. Case Managers must have a high-school diploma or equivalent, minimum of two years experience working with at-risk children and their families. Must be familiar with the community and services provided and demonstrate the ability to work effectively with children and families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practicum experience.
- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Children pre-K through grade 12 and their Medicaid eligible siblings who are "at-risk" of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals or suspensions.
6. Dysfunctional family situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to a teenage mother.
11. Frequent absences, tardies, or school transfers.
12. Limited English proficiency.
13. Free or reduced price lunch.
14. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
15. One or more years below grade placement in reading and math.
16. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
17. Frequent physical complaints, low self-esteem, or expresses feelings of lack of control of life.
18. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
19. History of exposure to direct or indirect violence.
20. History of sexual or physical abuse or neglect
21. Teenage mother or parents.
22. Pregnancy.

B. Areas of State in which services will be provided:

Entire State.

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Turner County.

C. Comparability of Services

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(2) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with the providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.

D. Definition of Services: (continued)

4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet with following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Turner County Department of Family and Children Services, Turner County Health Department, Turner County School System, Turner County Mental Health and Turner County Extension Service.
- f. Case Managers' Supervisors must hold a Bachelor's Degree in a human services field; i.e., psychology, sociology, social work, humanities, counseling, career services or have a minimum of five (5) years experience working with low income indigenous children and their families.
- g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children.

- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers of Section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

CHILDREN AT-RISK CASE MANAGEMENT SERVICES

**A. Target Group:**

Children Pre-K through grade 12 and their Medicaid eligible siblings, who are "at-risk" of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screen indicates that the child is not meeting developmental milestones.
2. No initial Health Check screen or no periodic screening.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to a teenage mother.
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. Transferred two or more times during the most recent school year.
15. One or more years below grade placement in reading or math.
16. Free or reduced price lunch.
17. Lack of appropriate physical necessities (clothing, medication, housing, proper hygiene, etc).
18. Pregnancy
19. Resides in home situation with guardian or caretaker other than natural parents.
20. Living in a Family Crisis Center or other non-permanent domicile.

**B. Areas of State in which services will be provided:**

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide):

The attendance zones of Walker County Schools and Chickamauga City Schools.

C. Comparability of Services

[ ] Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(2) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet with following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Walker County Schools, Chickamauga City Schools, Mental Health, Walker County Departments of Children & Youth, Family & Children Services and Health, Coca Cola, County Commissioners, Crisis Center & other Representatives from private Business, Law Enforcement and Consumers.
- f. Case Managers must have a High School diploma or equivalent and a demonstrated ability to work effectively with at-risk children and have two years of experience working with at-risk children and their families.
- g. Case managers must complete a pre-service training program and a Family Connection signed and supervised practice experience.

- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers of Section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Children ages 0-21 who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening.
3. Free or reduced price lunch.
4. One or more retentions.
5. Iowa Test of Basic Skills (ITBS) Test of Achievement and Proficiency (TAP) reading scores below the 35th percentile.
6. Five or more unexcused absences in any one twenty (20) day attendance period.
7. Two or more suspensions during the most recent school year.
8. Limited English proficiency.
9. Transferred two or more times during the most recent school year.
10. One or more years below grade placement in the reading basal.
11. Few friends or school alienation.
12. Little or no extracurricular involvement.
13. Frequent disciplinary referrals.
14. Dysfunctional home situation.
15. Disabled without mental impairment.
16. School-aged parents.
17. Economically or socially deprived.

B. Areas of State in which services will be provided:

Entire State.

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide):

Gordon County

C. Comparability of Services

[ ] Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(2) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet with following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Gordon County Schools; Gordon County Health Department, Gordon County Department of Family and Children Services, Gordon County Juvenile Court, and Gordon County Division of Youth Services.
- f. Case Management Supervisors must hold a Bachelor's Degree and have experience in the human services field; i.e., psychology, sociology, social work, humanities, counseling, career services and have experience working with low income indigenous children and their families.
- g. Case managers must hold a High School diploma or its equivalent and have experience working with low income indigenous children and their families.
- h. Both the Case Management Supervisor(s and Case Managers must complete a pre-service training program and a Family Connection designed and supervised practicum experience.

- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers of Section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Children ages 0 to 21 who are "at-risk" because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals or suspensions.
6. Dysfunctional family situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to a teenage mother,
11. Frequent absences, tardies, or school transfers.
12. Limited English proficiency.
13. Low Income Family
14. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
15. One or more years below grade placement in reading and math.
16. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
17. Frequent physical complaints, low self-esteem, or expresses feelings of lack of control of life.
18. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
19. History of exposure to direct or indirect violence.
20. History of sexual or physical abuse or neglect.
21. Family members with limited job skills and difficulty finding employment.
22. Inadequate utilities and household appliances.

B. Areas of State in which services will be provided:

Entire State.

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide):

Floyd County, Georgia

C. Comparability of Services

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(2) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet with following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Floyd County Department of Family and Children Services, Floyd County Health Department, Floyd County School System, the Rome City School System, Mental Health, Juvenile Court, Department of Children & Youth Services, and the Floyd County Health Department.

- f. Case Managers must have a high school diploma or the equivalent, and have knowledge of the following: Family dynamics and family needs; human diversity; community agencies and resources; providing services to families in poverty; strong interpersonal skills; and cultures of families to be served.
  - g. Case managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children aged 0-21 in Early County who are "at risk" of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening.
3. Free or reduced price lunch.
4. One or more retentions.
5. Iowa Test of Basic Skills (ITBS)/Test of Achievement and Proficiency (TAP) reading scores below the 35th percentile and not receiving special education services.
6. Five or more unexcused absences in any one twenty (20) day attendance period.
7. Two or more suspensions during the most recent school year.
8. Limited English proficiency.
9. Transferred two or more times during the most recent school year.
10. One or more years below grade placement in the reading or math.
11. Few friends or school alienation.
12. Little or no extracurricular involvement.
13. Children with family members identified as drug and/or alcohol abusers.
14. Inadequate health care.
15. Child/adolescent is a teen mother/father,
16. Frequent disciplinary referrals.
17. Dysfunctional home situation.
18. Disabled without mental impairment.
19. Inadequate utilities and household appliances.
20. Family members with limited job skills and difficulty finding employment.
21. Child/Adolescent is pregnant.
22. Parent or older sibling(s) was/is a teen parent.
23. History of incarceration and/or probation of child, parent, sibling.
24. Child, parent or caretaker with chronic health problems.
25. Poor parental involvement in meeting/addressing educational, physical health, mental and emotional needs of child.

**B. Areas of State in which services will be provided:**

- Entire State.  
 Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Early Country.

**C. Comparability of Services**

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.  
 Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

**D. Definition of Services:**

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

**E. Qualification of Providers:**

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet with following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Early County Health Department, Early County Department of Family and Children Services, Early County Juvenile Court & Division of Children and Youth Services, Early County Public Schools, Early County Mental Health and Kids Can Program, Blakely-Early County Housing Authority, Early County Commissioners, City of Blakely and Boys & Girls Club.
- f. Case Management Supervisors must hold a Bachelor's Degree in a human services field (i.e., psychology, sociology, social work, humanities, counseling, career services and have two years of experience working with at-risk children and their families.
- g. Case Managers must have a high school degree or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
- h. Both the case management supervisor(s) and case managers must complete a pre-service training program and a Family Connection designed and supervised practicum experience.

- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers of Section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children aged 0-21 in Early County who are "at risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No Health Check EPSDT initial screen or no periodic screening.
3. Free or reduced price lunch.
4. One or more retentions.
5. Iowa Test of Basic Reading Scores below the 35th percentile and not receiving special education services.
6. Five or more unexcused absences in any one twenty (20) day attendance period.
7. Two or more suspensions during the most recent school year.
8. Limited English proficiency.
9. Transferred two or more times during the most recent school year.
10. One or more years below grade placement in the reading or math program.
11. Few friends or school alienation.
12. Little or no extracurricular involvement.
13. Frequent disciplinary referrals.
14. Dysfunctional home situation.
15. Disabled without mental impairment.
16. Family members with limited job skills and difficulty finding employment.

B. Areas of State in which services will be provided:

Entire State.

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Grady County

C. Comparability of Services

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet with following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Grady County Health Department, Grady County Department of Family and Children Services, Grady County Juvenile Justice, Grady County Division of Children and Youth Services, Grady County Public Schools, Grady Mental Health, Grady County Government and Migrant Services.
- f. Case Management Supervisors must hold a Bachelor's Degree in a human services field (i.e., psychology, sociology, social work, humanities, counseling, career services and have two years of experience working with at-risk children and their families.
- g. Case Managers must have a high school degree or equivalent and a demonstrated ability to work effectively with at-risk children and have three years of experience working with at-risk children and their families.
- h. Both the case management supervisor(s) and case managers must complete a pre-service training program and a Family Connection designed and supervised practicum experience.

F. The state assures that the provision of case management services will not restrict an individual's free choice of providers of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children ages 0-21 in Tattnall County who are "at-risk of not completing a secondary education because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening.
3. Free or reduced price lunch.
4. One or more retentions.
5. Iowa Test of Basic Skills (ITBS)/Test of Achievement and Proficiency (TAP) reading scores below the 35th percentile and not receiving special education services.
6. Five or more unexcused absences in any one twenty (20) day attendance period.
7. Two or more suspensions during the most recent school year.
8. Limited English proficiency.
9. Transferred two or more times during the most recent school year.
10. One or more years below grade placement in the reading or math.
11. Children or children with family members identified as drug and/or alcohol abusers.
12. Inadequate health care.
13. Teenaged mother or parents.
14. Pregnancy; or

those displaying two of the above characteristics and at least one of the following factors:

1. Few friends or school alienation.
2. Little or no extracurricular involvement.
3. Frequent disciplinary referrals.
4. Dysfunctional home situation.



**A. Target Group: (continued)**

5. Disabled without mental impairment.
6. Inadequate utilities and household appliances.
7. Family members with limited job skills and difficulty finding employment.

**B. Areas of State in which services will be provided:**

- Entire State
- Only in the following geographic areas (authority of Section 19151(g)(1) of the Act is invoked to provide services 1088 than statewide):
- Tattnall County

**C. Comparability of services:**

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

**D. Definition of Service:**

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.

**D. Definition of Services:** (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

**E. Qualification of Providers:**

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet with following requirements:

- a. Must provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support Services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Tattnall County School System, Tattnall County Department of Children and Youth Services, Tattnall County Mental Health Department, Tattnall County Department of Family and Children Services and Tattnall County Public Health.
- f. Case Managers must hold a Bachelor's Degree in a human services field; i.e., psychology, sociology, social work, humanities, counseling, career services and have a minimum of one (1) year's experience working with low income indigenous children and their families.
- g. Case managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.

- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers of Section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Children aged 0-21 who are "at-risk of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening.
3. Free or reduced price lunch.
4. One or more retentions.
5. Iowa Test of Basic Skills (ITBS)/Test of Achievement and Proficiency (TAP) reading scores below the 35th percentile.
6. Five or more unexcused absences in any one twenty (20) day attendance period.
7. Two or more suspensions during the most recent school year.
8. Limited English proficiency.
9. Transferred two or more times during the most recent school year.
10. One or more years below grade placement in the reading basal.
11. Few friends or school alienation.
12. Little or no extracurricular involvement.
13. Child or children with family members identified as drug and/or alcohol abusers.
14. Inadequate health care.
15. Teenaged mother or parents.
16. Frequent disciplinary referrals.
17. Dysfunctional home situation.
18. Disabled without mental impairment.
19. Inadequate utilities and household appliances.
20. Family members with limited job skills and difficulty finding employment.
21. Pregnancy.

B. Areas of State in which services will be provided:

Entire State

Only in the following geographic areas (authority of Section 19151(g)(1) of the Act is invoked to provide services 1088 than statewide):  
Meriwether County

C. Comparability of services:

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Service:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet with following requirements:

- E. Qualifications of Providers (continued)
- a. Must have the capacity to provide the full range of at-risk case management services.
  - b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
  - c. Must have demonstrated direct experience in the coordination of family support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
  - d. Must have demonstrated the ability to obtain collaboration between public and private service providers.
  - e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Meriwether County Health Department, Meriwether County Department of Family and Children Services, Meriwether County Juvenile Court, Meriwether County Division of Children and Youth Services, Meriwether County Public Schools, Mental Health, and Meriwether County Commissioners.
  - f. Case Management Supervisors must hold a Bachelor's Degree in a human services field (i.e., psychology, sociology, social work, humanities, counseling, career services and have two years of experience working with at-risk children and their families.
  - g. Case Managers must have a high school degree or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Both the case management supervisor(s) and case managers must complete a pre-service training program and a Family Connection designed and supervised practicum experience.
- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management Services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children aged 0-21 who are "at-risk of not completing a secondary education program because they exhibit five or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35<sup>th</sup> percentile and below on Iowa Test of Basis Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period) or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Seminole County

C. Comparability of Services

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.



D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private service providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Seminole County Health Department, Seminole County Department of Family and Children Services, Seminole County Public Schools, Seminole County Mental Health, Seminole County Commissioners, City of Donalsonville, Southwest Health District 8, Unit 2.

E. Qualification of Providers: (continued)

- f. Case Management Supervisor must hold a Bachelor's Degree in a human services field; i.e., public and social services, counseling, humanities and have one year relative experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children aged 0-21 who are "at-risk of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Mental Health diagnosis.
6. Single parent family.
7. One or more grade retentions.
8. Limited English proficiency.
9. Free or reduced price lunch.
10. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
11. One or more years below grade placement in reading and math.
12. History of substance abuse, or at risk for sexually transmitted disease.
13. Frequent physical complaints, low self-esteem, or expresses feelings of lack of control of life.
14. History of exposure to direct or indirect violence.
15. History of sexual or physical abuse or neglect.
16. Iowa Test of Basic Skills (ITBS) Test of Achievement and Proficiency (TAP) reading scores below the 35th percentile and not receiving special education services.
17. Five or more unexcused absences in any one twenty (20) day attendance period.
18. Two or more suspensions during the most recent school year.
19. Transferred two or more times during the most recent school year.
20. Teenaged mother or parents.
21. Inadequate health care.
22. Frequent disciplinary referrals.
23. Dysfunctional home situation:
24. Disabled without mental impairment.
25. Inadequate utilities and household appliances.
26. Family members with limited job skills and difficulty finding employment.

B. Areas of State in which services will be provided:

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Worth County

C. Comparability of Services

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.

D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private service providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Worth County Health Department, Worth County Department of Family and Children Services, Worth County Juvenile Court, Worth County Division of Children and Youth Services, Worth County School System, Worth County Community Preservation Collaborative and Worth County Mental Health.

E. Qualification of Providers: (continued)

- f. Case Management Supervisor must hold a Master's Degree in a human services field; i.e., public and social services, counseling, humanities and have one year relative experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or its equivalent and have one year of experience working with at-risk children and their families.
  - h. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Children ages 0-21 who are "at-risk" of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening.
3. Free or reduced price lunch.
4. One or more retentions.
5. Iowa Test of Basic Skills (ITBS)/Test of Achievement and Proficiency (TAP) reading scores below the 35th percentile and not receiving special education services.
6. Five or more unexcused absences in any one twenty (20) day attendance period.
7. Two or more suspensions during the most recent school year.
8. Limited English proficiency.
9. Transferred two or more times during the most recent school year.
10. One or more years below grade placement in the reading basal; or
11. Child of a parent still in his/her teens:
12. Few friends, or school alienation.
13. Little or no extracurricular involvement.
14. Frequent disciplinary referrals.
15. Dysfunctional home situation.
16. Disabled without mental impairment.
17. Family members with limited job skills and difficulty finding employment.
18. Currently pregnant.
19. Became a parent as an adolescent.

B. Areas of State in which services will be provided:

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide):

Spalding County, Georgia.

C. Comparability of Services

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. The set of interrelated activities are as follows:  
Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child.  
Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet with following requirements:



- E. Qualifications of Providers (continued)
- a. Must have the capacity to provide the full range of at-risk case management services.
  - b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
  - c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
  - d. Must have demonstrated the ability to obtain collaboration between public and private service providers.
  - e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Spalding County Health Department, Spalding County Department Family and Children Services, Spalding County Division of Children and Youth Services, Spalding County Public Schools, Spalding County Mental Health, Spalding County Commissioners, and Griffin City Commissioners.
  - f. Case Management Supervisors must hold a Bachelor's Degree in a human services field (i.e., psychology, sociology, social work, humanities, counseling, career services and have two years of experience working with at-risk children and their families.
  - g. Case Managers must have a high school degree or equivalent and a demonstrated ability to work effectively with at-risk children and have three years of experience working with at-risk children and their families.
  - h. Both the case management supervisor(s) and case managers must complete a pre-service training program and a Family Connection designed and supervised practicum experience.
- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: Georgia

CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Children 0 to 21 who are "at-risk" of not completing a secondary education program because they exhibit three or more of the following characteristics or are infants who meet the eligibility requirements for Children 1st or Starting Program.

1. Developmental screen indicates the child is not meeting developmental milestones.
2. NO EPSDT initial screen or no periodic screening.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals or suspensions.
6. Dysfunctional family situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to a teenage mother.
11. Frequent absences, tardies, or school transfers.
12. Limited English proficiency.
13. Free or reduced price lunch.
14. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
15. One or more years below grade placement in reading and math.
16. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease,
17. Frequent physical complaints, low self-esteem, expresses feelings of lack of control of life.
18. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
19. History of exposure to direct or indirect violence.
20. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Dougherty County

C. Comparability of Services

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(2) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902 (a) (23) of the Act. Enrollment is open to all providers who can meet with following requirements:

- a. Must have qualified case manager(s) and the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Dougherty County Department of Family and Children Services, Dougherty County Health Department, and Dougherty County School System.

- f. Case Management Supervisors must hold a Bachelor's Degree in a human services field (i.e. psychology, sociology, social work, humanities, counseling, career services and have two years of experience working with at-risk children and their families.
  - g. Case Managers must have a high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and have three years of experience working with at-risk children and their families.
  - h. Both the Case Management Supervisors and Case Managers must complete a pre-service training program and a Family Connection designed and supervised practicum experience.
- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers of Section 1902 (a) (23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is reported on Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children ages 0-21 in Jefferson County who are "at-risk" of not completing a secondary education because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening.
3. Free or reduced price lunch.
4. One or more retentions.
5. Iowa Test of Basic Skills (TBS)/Test of Achievement and Proficiency (TAP) reading scores below the 35th percentile and not receiving special education services.
6. Five or more unexcused absences in any one twenty (20) day attendance period.
7. Two or more suspensions during the most recent school year.
8. Limited English proficiency.
9. Transferred two or more times during the most recent school year.
10. One or more years below grade placement in reading or math.
11. Children or children with family members identified as drug and/or alcohol abusers.
12. Inadequate health care.
13. Teenaged mother or parents.
14. Pregnancy; or

those displaying two of the above characteristics and at least one of the following factors:

1. Few friends or school alienation.
2. Little or no extracurricular involvement.
3. Frequent disciplinary referrals.
4. Dysfunctional home situation.

A. Target Group: (continued)

5. Disabled without mental impairment.
6. Inadequate utilities and household appliances.
7. Family members with limited job skills and difficulty finding employment.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Jefferson County

C. Comparability of Services

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers :

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902 (a) (23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).



- E. Qualifications of Providers (continued)
- d. Must have demonstrated the ability to obtain collaboration between public and private service providers.
  - e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Jefferson County Health Department, Jefferson County Department of Family and Children Services, Jefferson County Public Schools, Ogeechee Area Mental Health and Jefferson County Commissioners.
  - f. Case Management Supervisor must hold a Bachelor's Degree in a human services field; i.e., public and social services, counseling, humanities and have three years of experience working with a diverse population of low income children and their families.
  - g. Case Managers must have high school diploma or its equivalency, have a minimum of two years experience working with children and families from various racial and ethnic groups and be familiar with the Paulding community and the services provided.
  - h. Case Managers must complete a pre-service training program and Family Connection designed and supervised practice experience.
- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violations of Section 1902 (a) (23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, ages 0-21, who are "at-risk" of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen, no periodic screening or inadequate health care.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to teenage parent(s).
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. One or more years below grade placement in reading or math.
15. Free or reduced price lunch.
16. Lack of appropriate physical necessities (clothing, proper hygiene, etc.
17. Residing in home situation with guardian or caretaker other than natural parent(s).
18. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
19. Low achievement test scores (35th percentile and below on Iowa Test of Basis Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
20. History of exposure to direct or indirect violence.
21. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): Lumpkin County

C. Comparability of Services

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.

D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private service providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Lumpkin County Department of Family and Children Services, Lumpkin County Public Schools, Lumpkin County Mental Health, Lumpkin County Health Department Health District, Lumpkin County Juvenile Court and Ninth District Opportunity.

- E. Qualifications of Providers: (continued)
- f. Case Managers must have high school diploma or equivalent and a demonstrated ability to work effectively with at-risk children and their families.
  - g. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violations of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: GEORGIA

**PERINATAL CASE MANAGEMENT SERVICES**

- A. Target Group (42CFR 441.18(a) (8) (i) and 441.18(a) (9): All Medicaid eligible pregnant women within the state of Georgia at risk for an adverse birth outcome.
- B. Areas of the State in which services will be provided:  
  x   Entire State  
  \_\_   Only in the following geographic areas:
- C. Comparability of Services (§1902(a)(10)(B) and 1915(g)(1)):  
  \_\_   Services are provided in accordance with §1902 (a) (10) (B) of the Act.  
  x   Services are not comparable in amount, duration, and scope (§1915 (g) (1))
- D. Definition of services (42 CFR 440.169):

Perinatal Case Management services are defined as services furnished to assist women, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Perinatal Case Management includes the following assistance:

- One initial comprehensive face-to-face assessment per pregnancy of the woman's needs to determine her need for any medical, educational, social or other services.  
The assessment activities include:
  - Taking a client history;
  - Identifying the individual's needs and completing related documentation;
  - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.
- Women identified as at risk for an adverse birth outcome will have periodic reassessment of their needs monthly as a component of their case management follow up. Additional or different needs identified will be added to their plan of care. Reassessments may be face-to-face (for women with complex needs or at the woman's request) or telephonic.

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- Development (and periodic revision) of a plan of care that is based on the information collected through the assessment that:
  - Specifies the goals and actions to address the medical, social, educational, and other services needed by the woman;
  - Includes activities such as ensuring the active participation of the eligible woman, and working with the woman (or the woman's authorized health care decision maker) and others to develop those goals; and
  - Identifies a course of action to respond to the assessed needs of the eligible woman.
- Monitoring and follow up activities:
  - Activities and contacts with the woman (either face-to-face or telephonic) occur at least monthly during the pregnancy. They are necessary to ensure the plan of care is implemented and adequately addresses the eligible woman's needs. These activities and contacts may also be with family members, service providers, or other entities or individuals and conducted as frequently as necessary. The purpose of this monitoring is to determine whether the following conditions are met:
    - The services are being furnished in accordance with the woman's plan of care;
    - The services in the plan of care are adequate; and
  - Any changes in the needs or status of the woman are reflected in the plan of care.

Perinatal Case Management includes: contacts with non-eligible individuals that are directly related to identifying the eligible woman's needs and care for the purposes of helping the eligible woman access services; identifying needs and supports to assist the eligible woman in obtaining services; providing case managers with useful feedback; and alerting case managers to changes in the eligible woman's needs. (42 CFR 440.169 (e)).

E. Qualifications of the Provider (42 CFR 441.18 (a) (8) (v) and 42 CFR 441.18 (b)):

A Medicaid enrolled perinatal case management provider may be an individual or group entity qualified to provide perinatal case management services and eligible to enroll as a Medicaid provider under this program. Every perinatal case management provider must be or utilize a Perinatal Case Manager to deliver the perinatal case management services.

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A signed copy of the applicable license(s) must be submitted with the provider's application for enrollment.

The Perinatal Case Management provider must be a Medicaid enrolled:

- GA licensed physician
- Physician's Assistant working under the direction of a licensed physician
- Nurse Practitioner
- Certified Nurse-Midwife
- Entity that employs or arranges for registered nurses to furnish the perinatal case management services, such as a local public health agency.

The Perinatal Case Manager must:

- Have the capacity to provide the full range of perinatal case management services;
- Have demonstrated, direct experience in the delivery of healthcare services to women such as providing primary care, prenatal care, family planning, or case management services; and
- Have demonstrated the ability to provide or coordinate pregnancy-related health and human services.

Independent licensed registered nurses are not eligible to enroll as Perinatal Case Management providers under this program. Only Perinatal Case Management providers are allowed to bill for case management services under this program.

The Perinatal Case Manager may be a:

- GA licensed physician
- Physician's assistant working under the direction of a licensed physician
- Nurse practitioner
- Certified nurse midwife
- Licensed registered nurse

F. Freedom of Choice (42 CFR 441.18 (a) (1):

The State assures that the provision of perinatal case management services will not restrict an individual's free choice of providers in violation of section 1902 (a) (23) of the Act.

1. Eligible women will have free choice of any qualified Medicaid providers within the State.



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2. Eligible women will have free choice of any qualified Medicaid providers of other medical care under the State Plan.

- G. Access to Services (42 CFR 441.18 (a) (2), 42 CFR 441.18 (a) (3), and 42 CFR 441.18 (a) (6):

The State assures the following:

- Perinatal Case Management services will not be used to restrict an individual's access to other services under the State Plan.
- Women will not be compelled to receive perinatal case management services, condition receipt of perinatal case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on the receipt of perinatal case management services, and
- Providers of perinatal case management services do not exercise the state's authority to authorize or deny the provision of other services under the State Plan.

- H. Case Records (42 CFR 441.18 (a) (7)):

Perinatal Case Management providers maintain case records that document, for all women receiving perinatal case management services, the following:

1. The name of the woman
2. The dates of the perinatal case management services
3. The name of the perinatal case management provider and the perinatal case manager
4. The nature, content, units of perinatal case management service received and whether goals specified in the plan of care have been achieved
5. Whether the woman has declined services in the plan of care
6. The need for, and occurrence of, coordination with other case managers
7. A timeline for obtaining needed services
8. A timeline for re-evaluation of the plan.

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STATE/TERRITORY: GEORGIA

I. Limitations:

Perinatal Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service. (State Medicaid Manual (SMM) 4302.F)

Perinatal Case Management does not include, and FFP is not available in expenditures for services defined in §440.169 when the perinatal case management activities constitute the direct delivery of underlying medical, educational, social or other services to which an eligible woman has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements, recruiting and interviewing potential foster care parents; serving legal papers, making home investigations, providing transportation, administering foster care subsidies, making placement arrangements (42 CFR 441.18 (c))

FFP is only available for perinatal case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903 (c) of the Act. (§§1902 (a) (25) and 1905 (c)).

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State/Territory: Georgia

**CASE MANAGEMENT SERVICES**

A. Target Group: Infants and Toddlers with established risk for developmental delay.

B. Areas of State in which services will be provided:

- Entire State  
 Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide :

C. Comparability of Services

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902 (a) (10) (B) of the Act.

D. Definition of Services:

Early Intervention Case Management for infants and toddlers is an integral and necessary part of services designed to meet the developmental needs of each eligible child to enhance the child's development. Case management is an active, on-going process consisting of specific activities which are aimed at assisting parents on behalf of their child in gaining access to the early intervention services and to receive the rights and procedural safeguards that are authorized under the early intervention program.

The integral and necessary services and specific activities include:

1. Coordinating the referral and scheduling of evaluations and assessments;
2. Facilitating and participating in the development, review and evaluation of individualized family service plans (IFSP);

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3. Assisting parents or guardians in gaining access to early intervention services and other services identified in the IFSP for the benefit of the eligible child;
4. Assisting families on behalf of their child to identify and utilize available service providers and financial resources to obtain services and goods;
5. Coordinating and scheduling the child's appointments for early intervention services and other services, such as medical services for diagnostic and treatment purposes;
6. Facilitating the timely delivery of available services;
7. Informing families of the availability of advocacy services and support groups which will benefit the child;
8. For the benefit of the child, assist families in gaining access to the appropriate educational setting, day care or pre-school program or to other resources;
9. Arrange transportation services to all appointments made for the benefit of the eligible child; and,
10. Facilitating the development of a transition plan to pre-school services when appropriate.

E. Qualifications of Providers:

Enrollment will be accomplished in accordance with section 1902 (a)(23) of the Social Security Act. Enrollment is open to all providers who can meet the following requirements:

Providers must demonstrate knowledge and understanding about infants and toddlers who are eligible under Part H - Early Intervention Programs (EIP), the EIP regulations and the nature and scope of services available under Early Intervention, the system of payment for services and other pertinent information.

State/Territory: Georgia

1. Provider Qualifications:

- a. must have qualified case manager(s) and the capacity to provide the full range of management services to children with developmental delays;
- b. must meet applicable state and federal laws governing the participation of providers in the Medicaid program;
- c. must have demonstrated direct experience in the delivery of services to children with developmental delays of disabilities; and,
- d. must have established working relationships with other agencies (i.e., health departments, schools, Children's Medical Services, Cerebral Palsy Center, hospitals and clinics, etc.) to prevent duplication of services for the Medicaid population.

2. Case Management Staff Qualifications:

- a. must meet the qualifications of case managers under Part H of Public Law 99-457;
- b. have a Bachelor's degree in either social work, child and family studies, early childhood special education, psychology or a closely related field with two years of related experience; or
- c. have a Registered Nurse diploma with two years of related experience and licensed to practice in Georgia; or
- d. have a Master's degree in one of the above fields.
- e. Related experience must be working with children with special health care needs, developmental delay, or handicapping conditions.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

State/Territory: Georgia

- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE, MANAGEMENT SERVICES

A. Target Group:

Children 0-21 and their Medicaid eligible siblings who are "at-risk" of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Denver Developmental Screening Test or other developmental screening assessment indicates the child is not meeting developmental milestones.
2. NO EPSDT initial screen or no periodic screening.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis but not eligible for Special Education.
8. Single parent family.
9. One or more grade retentions.
10. Born to a teenage mother.
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. Transferred two or more times during the most recent school year.
15. One or more years below grade placement in reading or math.
16. Free or reduced price lunch.
17. Pregnancy.
18. Currently homeless or homeless within the past year.

- B. Areas of State in which services will be provided:
- Entire State.
  - Only in the following geographic areas (authority of Section 1915 (g) (1) of the Act is invoked to provide services less than statewide): Carroll County

- c. Comparability of Services
- Services are provided in accordance with Section 1902 (a) (10) (B) of the Act.
  - Services not comparable in amount, duration, and scope. Authority of Section 1915(g) (2) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with the providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.



The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902 (a) (23) of the Act. Enrollment is open to all providers who meet the following requirements:

- a. Must have qualified case manager(s) and the capacity to provide the full range of at-risk, case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.

- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private service providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Carroll County Health and Mental Health Departments, Carroll County Department of Family and Children Services, Carroll County Juvenile Court, Carol County Department of Children and Youth Services, and Carrollton City School System.
- f. Case Managers must have a high school diploma or equivalent; minimum of two years experience working with at-risk children and their families. Must be familiar with the community and services provided and demonstrate the ability to work effectively with children and families.
- g. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practicum experience.

- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902 (a) (23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Children pre-K through grade 12 who are "at-risk" of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. NO EPSDT initial screen or no periodic screening.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to a teenage mother.
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. Transferred two or more times during the most recent school year.
15. One or more years below grade placement in reading or math.
16. Free or reduced price lunch.
17. Lack of appropriate physical necessities (clothing, proper hygiene, etc.
18. Pregnancy

B. Areas of State in which services will be provided:

- Entire State.  
 Only in the following geographic areas  
(authority of Section 1915(g) (1) of the Act is  
invoked to provide services less than  
statewide):

The attendance zones of coffee County Schools  
within the Coffee County school zone.

C. Comparability of Services:

- Services provided in accordance  
Section 1902(a) (10) (B) of the Act.  
 Services are not comparable in amount,  
duration, and scope. Authority of Section  
1915 (g) (1) of the Act is invoked to provide  
services without regard to the requirements of  
Section 1902 (a) (10) (B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers, Case management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with eligible child and service providers to determine that the services received adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications  
Enrollment will be accomplished in accordance with Section 1902(a) (23) of the Act. Enrollment is open to all providers who meet the following requirements:
  - a. Must have qualified case manager(s) and the capacity to provide the full range of at-risk case management services.
  - b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.

- c. Must have demonstrated direct experience in the coordination educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private service providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Coffee County department of Family and Children Services, and coffee County Public Schools.
- f. Case Managers must be a registered nurse, licensed practical nurse or hold a Bachelor's Degree in human services field; i.e., humanities, counseling, career services and have three years of experience working with low income indigenous children and their families.
- g. Case managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.

- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a) (23) of the Act.
  - 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
  
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CASE MANAGEMENT SERVICES

A. Target Group:

Children in grades Pre K-12 and their Medicaid eligible siblings who are "at-risk" of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Within the low socio-economic level as evidenced by participation in the free or reduced lunch program, have parents who are unemployed, or employed but with frequent difficulties in money management.
2. Within a minority population or experiencing difficulties with cultural competencies or language proficiencies.
3. No EPSDT initial screening or lack of ongoing medical care/health maintenance due to difficulty in accessing health care providers.
4. Low achievement test scores, (35th percentile and below on ITBS, TAP), low grades, (failing two or more academic subjects in a grading period), or repeated two or more grades.
5. Frequent absences, tardiness or school transfers.
6. Frequent disciplinary referrals or suspensions.
7. Frequent physical complaints, low self-concept, or expresses feelings of lack of control of life.
8. Minimal social interaction with peers, limited extra curricular involvement, alienation from school with a potential to drop out.
9. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.

10. History of exposure to direct or indirect violence.
11. History of sexual or physical abuse or neglect.
12. Dysfunctional home situation.
13. Born to a teenage mother or single parent.
14. Pregnancy.

B. Areas of State in which services will be provided:

- Entire State.
- Only in the following geographic areas (authority of Section 1915(g) (1) of the Act is invoked to provide services less than statewide): The attendance zones of the following Houston County Schools: Perry & Thomas Elementary; Perry & Tabor Middle; and Northside & Perry High.

C. Comparability of Services

- Services are provided in accordance with Section 1902(a) (10) (B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g) (2) of the Act is invoked to provide services without regard to the requirements of Section 1902(a) (10) (B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. case management services will provide necessary coordination with providers of health, family support, employment, justice, housing counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902 (a) (23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have qualified case manager(s) and the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.

- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private service providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed collaborative agreement with the Houston County Schools, Houston County Department of Family and Children Services, Houston County Youth Services, Houston Drug Action Council, Houston County Commissioners, Court Appointed Special Advocate (CASA), Rainbow House, Inc., Middle Georgia Community Action Agency, Juvenile Court of Houston County, Peachbelt Mental Health Center, Houston County Health Department.
- f. Case Management Supervisor(s) must have 4 years experience in human service field; (i.e., nursing, psychology, sociology, social work, humanities, counseling or career services), and 2 years of supervisory experience working with low income indigenous children and their families.
- g. Case Manager(s) must have 2 years experience in a human service field; (i.e., nursing, psychology, sociology, social work, humanities, counseling, career services).
- h. Both the case management supervisor(s) and management staff person must complete a pre-service training program and a Family Connection designed and supervised practicum experience, and have broad knowledge of local resources.

- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902 (a) (23) of the Act.
  - 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
  
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
AT-RISK OF INCARCERATION CASE MANAGEMENT SERVICES

- A. Target Group: All Medicaid eligible emotionally disturbed  
or substance abusing beneficiaries under twenty-one years of  
age at-risk of incarceration who have been referred to a  
Foster Home or a non-residential intensive supervision  
program as an alternative to a secure confinement facility.
- B. Areas of State in which services will be provided:
- Entire State.
- Restricted Geographical Area
- C. Comparability of Services:
- Are provided in accordance with Section 1902\*(a) (10) (B)  
of the Act.
- Services are not comparable in amount, duration, and  
score. Authority of Section 1915(g) (1) of the Act is  
invoked to provide services without regard to the  
requirements of Section 1902 (a) (10) (B) of the Act.
- D. Definition of Services:
- Case Management is a set of interrelated activities for  
identifying, coordinating, and reviewing the delivery of  
appropriate services for EPSDT eligible emotionally  
disturbed or substance abusing Medicaid beneficiaries at-  
risk of incarceration. The purpose of case management  
services is to assist individuals in the target group in  
gaining access to needed medical, nutritional, social,  
educational, transportation, housing and other services; and  
to encourage the use of various community resources through  
referral to appropriate providers.

Case Management is performed through a set of interrelated activities which include the following:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the child.
2. Assisting the child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring the child and service provider to determine that the services received are adequate in meeting the child's needs.
4. Reassessment of the child to determine services needed to resolve any crisis situation resulting from divorce, death, separation, changes in family structure or living conditions, or other events.

E. Qualifications of Providers:

All providers, agencies and individual practitioners must:

1. Follow the mandates at 42 CFR 431 Subpart F regarding confidentiality.
2. Demonstrate the capacity to provide all core elements of case management services.

E. Qualifications of Providers (Continued)

3. Provide accurate documentation of costs and agree to participate in an annual cost study to determine reimbursement rates for service.
4. Document and maintain case records in accordance with state and federal requirements.
5. Maintain such records as are necessary to fully disclose the extent of services provided and to furnish the Department with information as it may periodically request.

All providers, agencies and individual practitioners must ensure that case managers:

6. Demonstrate skills in the process of identifying and assessing a wide range of children's needs, including antisocial behavior patterns, faulty attitude structure, healthy social adjustment, family interrelationships, and the establishment and attainment of life goals;
7. Demonstrate skills in assessing problems and needs of juvenile offenders;
8. Demonstrate skills in enlisting the cooperation of individuals of various backgrounds to develop remedial human service delivery programs for youthful offenders;
9. Are knowledgeable about local community resources and how to use those resources for the benefit of the child;
10. Demonstrate skills in recognizing drugs, symptoms of drug addiction, and the physical effects of drug abuse;
11. Are graduates of a college or university with an undergraduate degree in Psychology, Sociology, Social Work, Criminal Justice or a related field, or have four years work experience in the juvenile justice system; and



- E. Qualifications of Providers (Continued)
12. Are knowledgeable about the state's standards and policies related to community services for clients in the custody of the Department of children and Youth Services.
  13. Complete a practicum designed and supervised by the Department of Children and Youth Services. All potential providers may attend the practicum.
  14. Maintain regularly scheduled hours of operation and include provisions for recipients to receive services outside normal business hours.
  15. Be accessible to and willing to coordinate services within the recipient's residential/community setting as necessary.
- F. The state assures that all eligible recipients will have free choice of providers as provided in Section 1902 (a) (23) of the Act. The state assures that all qualified providers may participate in this program.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same service.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**  
**State/Territory: Georgia**

**CASE MANAGEMENT**

**A. Target Group:**

Medicaid recipients 21 years of age and older who have been diagnosed as having AIDS or symptomatic HIV disease as indicated through accepted testing procedures and as defined by the Centers for Disease Control, who are at the greatest risk of hospitalization, and who need specific intervention assistance with acute problem solving in one or more of the following situations:

1. acute medical needs such as respite care, dialysis, home health care, and services required during the later stages of illness;
2. loss of access to care;
3. substance abuse;
4. mental illness;
5. homelessness; or
6. crisis such as unplanned pregnancy, loss of employment or social support.

Optional targeted case management services will not be provided to clients in total care environments.

**B. Areas of state in which services will be provided:**

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide).

**C. Comparability of Services:**

- Services are provided in accordance with Section 1902 (a) (10) (B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

**D. Definition of services**

Case Management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for Medicaid eligible adults with AIDS who are at the greatest risk of hospitalization and need assistance with acute problem solving. The purpose of case management is to assist individuals in the target group in gaining access to needed medical, nutritional, social, educational, psychological, transportation, housing, legal, financial, and other services; and to reduce the incidence of costs of hospitalization by encouraging the use of various community resources through referral to appropriate providers.

The set of interrelated activities is as follows:

1. Obtaining a medical assessment from the recipient's primary physician; or physician, physician's assistant or nurse practitioner of the recipient's choice; conducting a psychosocial assessment in order to establish a comprehensive case file for the development and implementation of an individualized service plan to meet the assessed service needs of the eligible Medicaid recipient with AIDS. Establishing priorities for the initial linkages with providers. This unit of service may be billed only once for each eligible recipient.
2. Assisting the eligible recipient with AIDS in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and following-up with the eligible recipient and service providers to determine that the services received are adequate in meeting the recipient's assessed needs. Case management follow-up services are limited to twelve (12) visits annually.
4. Providing reassessment of eligible recipients with AIDS to determine the services needed to resolve any crisis situation resulting from changes in the recipient's medical condition, loss of social support, employment, housing, legal problems or other significant events. This level of follow-up services is limited to three (3) services annually.

**E. Qualifications of Providers:**

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a) (23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have qualified case manager(s) and the capacity to provide the full range of the case management services.
- b. Must meet the applicable state and federal laws governing, the participation of providers in the Medicaid program.
- c. Providers must have one (1) or more documented years experience in providing case management services to HIV disabled individuals.
- d. Providers must have a financial management system that provides documentation of services and costs.
- e. Case managers must have the equivalent of a high school diploma and meet one of the following:  
  
have at least two years of documented, verifiable case management experience or social services related work experience, coordinating activities to individuals with HIV/AIDS or other Acute or Chronic diseases  
  
**OR**  
  
hold a certificate of training in a social services area with one year of related training or work experience  
  
**OR**  
  
be a licensed registered nurse (RN), or licensed practical nurse (LPN), with one year of related training or work experience  
  
**OR**  
  
hold an Associate, Bachelor's or Master's degree with one year of any combination of related courses, training or work experience.
- f. Case Managers must have at least one year experience in a social services delivery system.
- g. Case Managers must have considerable skill in the methods of locating, developing, and coordinating the provision of supportive services in the community for the AIDS disabled individual.

- F. The state assures that the provision of the case management services will not restrict an individual's free choice of providers in violation of Section 1902(a) (23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other services under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

EPSDT eligible children who are "at-risk" of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. NO EPSDT initial screen or no periodic screening.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional home situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to a teenage mother.
11. Born to a parent who has not completed High School.
12. Five or more unexcused absences in any one twenty (20) day attendance period.
13. Limited English proficiency.
14. Transferred two or more times during the most recent school year.
15. One or more years below grade placement in reading or math.
16. Free or reduced price lunch.
17. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)

- 18. History of exposure to direct or indirect violence.
- 19. History of sexual or physical abuse or neglect.
- 20. Teenagers between the ages of 16 and 20 who have dropped out of school and who are willing to complete a planned educational program Leading to a high school diploma or GED.
- 21. Pregnancy.

B. Areas of State in which services will be provided:

- Entire State.
- Only in the following geographic areas (authority Section 1915 (g) (1) of the Act is invoked to provide services less than statewide):

Chatham County, Georgia

Comparability of Services

- Services are provided in accordance with Section 1902(a) (10) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

D. Definition of Services

Children at-risk case management is a set of interrelated activities identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services, and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with the providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.



The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902 (a) (23) of the Act. Enrollment is open to all providers who can meet with following requirements:

- a. Must provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.

- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Chatham County Health Department, Chatham County Department of Family and children Services, Chatham County Juvenile Court, Chatham County Division of Children and Youth Services, and The Tidelands Mental Health, Mental Retardation and Substance Abuse Program.
- f. Case management supervisors must hold a Master's Degree in a human services field (i.e., psychology, sociology; social work, humanities, counseling, career services and have two years of supervisory experience working with low income indigenous children and their families.
- g. Case managers must have a high school diploma or equivalent and have one year of experience working with low income families and their children.

- h. Case Management Supervisor(s) and Case Managers must complete a pre-service training program and a Youth Futures designed and supervised practicum experience.
- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a) (23) of the Act.
  - 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is reported on Attachment 4.19-B, pages 5d and 5e.

STATE/TERRITORY: GEORGIA

Reserved for later use.

STATE/TERRITORY: GEORGIA

Reserved for later use.

STATE/TERRITORY: GEORGIA

Reserved for later use.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Children ages 0 - 21 in Richmond County who are "at-risk" of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones;
2. NO EPSDT initial screen or no periodic screening;
3. Free or reduced price lunch;
4. One or more retentions;
5. Iowa Test of Basic Skills (ITBS)/Test of Achievement and Proficiency (TAP) or other comparable tests indicate reading scores below the 35th percentile and not receiving special education services;
6. Five or more unexcused absences in any one twenty (20) day attendance period;
7. Two or more suspensions during the most recent school year;
8. Limited English proficiency;
9. Transferred two or more times during the most recent school year;
10. One or more years below grade placement in the reading basal;
11. Children or children with family members identified as drug and/or alcohol abusers;
12. Inadequate health care;
13. Teenaged mother or parents;

14. Few friends or school alienation;
15. Little-or no extracurricular involvement;
16. Frequent disciplinary referrals;
17. Dysfunctional home situation;
18. Disabled without mental impairment;
19. Inadequate utilities and household appliances;
20. Family members with limited job skills and difficulty finding employment.

B. Areas of State in which services will be provided:

- Entire State.
- Only in the following geographic areas (authority of Section 1915(g) (1) of the Act is invoked to provide services less than statewide):

Richmond County

C. Comparability of Services

- Services are provided in accordance with Section 1902 (a) (10) (B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

D. Definition of Services

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational,



transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with the providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902 (a) (23) of the Act. Enrollment is open to all providers who can meet with following requirements:

- a. Must provide the full range of at-risk case management services.

- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
  - c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
  - d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
  - e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Richmond County Health Department, Richmond County Department of Family and children Services, Richmond County Juvenile Court, and Richmond County Division of Youth Services.
  - f. Case management supervisors must hold a Bachelor's Degree in a human services field (i.e., community health education, psychology, sociology, social work, humanities, counseling, career services and have two years of supervisory experience working with low income indigenous children and their families.
  - g. Case managers must have three years of experience working with low-income indigenous children and their families.
  - h. Both the case management supervisor(s) and case manager(s) must complete a pre-service training program and a family connection designed and supervised practicum experience.
- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a) (23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is reported on Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Children pre-K through grade 12 who are "at-risk" of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. NO EPSDT initial screen or no periodic screening.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals or suspensions.
6. Dysfunctional family situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to a teenage mother.
11. Frequent absences, tardies, or school transfers.
12. Limited English proficiency.
13. Free or reduced price lunch.
14. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
15. One or more years below grade placement in reading and math.
16. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
17. Frequent physical complaints, low self-esteem, expresses feelings of lack of control of life.
18. Low achievement test scores (35th percentile and below on Iowa Test of Basic Skills (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades.
19. History of exposure to direct or indirect violence.
20. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided :

Entire State.

Only in the following geographic areas (authority of Section 1915(g) (1) of the Act is invoked to provide services less than statewide): The attendance zones of the Mitchell County School system and the Pelham City School System.

C. Comparability of Services

Services are provided in accordance with Section 1902 (a) (10) (B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g) (2) of the Act is invoked to provide services without regard to the requirements of Section 1902(a) (10)(B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with the providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.

3. Monitoring and follow-up: with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs, Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a) (23) of the Act. Enrollment is open to all providers who can meet with following requirements:

- a. Must have qualified case manager(s) and the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed collaborative agreement with the Mitchell County Department of Family and Children Services, Mitchell County Health Department, Mitchell County School System and the Pelham City School System.

- f. Case Managers must hold a High School diploma or the equivalent, and must have demonstrated experience in the following: Family dynamics and family needs; human diversity; community agencies and resources; providing services to families in poverty; strong interpersonal skills; and cultures of families to be served.
  - g. Case managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Children in grades Pre K-12 who "at-risk" of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. NO EPSDT initial screen or no periodic screening.
3. Free or reduced price lunch.
4. One or more retentions.
5. Iowa Test of Basic Skills (ITBS)/Test of Achievement and Proficiency (TAP) reading scores below the 35th percentile and not receiving special education services.
6. Five or more unexcused absences during the most recent school year.
7. Two or more suspensions during the most recent year.
8. Limited English proficiency.
9. Transferred two school year. more times during the most Recent school year
10. One or more years below grade placement in the reading basal.
11. Born to a teenage, unmarried mother.

Or those displaying one of the above characteristics and at least one of the following factors:

1. Few friends or school alienation.
2. Little or no extracurricular involvement.



3. Frequent disciplinary referrals.
4. Dysfunctional home situation.
5. Disabled without mental impairment.

B. Areas of State in which services will be provided:

Entire State.

Only in the following geographic areas (authority of Section 1915(g) (1) of the Act is invoked to provide services less than statewide): The attendance zones of Beaverdam, Blackwell, Bowman, and Falling Creek Elementary Schools within the limits of Elbert County.

C. Comparability of Services

Services are provided in accordance with Section 1902 (a) (10) (B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a) (10) (B) of the Act.

D. Definition of Services

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with the providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a) (23) of the Act. Enrollment is open to all providers who can meet with following requirements:

- a. Must have qualified case manager(s) and the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.

- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Elbert County Health Department, Elbert County Department of Family and Children Services, Elbert County Juvenile Court, Elbert County Division of Children and Youth Services, and Elbert County Interagency Council.
- f. Case management supervisors must hold a Bachelor's Degree in a human services field (i.e., psychology, family development, sociology, social work, humanities, counseling, career services or associated fields) and have two years of experience working with low income indigenous children and their families.
- g. Case managers must hold a Bachelor's Degree in a human service field (i.e., psychology, sociology, social work, humanities, counseling, career services) or experience equivalent of two (2) years for each one year of college and have one year of experience working with low-income indigenous children and their families.
- h. Both the case management supervisor(s) and manager(s) must complete a pre-service training program and a Family Connection designed and supervised practicum experience.

- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902 (a) (23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CASE MANAGEMENT SERVICES

A. Target Group:

All Medicaid eligible children from birth through age seventeen who have been placed in Foster Care or are receiving Child Protective Services who are:

- 1) In out-of-home placement at imminent risk of out-of-home placement due to their families being unable to provide the minimum sufficient level of care, or whose families/environments create a serious threat to safety and welfare; or
- 2) Experiencing maltreatment or at imminent risk of maltreatment due to their parent(s) or caretaker(s) willfully or otherwise failing to meet the child's basic need for emotional and/or physical care and protection. This may include neglect, physical abuse, emotional neglect, medical neglect, emotional abuse, sexual abuse and exploitation; or
- 3) Determined through initial Department of Family and Children Services (DFCS) assessment to have demonstrated need for preventive/supportive services and but for the provision of these case management services would be at risk of maltreatment placement in a more costly or restrictive living arrangement.

B. Areas of the State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of §1915(g)(1) of the Act is invoked to provide services less than statewide)

C. Comparability of Services:

- x Services are not comparable in amount, duration, and scope. Authority of §1915(g) (2) of the Act is invoked to provide services without regard to the requirements of §1902(a)(10)(B) of the Act.

D. Definition of Services:

Case Management is of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible recipients. The purpose of case management services is to assist the targeted population in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral appropriate providers.

Child Protective Services Case Management is performed through a set of interrelated activities which include the following:

1. Establishing the comprehensive case file including development and implementation of an individualized service plan to meet the assessed service needs of the child;
2. Assisting the child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan;
3. Monitoring the child and service provider to determine that the services received are adequate in meeting the child's needs; or
4. Reassessment of the child to determine services needed to resolve any crisis situation --resulting from neglect, maltreatment, exploitation, divorce, death, separation, changes in family structure or living conditions, or other events.

E. Qualifications of Providers:

Child Protective Services Case Management providers must:

1. Demonstrate the capacity to provide all core elements of case management.
2. Provide accurate documentation of costs and agree to participate in an annual cost study to determine reimbursement rates for services;
3. Develop a billing system to appropriately identify and bill all liable third parties;
4. Document and maintain case records in accordance with state and federal requirements;
5. Complete a practicum designed and supervised by the Department of Family and Children Services.

E. QUALIFICATIONS OF PROVIDERS (Continued)

6. Maintain such records as are necessary to fully disclose the extent of services provided and to furnish the Department with information as it may periodically request. All service records, which must be maintained for three (3) years after the delivery of service, must meet requirements in Section 4302 of the State Medicaid manual.
7. Be skilled in the process of coordinating services for a wide range of children's needs;
8. Be knowledgeable about local community resources and how to use those resources for the benefit of the child;
9. Be graduates of a college or university with an undergraduate degree in Psychology, Sociology, Social work or a related field, or have one year of experience providing counseling, guidance services, referral services, or public assistance;
10. Be knowledgeable about the state's standards and policies related to community services for recipients who are children in the custody of the Department of Family and children Services.

- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of §1902 (a) (23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same service.



**STATE PLAN UNDER TITLE XIX OF SOCIAL SECURITY ACT  
STATE/TERRITORY: GEORGIA  
CASE MANAGEMENT SERVICES**

**A. Target Group**

All Medicaid eligible recipients age 18 and over who meet one of the following conditions are eligible for services in the Adult Protective Services Case Management Program:

- 1.) Recipients must be at imminent risk of or experiencing abuse, neglect or exploitation due to their inability to protect themselves or their caretaker's willful or otherwise failure to meet their basic needs for physical or emotional care and protection; or
- 2.) Recipients must be at significant or imminent risk of institutionalization due to their inability or their caretaker's inability to provide the minimum sufficient level of care in their own home; or
- 3.) Recipients must be wards of Directors of County Departments of Family and Children Services because they have been adjudicated by Probate court as being in need of a guardian of person.

**B. Areas of the state in which services will be provided:**

- Entire State
- Only in the following geographic areas (authority of §1915 (g) (1) of the Act is invoked to provide services less than statewide):

**C. Comparability of Services:**

- x   Services are not comparable in amount, duration, and scope. Authority of Section 1915 (g) (2) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

**D. Definition of Services:**

Case Management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible recipients. The purpose of case management services is to assist the targeted population in gaining access to needed medical, nutritional, social, educational, transportation, housing and other service; and to encourage the use of various community resources through referral to appropriate providers.

Case Management is performed through a set of interrelated activities which include the following:

1. Establishing the comprehensive case file including development and implementation of an individualized service plan to meet the assessed service needs of the client;
2. Assisting the client in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan;
3. Monitoring the client and service provider to determine that the services received are adequate in meeting the client's needs; or
4. Reassessment of the client to determine services needed to resolve any crisis situation resulting from neglect, maltreatment, exploitation, divorce, death, separation, changes in family structure or living conditions, or other events.

**E. Qualifications of Providers:**

All providers must:

1. Comply with the mandates of 42 CFR 431.300 subpart (F) regarding confidentiality.
2. Demonstrate the capacity to provide all core elements of case management services.
3. Provide accurate documentation of costs and agree to participate in an annual cost study to determine reimbursement rates for services;
4. Develop a billing system to appropriately identify and bill all liable third parties;
5. Document and maintain case records in accordance with state and federal requirements;
6. All providers must complete a practicum designed and supervised by the Department of Family and Children Services.

E. Qualifications of Providers: (Continued)

7. Maintain such records as are necessary to fully disclose the extent of services provided and to furnish the Department with information as it may periodically request. All service records, which must be maintained for three (3) years after the delivery of service, must meet the requirements in Section 4302 of the State Medicaid manual.
8. Be skilled in the process of coordinating services for a wide range of disabled adults' needs;
9. Be knowledgeable about local community resources and how to use those resources for the benefit of the client;
10. Be graduates of a college or university with an undergraduate degree in Psychology, Sociology, Social work or a related field, or have one year of experience providing counseling, guidance services, referral services, or public assistance; and
11. Be knowledgeable about the state's standards and policies related to community services for recipients who are wards of Directors of County Departments of Family and Children Services.

- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902 (a) (23) of the Act.
  - 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
  
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Children aged 0-21, who are at risk of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. NO EPSDT initial screen or no periodic screening.
3. Free or reduced price lunch.
4. One or more retentions.
5. Iowa Test of Basic skills (ITBS) /Test of Achievement and Proficiency (TAP) reading scores below the 35th percentile and not receiving special education services.
6. Five or more unexcused absences in any one twenty (20) day attendance period.
7. Two or more suspensions during the most recent school year.
8. Limited English proficiency.
9. Transferred two or more times during the most recent school year.
10. One or more years below grade placement in the reading basal.
11. Few friends or school alienation.
12. Little or no extracurricular involvement.
13. Children or children with family members identified as drug and/or alcohol abusers.
14. Inadequate health care.
15. Teenaged mother or parents.
16. Frequent disciplinary referrals,
17. Dysfunctional home situation.
18. Disabled without mental impairment.
19. Inadequate utilities and household appliances.
20. Family members with limited job skills and difficulty finding employment.
21. Pregnancy

B. Areas of state in which services will be provided :

- Entire State
- Only in the following geographic areas (authority of Section 1915(g) (1) of the Act is invoked to provide services less than statewide): Muscogee County

C. Comparability of Services

Services are provided in accordance with Section 1902 (a) (10) (B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a) (10) (B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers. Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible recipient. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each recipient.
2. Assistance to the eligible recipient in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with eligible recipients and service providers to determine that the services received are adequate in meeting the recipient's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible recipients to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers :

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902 (a) (23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must have the capacity to provide the full range of, at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public private service providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Muscogee County Health Department, Muscogee County Department of Family and Children Services, Muscogee County Juvenile Court, Muscogee County School District, the Housing Authority of Columbus, Columbus Parks and Recreation, Columbus Consolidated Government, Coalition for Children and Youth, and the E. E. Farley Homes Resident Council.
- f. Case Managers must hold a high school diploma equivalent and have extensive experience working with low income indigenous children and their families.
- g. The case management supervisor(s) and case managers must complete a preservice training program and a Family connection designed and supervised practicum experience.

F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violations of Section 1902 (a) (23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CASE MANAGEMENT SERVICES

**A. Target Group:**

Children 0 -21 and their Medicaid eligible siblings who are "at risk" of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screen (such as Denver, Vineland Adaptive Behavior Scale, Carolina Developmental Scale, First Step) indicates that the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening or inadequate health care.
3. Free or reduced price lunch.
4. One or more retentions.
5. Children with Iowa Test of Basic Skills (ITBS)/Test of Achievement and Proficiency (TAP) reading scores below the 50th percentile and not receiving special education services.
6. Frequent absences, tardiness or school transfers. .
7. Two or more suspensions during the most recent school year or frequent disciplinary referrals.
8. Has been referred to the Student Support Team.
9. Single parent family.
10. School alienation or few friends or little or no extracurricular involvement.
11. Residing in home situation with guardian or caretaker other than natural parent(s).
12. Born to a teen mother.
13. Low self-esteem or expresses feelings of lack of control.
14. History of exposure to direct or indirect violence.
15. History of sexual or physical abuse or neglect.
16. Lack of appropriate physical necessities (clothing, personal hygiene, etc.)

**B. Areas of State in which services will be provided:**

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): DeKalb County



C. Comparability of Services:

- Services are provided in accordance with Section 1902 (a) (10) (B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children.

The purpose of case management services is to assist those targeted at risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers.

Case Management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and following-up with eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 units annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

TRANSMITTAL	94-001
APPROVED	3-11-94
EFFECTIVE	1-1-94
SUPERSEDES	(NEW)

E. Qualification of Providers:

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

1. Must have the capacity to provide the full range of at-risk case management services.
2. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
3. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, social services, counseling services, psychological services, student assistance, special education, and nutritional services).
4. Must have demonstrated the ability to obtain collaboration between public and private service providers.
5. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the DeKalb County Board of Health, DeKalb County Department of Family and Children Services, DeKalb County Juvenile Court, Georgia Department of Children and Youth Services, City of Decatur, City Schools of Decatur, and Community Service Board.
6. Case management supervisors must hold a Bachelor's Degree in a human services field; i.e., psychology, sociology, social work, humanities, counseling, career services; and have two years of supervisory experience working with at-risk children and their families.
7. Case managers must have two (2) years of college and have two (2) years experience working with at-risk children and their families,
8. Both the case management supervisor(s) and the case managers must complete a pre-service training program and a Family Connection designed and supervised practicum experience.

F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Children in grades Pre K-12 and their Medicaid eligible siblings or offspring who are "at risk" of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. NO EPSDT initial screen or no periodic screening.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Mental Health diagnosis.
6. Single parent family.
7. One or more grade retentions.
8. Limited English proficiency.
9. Free or reduced price lunch.
10. Lack of appropriate physical necessities (clothing, proper hygiene, etc.)
11. One or more years below grade placement in reading and math.
12. History of substance abuse, or at risk for sexually transmitted disease.
13. Frequent physical complaints, low self-esteem, expresses feelings of lack of control of life.
14. History of exposure to direct or indirect violence.
15. History of sexual or physical abuse or neglect.
16. Iowa Test of Basic Skills (ITBS) Test of Achievement and Proficiency (TAP) reading scores below the 35th percentile and not receiving special education services.
17. Five or more unexcused absences in any one twenty (20) day attendance period.
18. Two or more suspensions during the most recent school year.
19. Transferred two or more times during the most recent school year.
20. Teenaged mother or parents.

B. Areas of State in which services will be provided:

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): The attendance zones of the Murray County School System.

C. Comparability of Services

Services are provided in accordance with Section 1902 (a) (19) (B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

D. Definition of Services

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902 (a) (23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private service providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Murray County Health Department, Murray County Department of Family and Children Services, Murray County Juvenile Court, and Murray County Division of Youth Services.
- f. Case Management Supervisors must hold a Master's Degree in management or human services field; i.e., psychology, sociology, social work, humanities, counseling, career services and have two years of supervisory experience working with low income indigenous children and their families.
- g. Case Managers must hold a high-school degree and have two years of experience working with low income indigenous children and their families.
- h. Case Managers must complete a pre-service training program and Family connection designed and supervised practicum experience.

- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902 (a) (23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is reported on Attachment 4.19-B, pages 5d and 5e.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**  
**State/Territory: Georgia**  
**CHILDREN AT-RISK CASE MANAGEMENT SERVICES**

**A. Target Group:**

Medicaid eligible children ages zero to seven and their Medicaid eligible siblings who are at-risk of not completing a secondary education because they exhibit three or more of the following:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening.
3. Few friends or school alienation.
4. Dysfunctional home situation.
5. Mental health diagnosis.
6. Single parent family.
7. Born to a teenage mother.
8. Born to a parent that has not completed High School.
9. Limited English proficiency.
10. Free or reduced price lunch.
11. Lack of appropriate physical necessities (clothing, proper hygiene, etc.).

**B. Areas of State in which services will be provided:**

Entire State

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide):

The attendance zones of the Clarke County School District within Athens - Clarke.

**C. Comparability of services:**

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.



**D. Definition of Services:**

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children and their siblings in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services; and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for the initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of the services identified in the service plan.
3. Monitoring and follow up with eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

**E. Qualification of Providers:**

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a) (23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private service providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the Clarke County Department of Family and Children Services, and Clarke County Public Schools.
- f. Case Managers must hold a Bachelor's degree in a human service field; i.e., psychology, sociology, social work, humanities, counseling, career services and have three years of experience working with low income indigenous children and their families.
- g. Case managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902 (a) (23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is reported on Attachment 4.19-B, pages 5d and 5e.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**  
**State/Territory: Georgia**  
**CHILDREN AT-RISK CASE MANAGEMENT SERVICES**

**A. Target Group:**

Medicaid eligible children ages 0 - 21 in Dawson County who are "at-risk" of not completing a secondary education because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening.
3. Free or reduced price lunch.
4. One or more retentions.
5. Iowa Test of Basic Skills (ITBS)/Test of Achievement and Proficiency (TAP) reading scores below the 35th percentile and not receiving special education services.
6. Five or more unexcused absences in any one twenty (20) day attendance period.
7. Two or more suspensions during the most recent school year.
8. Limited English proficiency.
9. Transferred two or more times during the most recent school year.
10. One or more years below grade placement in reading or math.
11. Children or children with family members identified as drug and/or alcohol abusers.
12. Inadequate health care.
13. Teenaged mother or parents.
14. Pregnancy; or

those displaying two of the above characteristics and at least one of the following factors:

1. Few friends or school alienation.
2. Little or no extracurricular involvement.
3. Frequent disciplinary referrals.
4. Dysfunctional home situation.
5. Disabled without mental impairment.
6. Inadequate utilities and household appliances.
7. Family members with limited job skills and difficulty finding employment.

**B. Areas of state in which services will be provided:**

- Entire State
- Only in the following geographic areas (authority of Section 1915(g) (1) of the Act is invoked to provide services less than statewide):
- Dawson County

**C. Comparability of services:**

- Services are provided in accordance with Section 1902 (a) (10) (B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 1915(g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a) (10) (B) of the Act.

**D. Definition of Services:**

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services; and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with the providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902 (a) (23) of the Act. Enrollment is open to all providers who can meet with following requirements:

- a. Must provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).

- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
  - e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Dawson County School System, Dawson County Department of Children and Youth Services, Dawson County Mental Health Department, Dawson County Department of Family and Children Services and Ninth District Opportunity, Inc.
  - f. Case Managers must have a high school diploma or equivalent, a minimum of two years experience working with at-risk children and their families, must be familiar with the community and services provided and demonstrate the ability to work with at-risk children and their families.
  - g. Case Managers must complete a pre-service training program and a Family Connection designed and supervised practicum experience.
- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902 (a) (23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is reported on Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Children ages 0 - 21 who are "at-risk of not completing a secondary education program because they exhibit three or more of the following characteristics:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening/inadequate health care.
3. Free or reduced price lunch.
4. One or more retentions.
5. Iowa Test of Basic Skills (ITBS)/Test of Achievement and Proficiency (TAP) reading scores below the 35th percentile and not receiving special education services.
6. Five or more unexcused absences in any one twenty (20) day attendance period.
7. Two or more suspensions during the most recent school year.
8. Limited English proficiency.
9. Transferred two or more times during the most recent school year.
10. One or more years below grade placement in the reading basal.
11. Few friends or school alienation.
12. Little or no extracurricular involvement.
13. Frequent disciplinary referrals.
14. Dysfunctional home situation.
15. Disabled without mental impairment.
16. Family members with limited job skills and difficulty finding employment.
17. Teen pregnancy.
18. Child or children with family members identified as drug and/or alcohol abusers.
19. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted diseases.
20. History of sexual or physical abuse or neglect.



B. Areas of State in which services will be provided:

- Entire State.
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide):  
Gwinnett County, Georgia.

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services, and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with the providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications  
Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet with following requirements:

- E. Qualifications of Providers: (continued)
- a. Must have the capacity to provide the full range of at-risk case management services.
  - b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
  - c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
  - d. Must have demonstrated the ability to obtain collaboration between public and private service providers.
  - e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Gwinnett County Health Department, Gwinnett County Department of Family and Children Services, Gwinnett County Juvenile Court, Gwinnett County Division of Children and Youth Services, Gwinnett County Public Schools, Gwinnett/Rockdale/Newton Mental Health, Gwinnett County Commissioners, Latin American Association, and Child Abuse Prevention Alliance.
  - f. Case Management Supervisors must hold a Bachelor's Degree in a human services field (i.e., psychology, sociology, social work, humanities, counseling, career services) and have two years of experience working with at-risk children and their families.
  - g. Case Managers must have a high school degree or equivalent and a demonstrated ability to work effectively with at-risk children and have three years of experience working with at-risk children and their families.
  - h. Both the case management supervisor(s) and case manager(s) must complete a pre-service training program and a Family Connection designed and supervised practicum experience.
- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 19021a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children ages 0-21 who are "at-risk" of not completing a secondary education program because they exhibit one or more of the following characteristics:

1. Developmental screen indicate the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening.
3. Few friends or school alienation.
4. Little or no extracurricular involvement.
5. Frequent disciplinary referrals.
6. Dysfunctional family situation.
7. Mental health diagnosis.
8. Single parent family.
9. One or more grade retentions.
10. Born to a teenage mother.
11. Frequent absences, tardies, or school transfers.
12. Limited English proficiency.
13. Free or reduced price lunch.
14. Lack of appropriate physical necessities (clothing, proper hygiene, etc.).
15. One or more years below grade placement in reading or math.
16. History of substance abuse, Juvenile Court involvement, or at risk for sexually transmitted disease.
17. Frequent physical complaints, low self-esteem, or expresses feelings of lack of control of life.
18. Low achievement scores (35<sup>th</sup> percentile or below on Iowa Test of (ITBS) or Test of Achievement and Proficiency (TAP), low grades (failing two or more academic subjects in a grading period), or repeated two or more grades. Basic Skills currently homeless or homeless within the past year.
19. History of exposure to direct or indirect violence.
20. History of sexual or physical abuse or neglect.

B. Areas of State in which services will be provided:

- Entire State.
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide): The attendance zones of the Dublin City School System and the Laurens County School System.

C. Comparability of Services:

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(2) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing, and other services, and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with the providers of health, family support, employment, justice, housing, counseling, nutrition, social, educational, transportation, and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.

D. Definition of Services: (continued)

3. Monitoring and follow-up with the eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.

E. Qualification of Providers:

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet with following requirements:

- a. Must have the capacity to provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education, and Nutritional Services).
- d. Must have demonstrated the ability to obtain collaboration between public and private services providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have signed a collaborative agreement with the Laurens County Department of Family and Children Services, Laurens County Health Department, Laurens County School System, the Dublin City School System, Community Mental Health Center, Department of Children and Youth Services, Dublin City Government, and the Laurens County Government.

- E. Qualification of Providers: (continued)
- f. Case Management Supervisors must hold a Master's Degree in a human service field; i.e., psychology, sociology, social work, humanities, counseling and have a minimum of two (2) years working with low income, at-risk children and their families.
  - g. Case Managers must hold a High School diploma and have a minimum of two (2) year's experience working with low income at-risk children and their Families.
  - h. Case managers must complete a pre-service training program and a Family Connection designed and supervised practice experience.
- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found on Attachment 4.19-B, pages 5d and 5e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: Georgia  
CHILDREN AT-RISK CASE MANAGEMENT SERVICES

**A. Target Group:**

Medicaid eligible children ages 0-18 who are at-risk of not completing a secondary education because they exhibit two or more of the following:

1. Developmental screen indicates the child is not meeting developmental milestones.
2. No EPSDT initial screen or no periodic screening.
3. Few friends or school alienation.
4. Dysfunctional home situation.
5. Mental health diagnosis.
6. Single parent family.
7. Born to a teenage family.
8. Born to a parent that has not completed High School.
9. Limited English proficiency.
10. Free or reduced price lunch.
11. Lack of appropriate physical necessities (clothing, proper hygiene, etc.).
12. History of exposure to direct or indirect family violence.
13. History of sexual or physical abuse or neglect.
14. Low self-esteem.

**B. Areas of State in which services will be provided:**

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less that statewide): The attendance zones of the following Tift County Schools: Annie Belle Clark, Charles Spencer, G. O. Bailey, Northside, Len Lastinger, and Omega elementary schools; Van Wilson and J. T. Reddick middle schools; and Tift County Junior High School and Tift County High School. Also to include residents within Turner County who are participant families of the Healthy Families Georgia program.

**C. Comparability of Services:**

- ( ) Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- (X) Services are not comparable in amount duration, and scope. Authority of Section 1915(g)(2) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

**D. Definition of Services:**

Children at-risk case management is a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for eligible at-risk children and their families. The purpose of case management services is to assist those targeted at-risk children in gaining access to needed medical, nutritional, social, educational, transportation, housing and other services, and to encourage the use of various community resources through referral to appropriate providers. Case management services will provide necessary coordination with providers of health, family support, employment, justice, housing counseling, nutrition, social, educational, transportation and other services when needed.

The set of interrelated activities are as follows:

1. Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the eligible child. Establishing priorities for initial linkages with providers. This unit of service may be billed only once for each eligible child.
2. Assistance to the eligible child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.
3. Monitoring and following-up with eligible child and service providers to determine that the services received are adequate in meeting the child's assessed needs. Case management follow-up services are limited to 12 visits annually.
4. Reassessment of eligible children to determine the services needed to resolve any crisis situation resulting from divorce, death, separation, family structure changes, changes in living conditions, or other events.



**E. Qualification of Providers:**

1. Provider Qualifications

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act. Enrollment is open to all providers who can meet the following requirements:

- a. Must provide the full range of at-risk case management services.
- b. Must meet the applicable state and federal laws governing the participation of providers in the Medicaid program.
- c. Must have demonstrated direct experience in the coordination of educational support services (e.g., social service, counseling services, psychological services, student assistance services, special education services, nutritional services).
- d. Must have demonstrated the ability to obtain collaboration between public and private service providers.
- e. In order to avoid duplication of services and to promote effective community level networking, case management providers must have a signed collaborative agreement with the following members of the Tift County Commission On Children and Youth: Tift County Board of Education, Tift and Turner County Departments of Family and Children Services, Early Intervention Services of Tift County, Community Connections, Tift County Department of Children and Youth Services, Tift and Turner County Health Departments, Behavioral Health Services of South Georgia (mental health), Child abuse Council of Tift County, Tifton Housing Authority, Tift General Hospital Tift County Recreation Department, City of Tifton Police department, Tift County Sheriff Department. Cooperative Extension Services of Tift and Turner Counties. Mother's Love Child Care Center, Kiddie Kollege. Big Brothers Big Sisters. PLIGHT, and Kid's Advocacy Coalition.
- f. Case Management Supervisor(s) must have four years experience in a human service field (i.e., nursing, psychology, counseling, sociology, or social work) and a minimum of two years of supervisor experience working with low income indigenous children and their families.

**E: Qualification of Providers:** (continued)

- g. Case Manager(s) must have two years experience in a human service field (i.e., nursing, psychology, counseling, sociology, or social work).
  - h. Both the case management supervisor(s) and case management staff person(s) must complete a pre-service training program and a Family Connection designed and supervised practicum experience, and have a broad knowledge of local resources.
- F.** The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.
- 1. Eligible recipients will have free choice of the providers of case management services
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G.** Payment for case management service under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Reimbursement methodology is found in Attachment 4.19-B, pages 5d and 5e.

**Amendment to Supplemental Drug-Rebate Agreement  
Between  
The State of Michigan, First Health Services Corporation  
And**

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WHEREAS, the State of Michigan, First Health Services Corporation ("First Health"), and \_\_\_\_\_ ("Manufacturer") have entered into a Supplemental Drug-Rebate Agreement Contract # NMPI- \_\_\_\_\_ (the "Agreement"), effective as of April 1, 2006: and

WHEREAS, the Centers for Medicare and Medicaid Services ("CMS") is now requiring certain changes to the Agreement before it will authorize them; and

WHEREAS, additional states have indicated their willingness to become Participating States, as defined in Section 3.14 of the Agreement, and thereby participate in the State Supplemental Rebates (as defined in Section 3.19 of the Agreement) available under the Agreement.

NOW, THEREFORE, IN CONSIDERATION OF THE MUTUAL COVENANTS, PROMISES, AND CONDITIONS CONTAINED HEREIN, THE PARTIES AGREE TO THE FOLLOWING AMENDMENTS TO THE AGREEMENT.

1. Section 1.1: "State" is changed to "States."
2. Any and all references to "U.S. Territories" is stricken from the entire Agreement.
3. Section 2.1: On line 3 "State" is changed to "States" and the clauses beginning immediately thereafter with "and/or" are deleted down to "Participating States" on line 8. On the third line, the words "CMS approved state-funded programs" are replaced with "non-Medicaid programs approved by CMS in the Medicaid state plan(s)".
4. Section 3.3: Is deleted in its entirety and "'Client State(s)'" is stricken from the entire agreement
5. Section 3.11: "State" within the parentheses on line one is made "States." In line three, "HHS approved state-funded programs" is deleted and replaced with "non-Medicaid programs approved by CMS in the Medicaid state plan(s)".
6. Section 3.12: This section is deleted in its entirety. "First Health Client's States" and "FH Client's States" are stricken from this Agreement.
7. Section 3.14: This section is modified to read as follows:

"Participating State(s)" means the (i) States as named in Section 1.1 hereof, and (ii) other states that, subsequent to the execution of this Agreement by the States, elect to participate under this Agreement and have all necessary authorizations and approvals from CMS to do so. Unless otherwise approved by CMS on a state by state basis, Participating States shall be limited to ones that have a CMS approved contract under which First Health has been engaged to provide PBA Services to that state. For each new Participating State, a unilateral amendment ("New Participating State

Amendment") to this Agreement shall be executed by the new Participating State and First Health and sent to the Manufacturer prior to the Participation Commencement Date. Each Participating State, including the new Participating State, must submit a state plan amendment adding the new Participating State to the Agreement to CMS for approval. A copy of the form Amendment is attached hereto as Exhibit A."

8. Section 3.16: This section is modified to read as follows:

"'Participation Commencement Date' means the latter of the date (i) a Manufacturer's Supplemental Covered Product is effectively placed in Participating States Preferred Drug List Program by distribution of it (via website or otherwise) to providers and prescribers, or (ii) the New Participating State Amendment is received by the Manufacturer from a new Participating State. It is the date when the Participating States entitlement to a rebate from the Manufacturer begins to accrue."

9. Section 3.20: On the second line: the phrase "state funded, HHS approved programs" is deleted and replaced with "non-Medicaid programs approved by CMS in the state plan(s) as provided in Section 2.1 hereof".

10. Section 5.1: The last sentence of this section is modified to read:

"Each Participating State will notify Manufacturer and First Health, within ten (10) business days of adoption and publication of a new or revised Preferred Drug List, when Manufacturer's Supplemental Covered Product is added to the Participating State's Preferred Drug List by providing Manufacturer and First Health a copy of the Preferred Drug List in accordance with the notice provisions of Section 9.2 hereof."

11. Section 8.3 is modified by deleting items (ii) and (iii) so that it now reads as follows:

"Termination by a FH Client of its PBA Services Agreement with First Health shall, as of the same termination effective date, terminate this Agreement as to that Participating State."

12. Section 9.9: This section is modified to read as follows:

"This Agreement will not be altered except by (i) an amendment in writing signed by all the parties, other than (ii) in the case of the addition of a new Participating State(s), by its execution of the New Participating State Amendment, both (i) and (ii) of which shall require the approval of CMS. It is acknowledged that the intent of the previous sentence is that the addition of a new Participating State(s) by amendment shall only require the consent of First Health and the approval of CMS, not Manufacturer. Manufacturer agrees that any Participating State may be added to this Agreement by amendment and that said Participating State's covered Medicaid (and other non-Medicaid programs approved by CMS in the Medicaid state plan(s)) lives shall apply to the provisions of Schedules 2 and 3 and will affect the rebates to all Participating States in accordance with Schedules 2 and 3. The New Participating State Amendment shall be executed by First Health and the new Participating State with a copy provided to Manufacturer for its records. Other than as stated herein, no individual is authorized to alter or vary the terms or make any representation or

inducement relative to it, unless the alteration appears by way of a written amendment, signed by duly appointed representatives of the Participating State(s), First Health, and the Manufacturer."

13. Section 9.11: In the second line, replace "other state funded" with "non-Medicaid programs approved by CMS in the Medicaid state plan(s)".
14. Except as expressly amended herein, all other terms, conditions and provisions of the Agreement shall remain in full force and effect and the parties hereto hereby ratify and confirm the same as of the date hereof. To the extent that any provisions of this Amendment conflict with the provisions of the Agreement, the provisions of Amendment shall control.

As evidence of their agreement to the foregoing terms and conditions, the parties have signed below.

MANUFACTURER

By: \_\_\_\_\_ Date: \_\_\_\_\_  
Name: \_\_\_\_\_  
Title \_\_\_\_\_

FIRST HEALTH SERVICES CORPORATION

By: \_\_\_\_\_ Date: \_\_\_\_\_  
Name: James G. Council  
Title: V.P. & Corporate Counsel

STATE OF MICHIGAN, DEPARTMENT OF COMMUNITY HEALTH

By: \_\_\_\_\_ Date: \_\_\_\_\_  
Name: David McLaury  
Title: Medical Services Administration

## SUPPLEMENTAL DRUG-REBATE AGREEMENT

CONTRACT # NMPI-

### PARTIES/PERIOD

1.1 This Supplemental Drug-Rebate Agreement ("Agreement") is made and entered into this 1st day of April, 2006, by and between the State of Michigan ("State"), represented by the Department of Community Health ("State"), First Health Services Corporation ("First Health"),  
\_\_\_\_\_ ("Manufacturer"), Labeler Code \_\_\_\_\_,

and such other states that subsequently join into this Agreement upon the terms hereafter set forth ("Participating State(s)"). The parties, in consideration of the covenants, conditions, agreements and stipulations expressed in this Agreement, do agree as follows:

### PURPOSE

2.1 It is the intent of this Agreement that (i) states that have entered into agreements for First Health to provide pharmacy benefit administration services ("PBA Services") to the state Medicaid and other CMS approved state pharmaceutical assistance programs that do not affect Best Price ("FH Clients"), including the State, and/or (ii) states that have entered into intergovernmental agreements, with the State for the latter to provide certain PBA Services to the state (" Client States") and/or (iii) states that have entered into intergovernmental agreements with a FH Client, for the FH Client to provide certain PBA Services to the state (FH Client's States) (states in categories (i), (ii), and (iii) often collectively referred to herein as "Participating States"), will receive State Supplemental Rebates, in addition to the rebates received under the CMS Rebate Agreement, pursuant to Section 1927 of the Social Security Act (42 U.S.C. § 1396r-8), for the Manufacturer's Supplemental Covered Product(s) quarterly utilization in the Participating States' Medicaid Programs in which there is Medicaid federal financial participation. It is also the intent of this Agreement that State Supplemental Rebates will be paid for utilization of the Manufacturer's Supplemental Covered Product(s) in other state funded programs that have been approved for inclusion by the Secretary of Health and Human Services ("HHS"). The parties also intend for this Agreement to meet the requirements of federal law at Section 1927 of the Social Security Act (42 U.S.C. §1396r-8).

### DEFINITIONS

3.1 'Average Manufacturer Price' (AMP) means Manufacturer's price for the Covered Product(s). AMP will be calculated as specified in Manufacturer's CMS Agreement.

3.2 'Best Price' means, in accordance with 42 U.S.C. §1396r-8(c)(1)(C), with respect to a Single Source Drug or Innovator Multiple Source Drug of a Manufacturer, the lowest price available from the Manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or government entity within the United States, excluding: (a) any price charged on or after October 1, 1992, to the Indian Health Services, the Department of Veterans Affairs, a State home receiving funds under Section 1741 of Title 38, United States Code, the Department of Defense, the Public Health Service, or a covered entity described in subsection (a)(5)(B) of Section 1927 of the Social Security Act; (b) any prices charged under the Federal Supply Schedule of the General Services Administration; (c) any prices used under a State Pharmaceutical Assistance Program; and (d) any depot prices and single award contract prices, as defined by the Secretary of any agency of the Federal Government. "Best Price" shall: (a) be inclusive of cash discounts, free goods that are contingent on any purchase requirement, volume discounts, and rebates (other than rebates under this section); (b) be determined without regard to special packaging, labeling, or identifiers on the dosage form or product or package; and (c) not take into account prices that are merely nominal in amount.

3.3 'Client State(s)' means those states who enter into an agreement with the State, with First Health's continuing consent, for the provision of PBA Services to the states' Medicaid and other CMS approved state pharmaceutical assistance programs.

3.4 'Covered Product(s)' means the pharmaceutical product(s) of the Manufacturer pursuant to Section 1927 of the Social Security Act (42 U.S.C. § 1396r-8).

3.5 'CMS Agreement' means the Manufacturer's drug rebate contract with the Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration, entered pursuant to Section 1927 of the Social Security Act (42 U.S.C. §1396r-8).

3.6 'CMS Basic Rebate' means, with respect to the Covered Product(s), the quarterly payment by Manufacturer pursuant to Manufacturer's CMS Agreement, made in accordance with Section 1927(c)(1) or Section 1927(c)(3) of the Social Security Act [42 U.S.C. §1396r-8(c)(1) and 42 U.S.C. & 1396r8(c)(3)].

3.7 'CMS CPI Rebate' means, with respect to the Covered Product(s), the quarterly payment by Manufacturer pursuant to Manufacturer's CMS Agreement, made in accordance with Section 1927(c)(2) of the Social Security Act (42 U.S.C. §1396r-8(c)(2)).

3.8 'CMS Rebate' means, with respect to the Covered Product(s), the quarterly payment by Manufacturer pursuant to Sections 4.1 of this Agreement.

3.9 'CMS Unit Rebate Amount' means, the unit amount computed by CMS to which the Medicaid utilization information may be applied by States in invoicing the Manufacturer for the rebate payment due.

3.10 'Drug Reimbursement Amount' means the total amount per unit allowable as calculated by the Participating States, specific to each drug, that the Participating States reimburse pharmacy providers per unit of drug under their Medicaid (and other state funded, HHS approved) programs, in accordance with applicable state and federal laws and regulations.

3.11 'First Health Client(s)' or 'FH Clients' means those states (including the State) that have entered or subsequently enter into agreements with First Health for the provision of PBA Services to the states' Medicaid and other CMS-approved state pharmaceutical assistance programs, subject to the supervision and oversight of such States.

3.12 'First Health Client's States' or 'FH Client's States' means those states that enter into an agreement with a FH Client, with First Health's continuing consent, for the provision of PBA Services to the states' Medicaid and other CMS-approved state pharmaceutical assistance programs.

3.13 'Manufacturer' means, for purposes of this Agreement, the party identified as such in Section 1.1 of this Agreement, which may be a pharmaceutical manufacturer, labeler or other entity not prohibited by law from entering into this Agreement.

3.14 'Participating State(s)' means the State, Client States, FH Clients and FH Client's States. all as defined herein.

3.15 'Participating States' Net Price Per Unit' or 'Net Price' means the amount(s) agreed upon by the parties to this Agreement in the attached "Supplemental Rebate Matrix, Schedule 2". Net Price' will vary in accordance with Schedule 2 and is dependent upon the factors detailed therein, which includes, but may not be limited to, the number of Medicaid (and other state funded, HHS approved) eligible recipient lives and the number of products in a Preferred Drug List's product category. Per the attached



3.23 'Supplemental Rebate Amount' means, with respect to the Supplemental Covered Product(s), the amount(s) specified in the attached Supplemental Bid Matrix, Schedule 2 and Supplemental Rebate Calculation, Schedule 3 that the Manufacturer has agreed to reimburse Participating States per unit of drug in accordance with the formula detailed in the above Schedules.

3.24 'Wholesale Acquisition Cost' or 'WAC' means the Manufacturer's U.S. Dollar wholesale acquisition price in effect on the last day of a quarter on a unit basis as published by a third party source, such as First Databank, for each product and represents the Manufacturer's published price for a drug product to wholesalers.

#### **MANUFACTURER'S RESPONSIBILITIES**

4.1 Manufacturer will calculate and provide each Participating State a CMS Rebate for the Covered Product(s), which includes the CMS Basic Rebate and CMS CP1 Rebate, as appropriate. The CMS Rebate represents the discount obtained by multiplying the units of the Covered Product(s) reimbursed by each Participating State in the preceding quarter by the per unit rebate amount provided to each Participating State by CMS. CMS will calculate the CMS Rebate amount in accordance with Manufacturer's CMS Agreement. Manufacturer's obligation for CMS Rebates will continue for the duration of the Manufacturer's CMS Agreement.

4.2 In addition to the CMS Rebates described in Section 4.1 of this Agreement, Manufacturer will remit to each Participating State a State Supplemental Rebate for the Supplemental Covered Product(s) that are in each Participating States Preferred Drug List Program. The State Supplemental Rebates will be calculated on a calendar quarter basis and provided via invoices to the Manufacturer's CMS financial contact. The State Supplemental Rebates for the quarter will be determined by multiplying the number of units of the Supplemental Covered Product(s) reimbursed by each Participating State in the preceding quarter by its Supplemental Rebate Amount. The Manufacturer's obligation for State Supplemental Rebates will continue for the duration of this Agreement. The Supplemental Rebate calculation is described in "Supplemental Rebate Calculation, Schedule 3".

4.3 The Manufacturer's obligation for State Supplemental Rebates will begin with the Rebate Billing Period for the second calendar quarter 2006, which begins April 1, 2006 (even if this Agreement is not fully executed by such date) and will continue through the Rebate Billing Period that ends March 31, 2009, subject to each Participating States' actual Participation Commencement Date as described in Section 3.16, *supra*. Notwithstanding the above, the Participating States reserve right to solicit

annually more favorable State Supplemental Rebates from Manufacturer by giving written notice thereof no less than ninety (90) days prior to the yearly anniversary of the effective date of this Agreement.

4.4 The quarters to be used for calculating the Rebates in Section 4.2 of this Agreement will be those ending on March 31, June 30, September 30, and December 31 of each calendar year during the term of this Agreement.

4.5 The participating Manufacturer will be required to submit each Participating State's State Supplemental Rebate payment within 38 days of the Manufacturer's receipt of the Participating State's Rebate Summary

4.6 Manufacturer will pay the State Supplemental Rebates, including any applicable interest in accordance with Section 1903 (d)(5) of the Act. Interest on the Rebates payable under Section 4.2 of this Agreement begins accruing 38 calendar days from the postmark date of each Participating State's invoice and supporting Rebate Summary sent to the Manufacturer and interest will continue to accrue until the postmark date of the Manufacturer's payment. For the rebate programs invoiced under this Agreement, if the date of mailing of a Rebate payable under Section 4.2 of this Agreement is 69 days or more from the date of mailing of the invoice, the interest rate will be calculated as required under federal guidelines for rebates described in Section 4.1 but will be increased by ten percentage points or the maximum allowed by that Participating State's state law. If a Participating State has not received the Rebates payable under Section 4.2 of this Agreement, including interest, within 180 days of the postmark date of said Participating State's invoice and supporting Rebate Summary sent to the Manufacturer, such Participating State may deem the Manufacturer to be in default and Participating State may terminate its participation in this Agreement by giving Manufacturer and First Health ninety (90) days advance written notice.

4.7 Manufacturer agrees to continue to pay State Supplemental Rebates on the Supplemental Covered Product(s) for as long as this Agreement or any of its Addenda are in force, and State Utilization Data shows that payment was made for that drug, regardless of whether the Manufacturer continues to market that drug. Manufacturer's obligation to pay State Supplemental Rebates on the Supplemental Covered Product(s) shall terminate twelve (12) months following the last expiration date of the last lot of Supplemental Covered Product sold by the Manufacturer. Notwithstanding the above, in the event Manufacturer's Supplemental Covered Product(s) is/are sold to another manufacturer, the original Manufacturer shall have no liability for rebates on utilization beyond those required by the Medicaid

program. Manufacturer shall provide the State and First Health with notice of the sale of said Supplemental Covered Product(s) concurrent with Manufacturer's notice to CMS.

4.8 Unless notified otherwise, Manufacturer will send Rebate payments by certified mail, return receipt requested, to the address provided to Manufacturer in each individual Participating State's Addendum.

#### **PARTICIPATING STATE(S)' RESPONSIBILITIES**

5.1 Each Participating State will consider the Manufacturer's Supplemental Covered Product(s) for inclusion in the Participating State's Preferred Drug List Program. Each individual Participating State reserves the right to select the products that will be in its Preferred Drug List Program and will only receive State Supplemental Rebates for Manufacturer's Supplemental Covered Products that are actually included in its Preferred Drug List Program. Manufacturer shall pay Participating States State Supplemental Rebates based upon Participating State(s)' utilization of Manufacturer's Supplemental Covered Product(s) that did not require prior authorization. Participating States shall not be entitled to State Supplemental Rebates for utilization of Manufacturer's Supplemental Covered Product(s) that occurred only subsequent to the obtaining of prior authorization unless the Supplemental Covered Product(s) have been assigned to a Product Category and all products in the Product Category are subject to prior authorization requirements. Each individual Participating State also reserves the right to determine, as a result of a Product Category review, that prior authorization is required for all preferred drugs in a Product Category. If a Participating State determines that prior authorization is required for any Supplemental Covered Product, then the Participating State will comply with all provisions of Section 1927( d) of the Social Security Act applicable to Prior Authorization programs. Each Participating State will notify, within ten (10) business days, First Health and the State when Manufacturer's Supplemental Covered Product is added to the Participating State's Preferred Drug List.

5.2 The State and/or First Health shall notify the Manufacturer whenever a Participating State adds one of Manufacturer's Supplemental Covered Products to its Preferred Drug List or when one of Manufacturer's Supplemental Covered Products is moved to a prior authorization status.

5.3 Each Participating State will provide aggregate State Utilization Data to the Manufacturer on a quarterly basis. This data will be based on paid claims data (data used to reimburse pharmacy providers) under each Participating State's Medicaid (and other state funded, HHS approved) Program(s), will be consistent with any applicable Federal or State guidelines, regulations and standards for such data and will be the basis for the Participating State's calculation of the State Supplemental Rebate.

5.4 Each Participating State will maintain those data systems used to calculate the State Supplemental Rebates. In the event material discrepancies are discovered, the Participating State will promptly justify its data or make an appropriate adjustment, which may include a credit as to the amount of the State Supplemental Rebates, or a refund to Manufacturer as the parties may agree.

5.5 Each Participating State shall maintain electronic claims records for the most recent four quarters that will permit Manufacturer to verify through an audit process the Rebate Summaries provided by the Participating State.

5.6 Upon implementation of this Agreement, and from time to time thereafter, Participating States and Manufacturer will meet to discuss any data or data system improvements which are necessary or desirable to ensure that the data and any information provided by the Participating States to Manufacturer are adequate for the purposes of this Agreement.

5.7 First Health, as the pharmacy benefit administrator, may assist the Participating States in fulfilling its responsibilities hereunder and is a party to this Agreement solely in its capacity as agent for, and subject to the supervision and oversight of the Participating State(s).

5.8 The State and each Participating State shall obtain CMS approval of its state Medicaid plan of which this Agreement forms a part. Manufacturer shall not be obligated to remit any Supplemental Rebates that have accrued and are due under this Agreement until after the affected State or Participating State has obtained CMS approval of its Supplemental Rebate Program of which this Agreement forms a part.

#### **DISPUTE RESOLUTION**

6.1 In the event that in any quarter a discrepancy in a Participating State's State Utilization Data is questioned by the Manufacturer, which the Manufacturer and the Participating State in good faith are unable to resolve, the Manufacturer will provide written notice of the discrepancy to the Participating State and First Health.

6.2 If the Manufacturer in good faith believes the Participating State's State Utilization Data is erroneous, the Manufacturer shall pay the Participating State that portion of the rebate claimed, that is not

in dispute by the required date. The balance in dispute, if any, will be paid by the Manufacturer to the Participating State by the due date of the next quarterly payment after resolution of the dispute.

6.3 The Participating State and the Manufacturer will use their best efforts to resolve the discrepancy within 60 days of receipt of written notification. Should additional information be required to resolve disputes, the Participating State and First Health will cooperate with the Manufacturer in obtaining the additional information.

6.4 In the event that the Participating State and the Manufacturer are not able to resolve a discrepancy regarding State Utilization Data as provided for in Sections 6.1 through 6.3, the Manufacturer may request a reconsideration of the Participating State's determination within 30 days after the end of the 60 day period identified in Section 6.3. The Manufacturer shall submit with its written request its argument in writing, along with any other materials, supporting its position to the Participating State and First Health. The Participating State shall review the written argument and materials and issue a decision in the matter.

#### **CONFIDENTIALITY PROVISIONS**

7.1 The parties agree that confidential information will not be released to any person or entity not a party to this contract. Confidential information, including trade secrets, will not be disclosed, or used except in connection with this Agreement or as may be required by law or judicial order.

7.2 The Manufacturer will hold Participating State' State Utilization Data confidential. If the Manufacturer audits this information or receives further information on such data from First Health or a Participating State, that information shall also be held confidential. The Manufacturer shall have the right to disclose Participating State(s)'s State Utilization Data to auditors who agree to keep such information confidential

7.3 Pursuant to 42 USC 1396r-8(b)(3)(D), and other applicable state or federal laws, the parties agree that this Agreement and all information provided pursuant to this Agreement will not be disclosed and that the parties will not duplicate or use the information, except in connection with this Agreement or as may be required by judicial order. The parties further agree that any information provided by Manufacturer to the State, First Health, or the Participating State(s) pursuant to this Agreement and this Agreement itself constitute trade secrets and/or confidential or proprietary commercial and financial

information not subject to public disclosure. Furthermore, the parties agree that any Manufacturer information received by First Health pursuant to this Agreement and distributed by First Health to the State and/or Participating States shall constitute trade secrets and/or confidential or proprietary commercial and financial information of the Manufacturer not subject to public disclosure, except as otherwise provided for herein. If the services of a third party are used to administer any portion of this Agreement, Sections 7.1 through 7.4 of this Agreement shall apply to the third party. In the event a Participating State cannot give satisfactory assurance that rebate pricing data will be exempt from public disclosure under applicable state law, then First Health (without assuming responsibility for any wrongful disclosure by a Participating State) shall limit the amount of such data made available to the Participating State by not disclosing to the Participating State any NDC-level pricing information. For purposes hereof "satisfactory assurance" shall be deemed given when the Participating State enters the statutory cite of the applicable exemption on its Participating State Addendum. In the event that either party is required by law to disclose any provision of this Agreement or pricing information to any person, such party shall provide advance written notice to the other party sufficiently advance of the proposed disclosure to allow the other party to seek a protective order or other relief.

7.4 Notwithstanding the non-renewal or termination of this Supplemental Rebate Agreement for any reason, these confidentiality provisions will remain in full force and effect.

#### **NON-RENEWAL or TERMINATION**

8.1 This Agreement shall be effective as of April 1, 2006 and shall have the term indicated in Section 4.3, *supra*.

8.2 Any Participating State may terminate its participation in this Agreement by giving Manufacturer and First Health written notice at least (90) days prior to the anniversary date of this Agreement, in which case termination shall become effective on the anniversary date of the date of execution of this Agreement. The termination of this Agreement by one or more Participating States shall not affect the Manufacturer's, First Health's or the other Participating States' obligations under this Agreement, other than any effect the reduction in the number of lives covered by the Agreement may have on the Supplemental Rebate payable hereunder. Manufacturer may terminate this Agreement and all Addenda by giving all Participating States and First Health written notice at least ninety (90) days prior to the anniversary date of this Agreement, in which case termination shall become effective on the anniversary date of the date of execution of this Agreement. Manufacturer's right of termination is limited to the right

to terminate the entire Agreement, Manufacturer may not terminate specific Addendum/Addenda of less than all Participating State(s).

8.3 Termination by (i) a FH Client of its PBA Services agreement with First Health, or (ii) by a Client State of its intergovernmental agreement with the State, or (iii) by a FH Client State of its intergovernmental agreement with a FH Client State shall, as of the same termination effective date, terminate this Agreement as to that Participating State.

8.4 Notwithstanding any non-renewal or termination of this Agreement, State Supplemental Rebates will still be due and payable from the Manufacturer under Section 4.2 for any Supplemental Covered Products for which Participating State(s)' obligation to reimburse arose prior to the effective date of termination of this Agreement.

8.5 On at least an annual basis or as mutually agreed upon by Manufacturer and First Health, Manufacturer shall have the opportunity to decrease the Net Price of jus Covered Products to increase the likelihood of product(s) utilization and/or inclusion in the Participating States Preferred Drug List Programs

#### GENERAL PROVISIONS

9.1 This Agreement will be governed and construed in accordance with 42 U.S.C. §1396r-8 and all other applicable federal and state law and regulations.

9.2 Any notice required to be given pursuant to the terms and provisions of this Agreement will be in writing and will be sent by certified mail, return receipt requested. Notice will be mailed to the addressees) specified in each individual Participating State's Addendum to this Agreement.

Notice to the State shall be sent to:

State of Michigan  
Department of Community Health Medical Services Administration  
Attn: Dave McLaury  
400 S. Pine Street  
Lansing, MI 48933

Notice to First Health shall be sent to:

First Health Services Corporation  
Attn: Teresa R. DiMarco, President  
With a copy to: Legal Department  
4300 Cox Road  
Glen Allen, Virginia 23060

Notice to Manufacturer will be sent to:

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9.3 The Manufacturer agrees to be bound by the laws of the United States of America and with respect to each Participating State, the law of that Participating State. Proper venue in any legal action shall be the venue of the Participating State that is party to the proceeding. Any action brought by Manufacturer must be brought separately against individual Participating States or First Health, unless all affected Participating States and First Health consent to joinder of the actions.

9.4 Nothing herein shall be construed or interpreted as limiting or otherwise affecting First Health or Participating State( s) ability to pursue its rights arising out of the terms and conditions of the Agreement in the event that a dispute between the parties is not otherwise resolved.

9.5 Manufacturer and the agents and employees of Manufacturer in the performance of this Agreement will act in an independent capacity and not as officers, employees or agents of First Health or any Participating State.

9.6 Manufacturer may not assign this Agreement, either in whole or in part, without the written consent of the Participating States and First Health. However, in the event of a transfer in ownership of the Manufacturer, the Agreement is automatically assigned to the new owner subject to the conditions in this Agreement. If the Agreement is assigned pursuant to this Section, Manufacturer shall provide First Health and the Participating States with an update of the information contained in Section 9.2, supra.



"Supplemental Rebate Matrix. Schedule 2", Net Price will be a factor in the equation that is determinative of the Supplemental Rebate Amount.

3.16 'Participation Commencement Date' means the date a Manufacturer's Supplemental Covered Product is effectively placed in a Participating States Preferred Drug List Program by distribution of it (via website or otherwise) to providers and prescribers. It is the date when the Participating States entitlement to a rebate from the Manufacturer accrues.

3.17 'Pharmacy Provider' means an entity licensed or permitted by law to dispense legend drugs, and enrolled as a State Medicaid Provider.

3.18 'Rebate Summary' means the individual Participating States' reports itemizing the State Utilization Data supporting each Participating State's invoice for Rebates. The Rebate Summary will comply in all respects with requirements for Medicaid Utilization Information in the CMS Agreement.

3.19 'State Supplemental Rebate' means, with respect to the Supplemental Covered Product(s), the quarterly payment by Manufacturer pursuant to Section 4.2 of this Agreement.

3.20 'State Utilization Data' means the data used by Participating States to reimburse pharmacy providers under Participating States' Medicaid Program (and other state funded, HHS approved programs). State Utilization Data excludes data from covered entities identified in Title 42 U.S.c. §256b(a)(4) in accordance with Title 42 V.S.C. §256b(a)(5)(A) and 1396r-8(a)(5)(C).

3.21 'Supplemental Covered Product' means the pharmaceutical product(s) of the Manufacturer, as detailed in the attached Supplemental Rebate Matrix. Schedule 2, upon which a State Supplemental Rebate will be paid pursuant to this Agreement.

3.22 'Supplemental Covered Product Category' or 'Product Category' means a defined group of pharmaceutical products considered to compete with one another in the market and that are also thought to be therapeutic alternatives in many situations. First Health Services has determined and defined the Product Categories in which manufacturers will bid. The Product Categories, set forth on the "Product Categories, Schedule 1" hereto, may be changed as deemed appropriate by Participating States.

9.7 Nothing in this Agreement will be construed so as to require the commission of any act contrary to law. If any provision of this Agreement is found to be invalid or illegal by a court of law, or inconsistent with federal requirements, this Agreement will be construed in all respects as if any invalid, unenforceable, or inconsistent provision were eliminated, and without any effect on any other provision.

9.8 First Health, Participating State(s) and Manufacturer declare that this Agreement, including attachments, schedules and addenda, contains a total integration of all rights and obligations of the parties. There are no extrinsic conditions, collateral agreements or undertakings of any kind. In regarding this Agreement as the full and final expression of their contract, it is the express intention of the parties that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period of time governed by this Agreement which are not expressly set forth herein are to have no force, effect, or legal consequences of any kind.

9.9 This Agreement will not be altered except by an amendment in writing signed by the parties or the addition of Participating State(s) by its execution of the Participating State Addendum, a copy of which is attached hereto. The addition of Participating State(s) by addendum/addenda shall only require the consent of First Health. Manufacturer agrees that any Participating State may be added to this Agreement by addendum, and that said Participating State's covered Medicaid (and other state funded, HHS/CMS approved state pharmaceutical assistance programs) lives shall apply to the provisions of Schedules 2 and 3 and will affect the rebates to all Participating States in accordance with Schedules 2 and 3. The addendum shall be executed by First Health and the new Participating State with a copy provided to Manufacturer for its records. Other than as stated herein, no individual is authorized to alter or vary the terms or make any representation or inducement relative to it, unless the alteration appears by way of a written amendment, signed by duly appointed representatives of the Participating State(s), First Health, and the Manufacturer.

9.10 The parties do not contemplate any circumstances under which indemnification of the other parties would arise. Nevertheless, should such circumstances arise, Manufacturer agrees to indemnify, defend and hold harmless the Participating States and First Health, their officers, agents and employees from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Manufacturer in the performance of this Agreement.

9.11 Inasmuch as the State Supplemental Rebates required by this Agreement are for state Medicaid (and other state funded, HHS/CMS approved state pharmaceutical assistance programs) program

beneficiaries, it is agreed, in accordance with Medicaid Drug Rebate Program Release #102 for State Medicaid Directors and other applicable law, that the State Supplemental Rebates do not establish a new 'Best Price' for purposes of participating Manufacturer's CMS Agreement.

9.12 In the event that Participating State(s) require(s) prior authorization of Manufacturer's Supplemental Covered Product(s) as part of a Product Category prior authorization under Section 5.1. State Supplemental Rebates shall nevertheless be payable hereunder.

9.13 If First Health or a Participating State makes changes to a Product Category that are considered to be a material change in the structure of the supplemental rebates program, Manufacturer may be allowed to re-submit bids for the Product Category/Categories affected.

9.14 As evidence of their Agreement to the foregoing terms and conditions, the parties have signed below.

STATE OF MICHIGAN, DEPARTMENT OF COMMUNITY HEALTH:

By: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

MANUFACTURER

By: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

FIRST HEALTH SERVICES CORPORATON

By: \_\_\_\_\_ Date: \_\_\_\_\_

Name: James G. Council

Title: VP & Corporate Counsel

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## EXHIBIT A

**New Participating State Amendment to Supplemental  
Drug-Rebate Agreement Between  
The States of Michigan, New Hampshire, Alaska, Nevada, Hawaii,  
Minnesota, Montana, Kentucky, Tennessee, New York, and  
District of Columbia; First Health Services Corporation  
And  
(Manufacturer Name ("Manufacturer"))**

WHEREAS, the State of Michigan, First Health Services Corporation ("First Health"), and Manufacturer have entered into a Supplemental Drug-Rebate Agreement (the "Agreement"), effective as of <<DATE>>; and

WHEREAS, the participating States as named in Section 8 below have become parties to the Agreement as Participating States by previous amendment or addenda; and

WHEREAS, additional states have indicated their willingness to become a new Participating State, as defined in Section 3.14 of the Agreement, and thereby participate in the State Supplemental Rebates (as defined in Section 3.19 of the Agreement) available under the Agreement.

Now, therefore, in consideration of the mutual covenants, promises, and conditions contained herein and in the Agreement, the parties agree as follows:

1. The State of Georgia is hereby added as a party to the Agreement as a new Participating State, as defined in Section 3.14 of the Agreement.
2. This Amendment shall become effective upon the date determined in accordance with Section 3.16 of the Agreement; provided that this Amendment shall not become effective until the effective date of the state plan amendment submitted to CMS on June 6, 2006.
3. An executed copy of this Amendment shall be sent via certified mail, return receipt requested to Manufacturer's address of record as set forth in the Agreement within five (5) business days of its execution by the parties. Any notice to Participating State shall be sent to the names and address in section 9 of this Exhibit:
4. This Addendum adds a new Participating State to the Agreement and does not otherwise change or alter the Agreement. The new Participating State(s) understand(s) and agrees to be bound by the terms of the Agreement.

**EXHIBIT A**

- 5. The undersigned State acknowledges that manufacturer rebate pricing information is confidential information under applicable Federal law and shall be exempt from public disclosure pursuant to State Code Section O.C.G.A. 50-18-70, et seq.
- 6. The undersigned State represents that it has not requested authorization from CMS to include any state pharmaceutical assistance program within the rebate provisions of the Agreement. The above representation shall not prohibit the undersigned State from requesting CMS authorization to include (other) pharmaceutical assistance programs within the Agreement at a later date. Upon receipt of CMS authorization, State shall give written notice to Manufacturer of the date Manufacturer's Supplemental Covered Product is effectively placed on the preferred drug list of the undersigned State's non-Medicaid programs approved by CMS in the Medicaid state plan(s) by completing the attached Exhibit A1.
- 7. The approximate enrollment in the undersigned State's Medicaid program at the time of execution of this Amendment is 364,000.
- 8. As of the effective date of this Amendment, the following are all of the Participating States under the Agreement:

<u>Michigan</u>	<u>Alaska</u>
<u>New York</u>	<u>Nevada</u>
<u>New Hampshire</u>	<u>Hawaii</u>
<u>Minnesota</u>	<u>Montana</u>
<u>Kentucky</u>	<u>Tennessee</u>
<u>District of Columbia</u>	

- 9. The contact information for each of the Participating States listed above in section 8 and new states shall be as follows:

<b>State of Michigan</b>	Department of Community Health Medical Services Administration Attn: Dave McLaury 400 S. Pine Street Lansing, MI 48933
<b>State of Nevada</b>	Division of Health Care Financing and Policy

**EXHIBIT A**

Nevada Department of Human Resources  
Mark Willden, Director  
1100 East Williams Street  
Carson City, Nevada 89701

**State of New  
Hampshire**

State of New Hampshire Department of Health  
and Human Services  
Commissioner John Stephen  
129 Pleasant Street  
Concord, NH 03301

**State of Alaska**

Dwayne Peebles  
Director of Health Care Services  
State of Alaska Health & Social Services Department  
Health Care Services Division  
4501 Business Park Boulevard, Ste. 24  
Anchorage, AK 99503

**State of Hawaii**

Lillian B. Koller, ESQ.,  
Director  
Department of Human Services  
P. O. Box 339  
Honolulu, HI 96809

**State of Minnesota**

Brian Osberg  
Deputy Secretary  
Minnesota Department of Human Services  
444 Lafayette Road North  
Saint Paul, Minnesota 55155

**State of Montana**

John Chapuis  
State Medicaid Director  
Montana Department of Public Health  
and Human Services  
P.O. Box 4210  
Helena, Montana 59604

**State of Kentucky**

Rebecca Cecil  
Deputy Undersecretary  
Commonwealth of Kentucky  
Cabinet for Health and Family Services  
275 East Main Street, 4W-A  
Frankfort, Kentucky 40621

**State of Tennessee**

State of Tennessee  
Department of Finance & Administration TennCare Bureau

**EXHIBIT A**

**State of New York**

Attn; David Beshara, Chief Pharmacy Officer  
310 Great Circle Drive  
Nashville, TN 37243  
PDP Program Manager  
Bureau of Program Guidance  
Office of Medicaid Management  
NYSDOH  
99 Washington Ave, Suite 720  
Albany, NY 12210-2806

STATE OF GEORGIA  
DEPARTMENT OF COMMUNITY  
HEALTH

FIRST HEALTH SERVICES CORP

By: \_\_\_\_\_  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_

By: \_\_\_\_\_  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_

**EXHIBIT A1**

**Participating State's Non-Medicaid Programs Approved by CMS in the  
Medicaid State Plan(s)**

Participating State: Georgia

Non-Medicaid programs approved by CMS in the Medicaid State Plan(s)- Date of Approval

1. **None**

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_



**SUPPLEMENTAL DRUG-REBATE AGREEMENT**  
**CONTRACT # NMPI- \_\_\_\_\_**

**PARTIES/PERIOD**

1.1 This Supplemental Drug-Rebate Agreement ("Agreement") is made and entered into this <<DATE>>, by and between the State of Michigan ("State"), represented by the Department of Community Health ("State"), First Health Services Corporation ("First Health"), \_\_\_\_\_ ("Manufacturer"), Labeler Code \_\_\_\_\_, and such other states that subsequently join into this Agreement upon the terms hereafter set forth ("Participating State(s)") The parties, in consideration of the covenants, conditions, agreements, and stipulations expressed in this Agreement, do agree as follows:

**PURPOSE**

2.1 It is the intent of this Agreement that (i) states that have entered into agreements for First Health to provide pharmacy benefit administration services ("PBA Services") to the state Medicaid and other non-Medicaid programs approved by CMS in the Medicaid state plan(s) that do not affect Best Price ("FH Clients"), including the States, ("Participating States"), will receive State Supplemental Rebates, in addition to the rebates received under the CMS Rebate Agreement, pursuant to Section 1927 of the Social Security Act (42 U.S.C. § 1396r-8), for the Manufacturer's Supplemental Covered Product(s) quarterly utilization in the Participating States' Medicaid Programs in which there is Medicaid federal financial participation. It is also the intent of this Agreement that State Supplemental Rebates will be paid for utilization of the Manufacturer's Supplemental Covered Product(s) in other state funded programs that have been approved for inclusion by the Secretary of Health and Human Services ("HHS"). The parties also intend for this Agreement to meet the requirements of federal law at Section 1927 of the Social Security Act (42 U.S.C. § 1396r-8).

**DEFINITIONS**

3.1 'Average Manufacturer Price' (AMP) means Manufacturer's price for the Covered Product(s). AMP will be calculated accordance with 42 U.S.C. 1396r-8(k)(1) and as specified in Manufacturer's CMS Agreement.

3.2 'Best Price' means, in accordance with 42 U.S.C. §1396r-8(c)(1)(C), with respect to a Single Source Drug or Innovator Multiple Source Drug of a Manufacturer, the lowest price available from the Manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance

organization, nonprofit entity, or government entity within the United States, excluding: (a) any price charged on or after October 1, 1992, to the Indian Health Services, the Department of Veterans Affairs, a State home receiving funds under Section 1741 of Title 38, United States Code, the Department of Defense, the Public Health Service, or a covered entity described in subsection (a)(5)(B) of Section 1927 of the Social Security Act; (b) any prices charged under the Federal Supply Schedule of the General Services Administration; (c) any prices used under a State Pharmaceutical Assistance Program; and (d) any depot prices and single award contract prices, as defined by the Secretary of any agency of the Federal Government. "Best Price" shall: (a) be inclusive of cash discounts, free goods that are contingent on any purchase requirement, volume discounts, and rebates (other than rebates under this section); (b) be determined without regard to special packaging, labeling, or identifiers on the dosage form or product or package; and (c) not take into account prices that are merely nominal in amount.

3.3 [Reserved]

3.4 'Covered Product(s)' means the pharmaceutical product(s) of the Manufacturer pursuant to Section 1927 of the Social Security Act (42 U.S.C. § 1396r-8).

3.5 'CMS Agreement' means the Manufacturer's drug rebate contract with the Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration, entered pursuant to Section 1927 of the Social Security Act (42 U.S.C. § 1396r-8).

3.6 'CMS Basic Rebate' means, with respect to the Covered Product(s), the quarterly payment by Manufacturer pursuant to Manufacturer's CMS Agreement, made in accordance with Section 1927(c)(1) or Section 1927(c)(3) of the Social Security Act [42 U.S.C. §1396r-8(c)(1) and 42 U.S.C. § 1396r8(c)(3)].

3.7 'CMS CPI Rebate' means, with respect to the Covered Product(s), the quarterly payment by Manufacturer pursuant to Manufacturer's CMS Agreement, made in accordance with Section 1927(c)(2) of the Social Security Act [42 U.S.C. §1396r-8(c)(2)].

3.8 'CMS Rebate' means, with respect to the Covered Product(s), the quarterly payment by Manufacturer pursuant to Sections 4.1 of this Agreement.

3.9 'CMS Unit Rebate Amount' means, the unit amount computed by CMS to which the Medicaid utilization information may be applied by States in invoicing the Manufacturer for the rebate payment due.

3.10 'Drug Reimbursement Amount' means the total amount per unit allowable as calculated by the Participating States, specific to each drug, that the Participating States reimburse pharmacy providers per unit of drug under their Medicaid (and other state funded, HHS approved) programs, in accordance with applicable state and federal laws and regulations.

3.11 'First Health Client(s)' or 'FH Clients' means those states (including the State) that have entered or subsequently enter into agreements with First Health for the provision of PBA Services to the states' Medicaid and other non-Medicaid programs approved by CMS in the Medicaid state plan(s), subject to the supervision and oversight of such States.

3.12 [Reserved]

3.13 'Manufacturer' means, for purposes of this Agreement, the party identified as such in Section 1.1 of this Agreement, which may be a pharmaceutical manufacturer, labeler or other entity not prohibited by law from entering into this Agreement.

3.14 'Participating State(s)' means the (i) States named in Section 1.1 hereof, and (ii) other states that, subsequent to the execution of this Agreement by the States, elect to participate under this Agreement and have all necessary authorizations and approvals from CMS to do so. Unless otherwise authorized by CMS on a state by state basis, Participating States shall be limited to ones that have a CMS authorized contract under which First Health has been engaged to provide PBA services to that State. For each new Participating State, a unilateral amendment ("New Participating State Amendment") to this Agreement shall be executed by the new Participating State and First Health and sent to the Manufacturer prior to the Participation Commencement Date. A copy of the New Participating State Amendment is attached hereto as Exhibit A.

3.15 'Participating States' Net Price Per Unit' or 'Net Price' means the amount(s) agreed upon by the parties to this Agreement in the attached "Supplemental Rebate Matrix, Schedule 2". 'Net Price' will vary in accordance with Schedule 2 and is dependent upon the factors detailed therein, which includes, but may not be limited to, the number of Medicaid (and other state funded, HHS approved) eligible recipient lives and the number of products in a Preferred Drug List's product category. Per the attached "Supplemental Rebate Matrix, Schedule 2", Net Price will be a factor in the equation that is determinative of the Supplemental Rebate Amount.

3.16 'Participation Commencement Date' is the latter of the date (i) a Manufacturer's Supplemental Covered Product is effectively placed in a Participating State's Preferred Drug List by distribution of the Preferred Drug List (via website or otherwise) to providers and prescribers or (ii) the New Participating State Amendment is fully executed and returned to the Manufacturer, or (iii) the effective date of CMS approval of the Participating State's applicable state plan amendment. It is the date when the Participating State(s)' entitlement to the State Supplemental Rebate(s) from the Manufacturer accrues.

3.17 'Pharmacy Provider' means an entity licensed or permitted by law to dispense legend drugs, and enrolled as a State Medicaid Provider.

3.18 'Rebate Summary' means the individual Participating States' reports itemizing the State Utilization Data supporting each Participating State's invoice for Rebates. The Rebate Summary will comply in all respects with requirements for Medicaid Utilization Information in the CMS Agreement.

3.19 'State Supplemental Rebate' means, with respect to the Supplemental Covered Product(s), the quarterly payment by Manufacturer pursuant to Section 4.2 of this Agreement.

3.20 'State Utilization Data' means the data used by Participating States to reimburse pharmacy providers under Participating States' Medicaid Program (and other non-Medicaid programs approved by CMS in the state plan(s) as provided in Section 2.1 hereof). State Utilization Data excludes data from covered entities identified in Title 42 U.S.C. §256b(a)(4) in accordance with Title 42 V.S.C. §256b(a)(5)(A) and 1396r-8(a)(5)(C).

3.21 'Supplemental Covered Product' means the pharmaceutical product(s) of the Manufacturer, as detailed in the attached Supplemental Rebate Matrix, Schedule 2, upon which a State Supplemental Rebate will be paid pursuant to this Agreement.

3.22 'Supplemental Covered Product Category' or 'Product Category' means a defined group of pharmaceutical products considered to compete with one another in the market and that are also thought to be therapeutic alternatives in many situations. First Health Services has determined and defined the Product Categories in which manufacturers will bid. The Product Categories, set forth on the "Product Categories, Schedule I" hereto, may be changed as deemed appropriate by Participating States.

3.23 'Supplemental Rebate Amount' means, with respect to the Supplemental Covered Product(s), the amount(s) specified in the attached Supplemental Bid Matrix, Schedule 2 and Supplemental Rebate Calculation, Schedule 3 that the Manufacturer has agreed to reimburse Participating States per unit of drug in accordance with the formula detailed in the above Schedules.

3.24 'Wholesale Acquisition Cost' or 'WAC' means the Manufacturer's U.S. Dollar wholesale acquisition price in effect on the last day of a quarter on a unit basis as published by a third party source, such as First Databank, for each product and represents the Manufacturer's published price for a drug product to wholesalers.

#### **MANUFACTURER'S RESPONSIBILITIES**

4.1 Manufacturer will calculate and provide each Participating State a CMS Rebate for the Covered Product(s), which includes the CMS Basic Rebate and CMS CPI Rebate, as appropriate. The CMS Rebate represents the discount obtained by multiplying the units of the Covered Product(s) reimbursed by each Participating State in the preceding quarter by the per unit rebate amount provided to each Participating State by CMS. CMS will calculate the CMS Rebate amount in accordance with Manufacturer's CMS Agreement. Manufacturer's obligation for CMS Rebates will continue for the duration of the Manufacturer's CMS Agreement.

4.2 In addition to the CMS Rebates described in Section 4.1 of this Agreement, Manufacturer will remit to each Participating State a State Supplemental Rebate for the Supplemental Covered Product(s) that are in each Participating States Preferred Drug List Program. The State Supplemental Rebates will be calculated on a calendar quarter basis and provided via invoices to the Manufacturer's CMS financial contact. The State Supplemental Rebates for the quarter will be determined by multiplying the number of units of the Supplemental Covered Product(s) reimbursed by each Participating State in the preceding quarter by its Supplemental Rebate Amount. The Manufacturer's obligation for State Supplemental Rebates will continue for the duration of this Agreement. The Supplemental Rebate calculation is described in "Supplemental Rebate Calculation, Schedule 3".

4.3 The Manufacturer's obligation for State Supplemental Rebates will begin with the Rebate Billing Period for the second calendar quarter 2006, which begins April 1, 2006 (even if this Agreement is not fully executed by such date) and will continue through the Rebate Billing Period that ends March 31, 2009, subject to each Participating States' actual Participation Commencement Date as described in Section 3.16, *supra*. Notwithstanding the above, the Participating States reserve the right to solicit

annually more favorable State Supplemental Rebates from Manufacturer by giving written notice thereof no less than ninety (90) days prior to the yearly anniversary of the effective date of this Agreement.

4.4 The quarters to be used for calculating the Rebates in Section 4.2 of this Agreement will be those ending on March 31, June 30, September 30, and December 31 of each calendar year during the term of this Agreement.

4.5 The participating Manufacturer will be required to submit each Participating State's State Supplemental Rebate payment within 38 days of the Manufacturer's receipt of the Participating State's Rebate Summary.

4.6 Manufacturer will pay the State Supplemental Rebates, including any applicable interest in accordance with Section 1903 (d)(5) of the Act. Interest on the Rebates payable under Section 4.2 of this Agreement begins accruing 38 calendar days from the postmark date of each Participating State's invoice and supporting Rebate Summary sent to the Manufacturer and interest will continue to accrue until the postmark date of the Manufacturer's payment. For the rebate programs invoiced under this Agreement, if the date of mailing of a Rebate payable under Section 4.2 of this Agreement is 69 days or more from the date of mailing of the invoice, the interest rate will be calculated as required under federal guidelines for rebates described in Section 4.1 but will be increased by ten percentage points or the maximum allowed by that Participating State's state law. If a Participating State has not received the Rebates payable under Section 4.2 of this Agreement, including interest, within 180 days of the postmark date of said Participating State's invoice and supporting Rebate Summary sent to the Manufacturer, such Participating State may deem the Manufacturer to be in default and Participating State may terminate its participation in this Agreement by giving Manufacturer and First Health ninety (90) days advance written notice.

4.7 Manufacturer agrees to continue to pay State Supplemental Rebates on the Supplemental Covered Product(s) for as long as this Agreement or any of its Addenda are in force, and State Utilization Data shows that payment was made for that drug, regardless of whether the Manufacturer continues to market that drug. Manufacturer's obligation to pay State Supplemental Rebates on the Supplemental Covered Product(s) shall terminate twelve (12) months following the last expiration date of the last lot of Supplemental Covered Product sold by the Manufacturer. Notwithstanding the above, in the event Manufacturer's Supplemental Covered Product(s) is/are sold to another manufacturer, the original Manufacturer shall have no liability for rebates on utilization beyond those required by the Medicaid

program. Manufacturer shall provide the State and First Health with notice of the sale of said Supplemental Covered Product(s) concurrent with Manufacturer's notice to CMS.

4.8 Unless notified otherwise, Manufacturer will send Rebate payments by certified mail, return receipt requested, to the address provided to Manufacturer in each individual Participating State's Addendum.

#### **PARTICIPATING STATE(S)' RESPONSIBILITIES**

5.1 Each Participating State will consider the Manufacturer's Supplemental Covered Product(s) for inclusion in the Participating State's Preferred Drug List Program. Each individual Participating State reserves the right to select the products that will be in its Preferred Drug List Program and will only receive State Supplemental Rebates for Manufacturer's Supplemental Covered Products that are actually included in its Preferred Drug List Program. Manufacturer shall pay Participating States State Supplemental Rebates based upon Participating State(s)' utilization of Manufacturer's Supplemental Covered Product(s) that did not require prior authorization. Participating States shall not be entitled to State Supplemental Rebates for utilization of Manufacturer's Supplemental Covered Product(s) that occurred only subsequent to the obtaining of prior authorization unless the Supplemental Covered Product(s) have been assigned to a Product Category and all products in the Product Category are subject to prior authorization requirements. Each individual Participating State also reserves the right to determine, as a result of a Product Category review, that prior authorization is required for all preferred drugs in a Product Category. If a Participating State determines that prior authorization is required for any Supplemental Covered Product, then the Participating State will comply with all provisions of Section 1927( d) of the Social Security Act applicable to Prior Authorization programs. Each Participating State will notify Manufacturer and First Health, within ten (10) business days of adoption and publication of a new or revised Preferred Drug List, when Manufacturer's Supplemental Covered Product is added to the Participating State's Preferred Drug List by providing Manufacturer and First Health a copy of the Preferred Drug List in accordance with the notice provisions of Section 9.2 hereof.

5.2 The State and/or First Health shall notify the Manufacturer whenever a Participating State adds one of Manufacturer's Supplemental Covered Products to its Preferred Drug List or when one of Manufacturer's Supplemental Covered Products is moved to a prior authorization status.

5.3 Each Participating State will provide aggregate State Utilization Data to the Manufacturer on a quarterly basis. This data will be based on paid claims data (data used to reimburse pharmacy providers)

under each Participating State's Medicaid (and other state funded, HHS approved) Program(s), will be consistent with any applicable Federal or State guidelines, regulations and standards for such data, and will be the basis for the Participating State's calculation of the State Supplemental Rebate.

5.4 Each Participating State will maintain those data systems used to calculate the State Supplemental Rebates. In the event material discrepancies are discovered, the Participating State will promptly justify its data or make an appropriate adjustment, which may include a credit as to the amount of the State Supplemental Rebates, or a refund to Manufacturer as the parties may agree.

5.5 Each Participating State shall maintain electronic claims records for the most recent four quarters that will permit Manufacturer to verify through an audit process the Rebate Summaries provided by the Participating State.

5.6 Upon implementation of this Agreement, and from time to time thereafter, Participating States and Manufacturer will meet to discuss any data or data system improvements which are necessary or desirable to ensure that the data and any information provided by the Participating States to Manufacturer are adequate for the purposes of this Agreement.

5.7 First Health, as the pharmacy benefit administrator, may assist the Participating States in fulfilling its responsibilities hereunder and is a party to this Agreement solely in its capacity as agent for, and subject to the supervision and oversight of the Participating State(s).

5.8 The State and each Participating State shall obtain CMS approval of its state Medicaid plan of which this Agreement forms a part. Manufacturer shall not be obligated to remit any Supplemental Rebates that have accrued and are due under this Agreement until after the affected State or Participating State has obtained CMS approval of its Supplemental Rebate Program of which this Agreement forms a part.

#### **DISPUTE RESOLUTION**

6.1 In the event that in any quarter a discrepancy in a Participating State's State Utilization Data is questioned by the Manufacturer, which the Manufacturer and the Participating State in good faith are unable to resolve, the Manufacturer will provide written notice of the discrepancy to the Participating State and First Health.



6.2 If the Manufacturer in good faith believes the Participating State's State Utilization Data is erroneous, the Manufacturer shall pay the Participating State that portion of the rebate claimed, that is not in dispute by the required date. The balance in dispute, if any, will be paid by the Manufacturer to the Participating State by the due date of the next quarterly payment after resolution of the dispute.

6.3 The Participating State and the Manufacturer will use their best efforts to resolve the discrepancy within 60 days of receipt of written notification. Should additional information be required to resolve disputes, the Participating State and First Health will cooperate with the Manufacturer in obtaining the additional information.

6.4 In the event that the Participating State and the Manufacturer are not able to resolve a discrepancy regarding State Utilization Data as provided for in Sections 6.1 through 6.3, the Manufacturer may request a reconsideration of the Participating State's determination within 30 days after the end of the 60 day period identified in Section 6.3. The Manufacturer shall submit with its written request its argument in writing, along with any other materials, supporting its position to the Participating State and First Health. The Participating State shall review the written argument and materials and issue a decision in the matter.

#### **CONFIDENTIALITY PROVISIONS**

7.1 The parties agree that confidential information will not be released to any person or entity not a party to this contract. Confidential information, including trade secrets, will not be disclosed, or used except in connection with this Agreement or as may be required by law or judicial order.

7.2 The Manufacturer will hold Participating State' State Utilization Data confidential. If the Manufacturer audits this information or receives further information on such data from First Health or a Participating State, that information shall also be held confidential. The Manufacturer shall have the right to disclose Participating State(s)'s State Utilization Data to auditors who agree to keep such information confidential.

7.3 Pursuant to 42 USC 1396r-8(b)(3)(D), and other applicable state or federal laws, the parties agree that this Agreement and all information provided pursuant to this Agreement will not be disclosed and that the parties will not duplicate or use the information, except in connection with this Agreement or as may be required by law or judicial order. The parties further agree that any information provided by

Manufacturer to the State, First Health, or the Participating State(s) pursuant to this Agreement and this Agreement itself constitute trade secrets and/or confidential or proprietary commercial and financial information not subject to public disclosure. Furthermore, the parties agree that any Manufacturer information received by First Health pursuant to this Agreement and distributed by First Health to the State and/or Participating States shall constitute trade secrets and/or confidential or proprietary commercial and financial information of the Manufacturer not subject to public disclosure, except as otherwise provided for herein. If the services of a third party are used to administer any portion of this Agreement, Sections 7.1 through 7.4 of this Agreement shall apply to the third party. In the event a Participating State cannot give satisfactory assurance that rebate pricing data provided under this Agreement will be exempt from public disclosure under applicable state law, then First Health (without assuming responsibility for any wrongful disclosure by a Participating State) shall limit the amount of such data made available to the Participating State by not disclosing to the Participating State any NDC- level pricing information. For purposes hereof "satisfactory assurance" shall be deemed given when the Participating State enters the statutory cite of the applicable exemption on its Participating State Addendum. In the event that either party is required by law to disclose any provision of this Agreement or pricing information to any person, such party shall provide advance written notice to the other party sufficiently in advance of the proposed disclosure to allow the other party to seek a protective order or other relief.

7.4 Notwithstanding the non-renewal or termination of this Supplemental Rebate Agreement for any reason, these confidentiality provisions will remain in full force and effect.

#### **NON-RENEWAL or TERMINATION**

8.1 This Agreement shall be effective as of April 1, 2006 and shall have the term indicated in Section 4.3, *supra*.

8.2 Any Participating State may terminate its participation in this Agreement by giving Manufacturer and First Health written notice at least (90) days prior to the anniversary date of this Agreement, in which case termination shall become effective on the anniversary date of the date of execution of this Agreement. The termination of this Agreement by one or more Participating States shall not affect the Manufacturer's, First Health's or the other Participating States' obligations under this Agreement, other than any effect the reduction in the number of lives covered by the Agreement may have on the Supplemental Rebate payable hereunder. Manufacturer may terminate this Agreement and all Addenda by

giving all Participating States and First Health written notice at least ninety (90) days prior to the anniversary date of this Agreement, in which case termination shall become effective on the anniversary date of the date of execution of this Agreement. Manufacturer's right of termination is limited to the right to terminate the entire Agreement. Manufacturer may not terminate specific Addendum/Addenda of less than all Participating State(s).

8.3 Termination by a FH Client of its PBA Services Agreement with First Health shall, as of the same termination effective date, terminate this Agreement as to that Participating State.

8.4 Notwithstanding any non-renewal or termination of this Agreement, State Supplemental Rebates will still be due and payable from the Manufacturer under Section 4.2 for any Supplemental Covered Products for which Participating State(s)' obligation to reimburse arose prior to the effective date of termination of this Agreement.

8.5 On at least an annual basis or as mutually agreed upon by Manufacturer and First Health, Manufacturer shall have the opportunity to decrease the Net Price of its Covered Products to increase the likelihood of product(s) utilization and/or inclusion in the Participating States Preferred Drug List Programs.

#### GENERAL PROVISIONS

9.1 This Agreement will be governed and construed in accordance with 42 U.S.C. § 1396r-8 and all other applicable federal and state law and regulations.

9.2 Any notice required to be given pursuant to the terms and provisions of this Agreement will be in writing and will be sent by certified mail, return receipt requested. Notice will be mailed to the addressees specified in each individual Participating State's Addendum to this Agreement.

Notice to the State shall be sent to:

State of Michigan  
Department of Community Health Medical Services Administration  
Attn: Dave McLaury  
400 S. Pine Street  
Lansing, MI 48933

Notice to First Health shall be sent to:

First Health Services Corporation  
Attn: James McGarry, President  
With a copy to: Legal Department  
4300 Cox Road  
Glen Allen, Virginia 23060

Notice to Manufacturer will be sent to:

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9.3 The Manufacturer agrees to be bound by the laws of the United States of America and with respect to each Participating State, the law of that Participating State. Proper venue in any legal action shall be the venue of the Participating State that is party to the proceeding. Any action brought by Manufacturer must be brought separately against individual Participating States or First Health, unless all affected Participating States and First Health consent to joinder of the actions.

9.4 Nothing herein shall be construed or interpreted as limiting or otherwise affecting First Health or Participating State(s) ability to pursue its rights arising out of the terms and conditions of the Agreement in the event that a dispute between the parties is not otherwise resolved.

9.5 Manufacturer and the agents and employees of Manufacturer in the performance of this Agreement, will act in an independent capacity and not as officers, employees or agents of First Health or any Participating State.

9.6 Manufacturer may not assign this Agreement, either in whole or in part, without the written consent of the Participating States and First Health. However, in the event of a transfer in ownership of the Manufacturer, the Agreement is automatically assigned to the new owner subject to the conditions in this Agreement. If the Agreement is assigned pursuant to this Section, Manufacturer shall provide First Health and the Participating States with an update of the information contained in Section 9.2, *supra*.

9.7 Nothing in this Agreement will be construed so as to require the commission of any act contrary to law. If any provision of this Agreement is found to be invalid or illegal by a court of law, or inconsistent with federal requirements, this Agreement will be construed in all respects as if any invalid, unenforceable, or inconsistent provision were eliminated, and without any effect on any other provision.

9.8 First Health, Participating State(s) and Manufacturer declare that this Agreement, including attachments, schedules and addenda, contains a total integration of all rights and obligations of the parties. There are no extrinsic conditions, collateral agreements or undertakings of any kind. In regarding this Agreement as the full and final expression of their contract, it is the express intention of the parties that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period of time governed by this Agreement which are not expressly set forth herein are to have no force, effect, or legal consequences of any kind

9.9 This Agreement will not be altered except by (i) an amendment in writing signed by all the parties, other than (ii) in the case of the addition of a new Participating State(s), by its execution of the New Participating State Amendment. It is acknowledged that the intent of the previous sentence is that the addition of a new Participating State(s) by amendment shall only require the consent of First Health and the approval of CMS, not Manufacturer. Manufacturer agrees that any Participating State may be added to this Agreement by amendment and that said Participating State's covered Medicaid (and other non-Medicaid programs approved by CMS in the Medicaid state plan(s)) lives shall apply to the provisions of Schedules 2 and 3 and will affect the rebates to all Participating States in accordance with Schedules 2 and 3. The New Participating State Amendment shall be executed by First Health and the new Participating State with a copy provided to Manufacturer for its records. Other than as stated herein, no individual is authorized to alter or vary the terms or make any representation or inducement relative to it, unless the alteration appears by way of a written amendment, signed by duly appointed representatives of the Participating State(s), First Health, and the Manufacturer. Any modification or amendment must be authorized by CMS.

9.10 The parties do not contemplate any circumstances under which indemnification of the other parties would arise. Nevertheless, should such circumstances arise, Manufacturer agrees to indemnify, defend and hold harmless the Participating States and First Health, their officers, agents and employees from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Manufacturer in the performance of this Agreement.

9.11 Inasmuch as the State Supplemental Rebates required by this Agreement are for state Medicaid (and non-Medicaid programs approved by CMS in the Medicaid state plan(s)) program beneficiaries, it is agreed, in accordance with Medicaid Drug Rebate Program Release #102 for State Medicaid Directors and other applicable law, that the State Supplemental Rebates do not establish a new 'Best Price' for purposes of participating Manufacturer's CMS Agreement.

9.12 In the event that Participating State(s) require(s) prior authorization of Manufacturer's Supplemental Covered Product(s) as part of a Product Category prior authorization under Section 5.1, State Supplemental Rebates shall nevertheless be payable hereunder.

9.13 If First Health or a Participating State makes changes to a Product Category that are considered to be a material change in the structure of the supplemental rebates program, Manufacturer may be allowed to re-submit bids for the Product Category/Categories affected.

9.14 As evidence of their Agreement to the foregoing terms and conditions, the parties have signed below.

STATE OF MICHIGAN, DEPARTMENT OF COMMUNITY HEALTH:

By: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

MANUFACTURER

By: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

FIRST HEALTH SERVICES CORPORATON

By: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

## EXHIBIT A

### **New Participating State Amendment to Supplemental Drug-Rebate Agreement Between Participating States; First Health Services Corporation And (Manufacturer Name ("Manufacturer"))**

WHEREAS, the State of Michigan, First Health Services Corporation ("First Health"), and Manufacturer have entered into a Supplemental Drug-Rebate Agreement (the "Agreement"), effective as of <<DATE>>; and

WHEREAS, the participating States as named in Section 8 below have become parties to the Agreement as Participating States by previous amendment or addenda; and

Now, therefore, in consideration of the mutual covenants, promises, and conditions contained herein and in the Agreement, the parties agree as follows:

1. The State of Georgia is hereby added as a party to the Agreement as a new Participating State, as defined in Section 3.14 of the Agreement.
2. This Amendment shall become effective upon the date determined in accordance with Section 3.16 of the Agreement; provided that this Amendment shall not become effective until the effective date of the state plan amendment submitted to CMS on June 6, 2006.
3. An executed copy of this Amendment shall be sent via certified mail, return receipt requested to Manufacturer's address of record as set forth in the Agreement within five (5) business days of its execution by the parties.
4. This Addendum adds a new Participating State to the Agreement and does not otherwise change or alter the Agreement. The new Participating State(s) understand(s) and agrees to be bound by the terms of the Agreement.
5. The undersigned State acknowledges that manufacturer rebate pricing information is confidential information under applicable Federal law and shall be exempt from public disclosure pursuant to State Code Section O.C.G.A. 50-18-70, et seq.
6. The undersigned State represents that it has not requested authorization from CMS to include any state pharmaceutical assistance program within the rebate provisions of the Agreement.

**EXHIBIT A**

The above representation shall not prohibit the undersigned State from requesting CMS authorization to include (other) pharmaceutical assistance programs within the Agreement at a later date. Upon receipt of CMS authorization, State shall give written notice to Manufacturer of the date Manufacturer's Supplemental Covered Product is effectively placed on the preferred drug list of the undersigned State's non-Medicaid programs approved by CMS in the Medicaid state plan(s) by completing the attached Exhibit A1.

- 7. The approximate enrollment in the undersigned State's Medicaid program at the time of execution of this Amendment is 364,000.
- 8. As of the effective date of this Amendment, the following are all of the Participating States under the Agreement:

<u>Michigan</u>	<u>Alaska</u>
<u>New York</u>	<u>Nevada</u>
<u>New Hampshire</u>	<u>Hawaii</u>
<u>Minnesota</u>	<u>Montana</u>
<u>Kentucky</u>	<u>Tennessee</u>
<u>District of Columbia</u>	



**EXHIBIT A**

STATE OF GEORGIA  
DEPARTMENT OF COMMUNITY  
HEALTH

By: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

FIRST HEALTH SERVICES CORP

By: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**EXHIBIT A1**

**Participating State's Non-Medicaid Programs Approved by CMS in the Medicaid State Plan(s)**

Participating State: Georgia

Non-Medicaid programs approved by CMS in the Medicaid State Plan(s)- Date of Approval

1. **None**

- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_

under each Participating State's Medicaid (and other state funded, HHS approved) Program(s), will be consistent with any applicable Federal or State guidelines, regulations and standards for such data, and will be the basis for the Participating State's calculation of the State Supplemental Rebate.

5.4 Each Participating State will maintain those data systems used to calculate the State Supplemental Rebates. In the event material discrepancies are discovered, the Participating State will promptly justify its data or make an appropriate adjustment, which may include a credit as to the amount of the State Supplemental Rebates, or a refund to Manufacturer as the parties may agree.

5.5 Each Participating State shall maintain electronic claims records for the most recent four quarters that will permit Manufacturer to verify through an audit process the Rebate Summaries provided by the Participating State.

5.6 Upon implementation of this Agreement, and from time to time thereafter, Participating States and Manufacturer will meet to discuss any data or data system improvements which are necessary or desirable to ensure that the data and any information provided by the Participating States to Manufacturer are adequate for the purposes of this Agreement.

5.7 First Health, as the pharmacy benefit administrator, may assist the Participating States in fulfilling its responsibilities hereunder and is a party to this Agreement solely in its capacity as agent for, and subject to the supervision and oversight of the Participating State(s).

5.8 The State and each Participating State shall obtain CMS approval of its state Medicaid plan of which this Agreement forms a part. Manufacturer shall not be obligated to remit any Supplemental Rebates that have accrued and are due under this Agreement until after the affected State or Participating State has obtained CMS approval of its Supplemental Rebate Program of which this Agreement forms a part.

**DISPUTE RESOLUTION**

6.1 In the event that in any quarter a discrepancy in a Participating State's State Utilization Data is questioned by the Manufacturer, which the Manufacturer and the Participating State in good faith are unable to resolve, the Manufacturer will provide written notice of the discrepancy to the Participating State and First Health.

6.2 If the Manufacturer in good faith believes the Participating State's State Utilization Data is erroneous, the Manufacturer shall pay the Participating State that portion of the rebate claimed, that is not in dispute by the required date. The balance in dispute, if any, will be paid by the Manufacturer to the Participating State by the due date of the next quarterly payment after resolution of the dispute.

6.3 The Participating State and the Manufacturer will use their best efforts to resolve the discrepancy within 60 days of receipt of written notification. Should additional information be required to resolve disputes, the Participating State and First Health will cooperate with the Manufacturer in obtaining the additional information.

6.4 In the event that the Participating State and the Manufacturer are not able to resolve a discrepancy regarding State Utilization Data as provided for in Sections 6.1 through 6.3, the Manufacturer may request a reconsideration of the Participating State's determination within 30 days after the end of the 60 day period identified in Section 6.3. The Manufacturer shall submit with its written request its argument in writing, along with any other materials, supporting its position to the Participating State and First Health. The Participating State shall review the written argument and materials and issue a decision in the matter.

#### **CONFIDENTIALITY PROVISIONS**

7.1 The parties agree that confidential information will not be released to any person or entity not a party to this contract. Confidential information, including trade secrets, will not be disclosed, or used except in connection with this Agreement or as may be required by law or judicial order.

7.2 The Manufacturer will hold Participating State' State Utilization Data confidential. If the Manufacturer audits this information or receives further information on such data from First Health or a Participating State, that information shall also be held confidential. The Manufacturer shall have the right to disclose Participating State(s)'s State Utilization Data to auditors who agree to keep such information confidential.

7.3 Pursuant to 42 USC 1396r-8(b)(3)(D), and other applicable state or federal laws, the parties agree that this Agreement and all information provided pursuant to this Agreement will not be disclosed and that the parties will not duplicate or use the information, except in connection with this Agreement or as may be required by law or judicial order. The parties further agree that any information provided by

Manufacturer to the State, First Health, or the Participating State(s) pursuant to this Agreement and this Agreement itself constitute trade secrets and/or confidential or proprietary commercial and financial information not subject to public disclosure. Furthermore, the parties agree that any Manufacturer information received by First Health pursuant to this Agreement and distributed by First Health to the State and/or Participating States shall constitute trade secrets and/or confidential or proprietary commercial and financial information of the Manufacturer not subject to public disclosure, except as otherwise provided for herein. If the services of a third party are used to administer any portion of this Agreement, Sections 7.1 through 7.4 of this Agreement shall apply to the third party. In the event a Participating State cannot give satisfactory assurance that rebate pricing data provided under this Agreement will be exempt from public disclosure under applicable state law, then First Health (without assuming responsibility for any wrongful disclosure by a Participating State) shall limit the amount of such data made available to the Participating State by not disclosing to the Participating State any NDC- level pricing information. For purposes hereof "satisfactory assurance" shall be deemed given when the Participating State enters the statutory cite of the applicable exemption on its Participating State Addendum. In the event that either party is required by law to disclose any provision of this Agreement or pricing information to any person, such party shall provide advance written notice to the other party sufficiently in advance of the proposed disclosure to allow the other party to seek a protective order or other relief.

7.4 Notwithstanding the non-renewal or termination of this Supplemental Rebate Agreement for any reason, these confidentiality provisions will remain in full force and effect.

#### **NON-RENEWAL or TERMINATION**

8.1 This Agreement shall be effective as of April 1, 2006 and shall have the term indicated in Section 4.3, *supra*.

8.2 Any Participating State may terminate its participation in this Agreement by giving Manufacturer and First Health written notice at least (90) days prior to the anniversary date of this Agreement, in which case termination shall become effective on the anniversary date of the date of execution of this Agreement. The termination of this Agreement by one or more Participating States shall not affect the Manufacturer's, First Health's or the other Participating States' obligations under this Agreement, other than any effect the reduction in the number of lives covered by the Agreement may have on the Supplemental Rebate payable hereunder. Manufacturer may terminate this Agreement and all Addenda by

giving all Participating States and First Health written notice at least ninety (90) days prior to the anniversary date of this Agreement, in which case termination shall become effective on the anniversary date of the date of execution of this Agreement. Manufacturer's right of termination is limited to the right to terminate the entire Agreement. Manufacturer may not terminate specific Addendum/Addenda of less than all Participating State(s).

8.3 Termination by a FH Client of its PBA Services Agreement with First Health shall, as of the same termination effective date, terminate this Agreement as to that Participating State.

8.4 Notwithstanding any non-renewal or termination of this Agreement, State Supplemental Rebates will still be due and payable from the Manufacturer under Section 4.2 for any Supplemental Covered Products for which Participating State(s)' obligation to reimburse arose prior to the effective date of termination of this Agreement.

8.5 On at least an annual basis or as mutually agreed upon by Manufacturer and First Health, Manufacturer shall have the opportunity to decrease the Net Price of its Covered Products to increase the likelihood of product(s) utilization and/or inclusion in the Participating States Preferred Drug List Programs.

#### GENERAL PROVISIONS

9.1 This Agreement will be governed and construed in accordance with 42 U.S.C. § 1396r-8 and all other applicable federal and state law and regulations.

9.2 Any notice required to be given pursuant to the terms and provisions of this Agreement will be in writing and will be sent by certified mail, return receipt requested. Notice will be mailed to the addressees specified in each individual Participating State's Addendum to this Agreement.

Notice to the State shall be sent to:

State of Michigan  
Department of Community Health Medical Services Administration  
Attn: Dave McLaury  
400 S. Pine Street  
Lansing, MI 48933

Notice to First Health shall be sent to:

First Health Services Corporation  
Attn: James McGarry, President  
With a copy to: Legal Department  
4300 Cox Road  
Glen Allen, Virginia 23060

Notice to Manufacturer will be sent to:

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9.3 The Manufacturer agrees to be bound by the laws of the United States of America and with respect to each Participating State, the law of that Participating State. Proper venue in any legal action shall be the venue of the Participating State that is party to the proceeding. Any action brought by Manufacturer must be brought separately against individual Participating States or First Health, unless all affected Participating States and First Health consent to joinder of the actions.

9.4 Nothing herein shall be construed or interpreted as limiting or otherwise affecting First Health or Participating State(s) ability to pursue its rights arising out of the terms and conditions of the Agreement in the event that a dispute between the parties is not otherwise resolved.

9.5 Manufacturer and the agents and employees of Manufacturer in the performance of this Agreement, will act in an independent capacity and not as officers, employees or agents of First Health or any Participating State.

9.6 Manufacturer may not assign this Agreement, either in whole or in part, without the written consent of the Participating States and First Health. However, in the event of a transfer in ownership of the Manufacturer, the Agreement is automatically assigned to the new owner subject to the conditions in this Agreement. If the Agreement is assigned pursuant to this Section, Manufacturer shall provide First Health and the Participating States with an update of the information contained in Section 9.2, *supra*.

9.7 Nothing in this Agreement will be construed so as to require the commission of any act contrary to law. If any provision of this Agreement is found to be invalid or illegal by a court of law, or inconsistent with federal requirements, this Agreement will be construed in all respects as if any invalid, unenforceable, or inconsistent provision were eliminated, and without any effect on any other provision.

9.8 First Health, Participating State(s) and Manufacturer declare that this Agreement, including attachments, schedules and addenda, contains a total integration of all rights and obligations of the parties. There are no extrinsic conditions, collateral agreements or undertakings of any kind. In regarding this Agreement as the full and final expression of their contract, it is the express intention of the parties that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period of time governed by this Agreement which are not expressly set forth herein are to have no force, effect, or legal consequences of any kind

9.9 This Agreement will not be altered except by (i) an amendment in writing signed by all the parties, other than (ii) in the case of the addition of a new Participating State(s), by its execution of the New Participating State Amendment. It is acknowledged that the intent of the previous sentence is that the addition of a new Participating State(s) by amendment shall only require the consent of First Health and the approval of CMS, not Manufacturer. Manufacturer agrees that any Participating State may be added to this Agreement by amendment and that said Participating State's covered Medicaid (and other non-Medicaid programs approved by CMS in the Medicaid state plan(s)) lives shall apply to the provisions of Schedules 2 and 3 and will affect the rebates to all Participating States in accordance with Schedules 2 and 3. The New Participating State Amendment shall be executed by First Health and the new Participating State with a copy provided to Manufacturer for its records. Other than as stated herein, no individual is authorized to alter or vary the terms or make any representation or inducement relative to it, unless the alteration appears by way of a written amendment, signed by duly appointed representatives of the Participating State(s), First Health, and the Manufacturer. Any modification or amendment must be authorized by CMS.

9.10 The parties do not contemplate any circumstances under which indemnification of the other parties would arise. Nevertheless, should such circumstances arise, Manufacturer agrees to indemnify, defend and hold harmless the Participating States and First Health, their officers, agents and employees from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Manufacturer in the performance of this Agreement.



9.11 Inasmuch as the State Supplemental Rebates required by this Agreement are for state Medicaid (and non-Medicaid programs approved by CMS in the Medicaid state plan(s)) program beneficiaries, it is agreed, in accordance with Medicaid Drug Rebate Program Release #102 for State Medicaid Directors and other applicable law, that the State Supplemental Rebates do not establish a new 'Best Price' for purposes of participating Manufacturer's CMS Agreement.

9.12 In the event that Participating State(s) require(s) prior authorization of Manufacturer's Supplemental Covered Product(s) as part of a Product Category prior authorization under Section 5.1, State Supplemental Rebates shall nevertheless be payable hereunder.

9.13 If First Health or a Participating State makes changes to a Product Category that are considered to be a material change in the structure of the supplemental rebates program, Manufacturer may be allowed to re-submit bids for the Product Category/Categories affected.

9.14 As evidence of their Agreement to the foregoing terms and conditions, the parties have signed below.

STATE OF MICHIGAN, DEPARTMENT OF COMMUNITY HEALTH:

By: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

MANUFACTURER

By: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

FIRST HEALTH SERVICES CORPORATON

By: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

## EXHIBIT A

### **New Participating State Amendment to Supplemental Drug-Rebate Agreement Between Participating States; First Health Services Corporation And (Manufacturer Name ("Manufacturer"))**

WHEREAS, the State of Michigan, First Health Services Corporation ("First Health"), and Manufacturer have entered into a Supplemental Drug-Rebate Agreement (the "Agreement"), effective as of <<DATE>>; and

WHEREAS, the participating States as named in Section 8 below have become parties to the Agreement as Participating States by previous amendment or addenda; and

Now, therefore, in consideration of the mutual covenants, promises, and conditions contained herein and in the Agreement, the parties agree as follows:

1. The State of Georgia is hereby added as a party to the Agreement as a new Participating State, as defined in Section 3.14 of the Agreement.
2. This Amendment shall become effective upon the date determined in accordance with Section 3.16 of the Agreement; provided that this Amendment shall not become effective until the effective date of the state plan amendment submitted to CMS on June 6, 2006.
3. An executed copy of this Amendment shall be sent via certified mail, return receipt requested to Manufacturer's address of record as set forth in the Agreement within five (5) business days of its execution by the parties.
4. This Addendum adds a new Participating State to the Agreement and does not otherwise change or alter the Agreement. The new Participating State(s) understand(s) and agrees to be bound by the terms of the Agreement.
5. The undersigned State acknowledges that manufacturer rebate pricing information is confidential information under applicable Federal law and shall be exempt from public disclosure pursuant to State Code Section O.C.G.A. 50-18-70, et seq.
6. The undersigned State represents that it has not requested authorization from CMS to include any state pharmaceutical assistance program within the rebate provisions of the Agreement.

**EXHIBIT A**

The above representation shall not prohibit the undersigned State from requesting CMS authorization to include (other) pharmaceutical assistance programs within the Agreement at a later date. Upon receipt of CMS authorization, State shall give written notice to Manufacturer of the date Manufacturer's Supplemental Covered Product is effectively placed on the preferred drug list of the undersigned State's non-Medicaid programs approved by CMS in the Medicaid state plan(s) by completing the attached Exhibit A1.

- 7. The approximate enrollment in the undersigned State's Medicaid program at the time of execution of this Amendment is 364,000.
- 8. As of the effective date of this Amendment, the following are all of the Participating States under the Agreement:

<u>Michigan</u>	<u>Alaska</u>
<u>New York</u>	<u>Nevada</u>
<u>New Hampshire</u>	<u>Hawaii</u>
<u>Minnesota</u>	<u>Montana</u>
<u>Kentucky</u>	<u>Tennessee</u>
<u>District of Columbia</u>	

**EXHIBIT A**

STATE OF GEORGIA  
DEPARTMENT OF COMMUNITY  
HEALTH

By: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

FIRST HEALTH SERVICES CORP

By: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**EXHIBIT A1**

**Participating State's Non-Medicaid Programs Approved by CMS in the  
Medicaid State Plan(s)**

Participating State: Georgia

Non-Medicaid programs approved by CMS in the Medicaid State Plan(s)- Date of Approval

1. **None**

- |    |       |       |
|----|-------|-------|
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |
| 5. | _____ | _____ |
| 6. | _____ | _____ |

## RELATIONS WITH STANDARD-SETTING AND SURVEY AGENCIES

Designated Agency

The Georgia Department of Human Resources establishes and maintains standards for health, and standards other than those relating to health, for institutions that provide services to Medicaid recipients. This Department is responsible for licensing health institutions in the State and determines for Medicaid if institutions meet requirements for participation in the Medicaid Program.

Standards

Categories of health and other standards which institutions must meet are described below.

## Long Term Care Facilities

Facilities must meet Medicare conditions of participation at 42 CFR 405 Subpart K and requirements at 42 CFR 442 Subparts A through G, as appropriate to the facility type.

SNF Nursing Service: Nursing service must be under the direction of an appropriately licensed full-time nurse. There must be supervised nursing and sufficient nursing staff on duty at all times to provide care for each patient according to needs. All nursing care and related services must be carried out in accordance with the facility's patient care policies.

ICF Personal Care Service: An appropriately licensed nurse must be employed full-time as supervisor of care. Sufficient staff must be on duty at all times to insure proper care of each resident. All resident care and related services must be carried out according to written policies.

SNF Professional Service: Each facility must have an organized professional staff with a physician designated as chief of staff. Patients are admitted only on referral of a physician and are under the continuing care of a physician. Patients' plans of care are reviewed by the attending physician as directed by Federal and State requirements.

ICF Professional Service: Residents are admitted only through medical/psychological evaluation and referral. The health care of each resident is under continuing supervision of a physician who sees the resident as needed and in no case less often than directed by Federal and State agency requirements.

## Long term care facilities must

Have a governing body which is responsible for the overall conduct of the facility and for compliance with pertinent laws and regulations.

Be under the supervision of an appropriately licensed administrator.

Fully disclose ownership and make known to the State corporate officers and others owning ten percent or more of the ownership.

Satisfy fire, safety, sanitation and health requirements.

Have a written transfer agreement in effect with one or more hospitals or nursing homes, as appropriate, to assure prompt transfer of care when needed.

Be operated according to policies established by the State agency.

Maintain a separate personnel folder for each employee containing all personal information; application and qualifications for employment; physical examination and job title assigned.

Provide dietary service under supervision of qualified personnel. Nutritionally adequate meals are required in sufficient numbers with between-meal and bedtime snacks. Modified diets are provided on written orders of a physician or dentist.

Provide social services by on-staff caseworkers or through arrangements with an appropriate outside agency.

Comply with State and Federal laws and regulations in providing pharmacy services and in handling patient medication.

Provide care to each patient/resident according to need and the individual plan of care.

Have an effective microbial and infection control program.

Use restraint and/or forcible seclusion only on a signed physician order except in emergency and then only until a physician can be consulted.

Maintain medical and health records for each patient/resident according to accepted professional standards and practices.

Provide patient activities according to the needs and interests of patients/residents.

Be constructed, equipped and maintained to protect the health and safety of patients, personnel and the public and be accessible to and functional for the physically handicapped.

Have a written, acceptable disaster plan.

Hospitals must

Meet conditions of participation in the Medicare Program as provided at 42 CFR 405 Subpart J.

Have a governing body which is responsible for compliance with all pertinent laws and regulations.

Have a professional staff organized under bylaws which is responsible for quality of medical care provided and for ethical professional practices of its members.

Have an administrator who is responsible for the management and operation of the hospital.

Fully disclose ownership and make known to the State corporate officers and others owning ten percent or more of ownership.

Comply with all laws, codes, ordinances and regulations which apply to its location, construction, maintenance and operation. The condition of the physical plant and overall hospital environment must be developed and maintained to insure health and safety of patients and staff.

Provide nursing service under the supervision of a registered nurse and have available professional nursing service for all patients at all times.

Provide qualified personnel to operate services included in its program such as administration and business, dietary, emergency room, housekeeping, laboratory, laundry, maintenance, medical records, pharmacy, therapy and X-ray.

Maintain a separate personnel folder for each employee containing all personal information; application; qualifications for employment; physical examination and job description.

Maintain medical records for each patient containing sufficient information to validate the diagnosis and establish the basis for treatment.

Provide pharmaceutical services under the direction of a registered pharmacist in accordance with Federal and State laws.

Have a clinical laboratory equipped and staffed to perform services commensurate with needs.

Make available anatomical pathology and blood bank services in the facility or by arrangement.



Provide radiological services within the facility or which are readily available by arrangement.

Have a written, acceptable disaster plan.

The Department keeps these standards on file and makes them available to HHS on request.

#### Written Agreement

The Department has a written agreement with the Department of Human Resources covering activities of the Office of Regulatory Services in carrying out its responsibilities. The agreement specifies that Federal standards and designated forms, methods and procedures will be used to determine institutional certification and enrollment eligibility.

Inspectors surveying the institution will complete inspection reports, note whether each requirement is satisfied and document deficiencies in reports.

The survey agency keeps on file all information/reports used to determine that participating facilities meet Federal requirements and will make them readily accessible to HHS and Medicaid as necessary for meeting other plan requirements and effective administration of the Medicaid Program.

#### Responsibilities of Survey Agency

In certifying skilled and intermediate care facilities, the survey agency reviews and evaluates medical and independent professional review team reports and statements from facility payroll records showing the average number and types of personnel, in full-time equivalents, on each tour of duty during at least one week of each quarter.

The survey agency takes necessary action to achieve compliance or withdraws certification and has qualified personnel perform on-site inspections at least once during each certification period or more frequently if there is a compliance question. For ICFs with deficiencies described in 42 CFR 442.112-113, on-site inspections are performed within six months after initial correction plan approval and every six months thereafter as required.

### Certification of Need for Care

Prior to a patient being admitted to a facility or transferred between facilities, the patient's attending physician will evaluate the need for Nursing Facility placement by assessing social and medical information. This also includes the physician completing and signing the DMA-6. The DMA-6 verifies certification by the physician that the applicant is determined eligible for Nursing Facility Level of Care. When certification of Level of Care is assigned it is valid for sixty (60) days. Certifications and attestations for the Level of Care are performed according to Federal timeliness requirements.

### Review Medical Evaluation and Admission

Before admission to an institution for the mentally retarded or related conditions, Intermediate Care Facility for the Mentally Retarded (ICFMR), an interdisciplinary team of health professionals makes a comprehensive medical and social evaluation and a psychological evaluation of each applicant's/recipient's need for care in the ICFMR.

Evaluations made before admission include:

- Diagnoses.
- Current medical, social and developmental findings.
- Mental/ physical functional capacity.
- Prognoses.
- Services needed.
- Recommendation of admission to or continued ICFMR care.

### Plan of Care

A physician must legalize a written plan of care, the active treatment services, by personally signing the plan for each applicant or recipient before admission to an ICFMR. Medical and social information is required to be submitted on the Plan of Care which contains the following elements:

- Identification of the recipient.
- Name of the recipient's physician.
- Date of admission.
- Dates of application for and authorization of Medicaid benefits if application is made after admission.
- Diagnoses, symptoms, complaints, and complications indicating the need for admission.
- Description of the functional level of the individual.

Plan of Care: Nursing Facilities (Continued)

- Objectives.
- Orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures designed to meet the objectives of the plan of care.
- Plans for continuing care, including review and modification of the plan of care.
- Plans for discharge.

The team must review and follow through each plan as required by 42CFR483.440.

Explanation of Alternative Services

Before admission to a ICFMR, if the physician recommends services for an applicant or recipient whose needs could be met by alternative services that are currently unavailable, the facility must enter this fact in the recipient's record and begin to look for alternative services.

RELATIONS WITH STATE HEALTH AND VOCATIONAL  
REHABILITATION AGENCIES AND TITLE V GRANTEES

The Department has an agreement with the Georgia Department of Human Resources to establish cooperative administration and supervision for certain services. Mutual objectives for the arrangement are to produce a statewide system for informing and referral and to enhance the administrative capability to provide maximum utilization of services.

DHR agrees to provide the various support services described in this contract, and DMA agrees to pay DHR the appropriate federal share of the cost of these services on a quarterly basis, with the exception of the Community Care Services program for which DHR agrees to pay DMA the appropriate non-federal share of the cost of the Community Care Services program on a quarterly basis. DHR agrees to bear the non-Federal share of such costs from state or other funds eligible for use in matching such non-Federal share for all other services. DMA and DHR mutually agree that the level and extent of services provided in this contract are contingent upon the availability of both State and federal funds. In the event either party determines that a service or activity provided for in this contract cannot be performed, a formal written notice will be provided to the Commissioner of the other party no less than thirty (30) days prior to deletion of the service or activity.

Pursuant to the requirements of 42 CFR 431.615, DHR and DMA have established a coordinating committee consisting of the Commissioner or his designee from DMA, the Commissioner or his designee from DHR, and a representative of each appropriate program division of DHR and DM. Said committee shall meet no less than once per quarter to review and evaluate the services provided for in this contract, to explore other avenues of interaction between the parties, and to otherwise meet the requirement of 42 CFR 431.615. The committee, at its discretion, may set up subcommittees to research and/or develop recommendations for solutions to pertinent issues.

Non-Emergency Transportation (NET)

Medicaid Related NET

The provision of Medicaid related NET services (with the exception of EPSDT related NET and NET services provided by direct provider) is the responsibility of the appropriate county Department of Family and Children Services. The local office will arrange and coordinate or provide non-emergency transportation services to DMA eligible clients in accordance with DMA's Policies and Procedures Manual for Non-Emergency Transportation.

**TRANSMITTAL 94-12**

**APPROVED 5-19-94**

**EFFECTIVE 4-01-94**

**SUPERSEDES 86-22**

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**RELATIONS WITH STATE HEALTH AND VOCATIONAL REHABILITATION AGENCIES AND  
TITLE V GRANTEES****EPSDT Related NET**

During Fiscal Year 1986, the responsibility for arranging and coordinating or providing non-emergency transportation services for EPSDT Services will be transferred on a phased-in basis from DFCS to DPH with local health department case managers assuming full responsibility. This will include the locating and negotiation of NET services with the providers of this services to establish contractual arrangements for this purpose. DHR will encourage local health departments to negotiate with local DFCS for assistance in developing or sharing lists of these providers, or the actual provision of the NET services in counties where appropriate and feasible. DMA, Division of Program Management, agrees to provide recipients with notice of availability of non-emergency transportation services. Program Management agrees to provide to DHR NET Manuals, manual revisions, and copies of the Medicaid Provider list.

DHR and DMA Program Management agree to work jointly in the development of policies and procedures for non-emergency transportation services.

**Family Planning Services**

DFCS agrees that the county offices will inform and explain the availability of family planning services and provide literature to recipients in need of such services.

DHR, Division of Public Health (DPH), agrees to administer a statewide program of family planning clinic services which shall include the provision of pregnancy testing and family planning services to eligible recipients, development of contractual relations with non-profit clinics which provide family planning services, documentation of services rendered and the establishment of policy and procedures in conformity with DMA's policy.

DPH agrees to monitor and evaluate the scope, quality, and utilization of family planning services and to provide clinic utilization reports to DMA. These reports must be sent to the Division Director, Program Management.

DPH agrees to submit a monthly computer tape to the DMA, Systems Management Division, which shall contain at a minimum the name and Medicaid number of clients receiving pregnancy test or other family planning services.

DMA agrees to provide reimbursement to the DPH for Medicaid covered services rendered to eligible recipients.

DPH, DFCS and DMA agree to work jointly in the development of policies and procedures for Family Planning services.

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RELATIONS WITH STATE HEALTH AND VOCATIONAL REHABILITATION AGENCIES AND  
TITLE V GRANTEES

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Division of Family and Children Services (DFCS)

DFCS agrees that county DFCS offices will notify, verbally and in writing, all eligible clients under 21 years (at the point of application and each reapplication) of the availability and advantage of the EPSDT Program using the EPSDT pamphlet or other resources provided by DMA.

DFCS agrees that county DFCS offices will offer newly eligible clients screening and support services and will document acceptance or declination of the program. Dates of informing, acceptance or declination of the program will be documented by DFCS on Form 256. DFCS agrees to send the Case Summary Form and final case summary to DPH.

DFCS agrees to appoint a state eligibility representative who will serve an EPSDT Interdivisional Committee, accompany Program Management staff on the quarterly EPSDT program overviews and make arrangements for Program Management staff to visit county DFCS offices.

Division of Public Health (DPH)

DPH agrees that case managers will contact all individuals listed on the DMA EPSDT newly eligible report, including SSI recipients, and all newly eligible EPSDT individuals on the first page of the final case summary form PARIS (DFCS Computer System).

DPH agrees that county DPH offices will assist eligible clients in locating participating Medicaid screening, diagnostic and treatment providers and offer support services assistance with scheduling appointments and transportation when requested for screening, diagnosis and treatment.

DPH agrees to develop and use in all counties a DMA-approved referral protocol.

DPH agrees that each county office will recall all eligible children including SSI children due rescreening using as their primary tool the EPSDT Due List provided monthly by DMA. DPH agrees to document the dates of recall and recall responses.

DPH agrees that case managers will contact recipients overdue for rescreening as listed on the overdue list.

DPH agrees that each county office will provide local Medicaid screening providers with information on the current screening status of children.

RELATIONS WITH STATE HEALTH AND VOCATIONAL  
REHABILITATION AGENCIES AND TITLE V GRANTEES

DPH agrees that each county office will document and provide to Program Management information on the local provision of EPSDT informing, tracking, and follow-up on all eligible children.

DPH agrees to provide follow-up for screening, diagnosis and treatment within 120 days of receiving notification of eligible clients and acceptance of EPSDT services by client.

DPH agrees to assign full-time nurses to perform program reviews and evaluate the provision of EPSDT screening services in county health departments and provide reports to DMA. The reports will describe problems identified at the time of the program review visit and will outline a plan of corrective action and follow-up on the appropriateness of the corrective action, subject to DMA review and approval.

DPH agrees to provide training for DPH nurses who perform EPSDT screenings.

DPH agrees to appoint a state representative(s) who will serve on a EPSDT Interdivisional Committee, accompany Program Management staff to perform quarterly county EPSDT program overviews, or make arrangements for Program Management staff to visit county health departments.

DPH State Office agrees to set minimal standards and protocols for each component of the EPSDT examination or screening services, and to maintain written evidence of such standards.

DPH agrees that county case managers will inform EPSDT eligibles who are eligible for Title V services of the services available to them and will refer them to Title V grantees, if desired.

DMA will provide state DPH office with reports generated from data on the DMA-267.

DMA will provide state and county DPH offices with the following:

- EPSDT manuals and revisions
- EPSDT pamphlets
- EPSDT screen/claim forms
- Lists of new EPSDT individuals
- Quarterly lists of Medicaid and screening providers
- Lists of recipients due for screening
- Monthly lists of recipients 120 days late for rescreening

DMA agrees to reimburse DPH for screening services on a claim-for-claim basis at the reimbursement rate in effect on the date of screening.

**TN NO. 94-39      DATE/RECEIPT 12-20-94**  
**SUPERSEDES      DATE/APPROVED 2-21-95**  
**TN NO. 86-22      DATE/EFFECTIVE 10-1-94**

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RELATIONS WITH STATE HEALTH AND VOCATIONAL REHABILITATION AGENCIES AND  
TITLE V GRANTEES

DMA agrees to provide the state DPH with the following materials related to the provision of EPSDT services by the health departments:

A quarterly screening report giving the number of individuals by age sequence receiving services, (subject to availability).

A quarterly report of child health status giving the numbers of children screened by age sequence and county and the type of abnormality referred, (subject to availability).

Statewide list of the numbers of Medicaid enrolled recipients by county twice a year.

A monthly claims processing activity report giving the number and reasons for claims being rejected; in-process or pending.

Provider ranking list twice a year.

Subject to Federal Regulation, DMA agrees to provide matching federal funds at 75% Federal for nursing positions to perform program reviews.

DFCS, DPH and DMA agree to hold interdivisional meetings at least quarterly.

DPH and DMA agree to conduct EPSDT program reviews in counties and to do so jointly with state representatives identified by the respective Division.

DFCS, DPH and DMA agree to work jointly to develop policies and procedures for the EPSDT Program.

Community Care Services Program (CCSP)

DFCS agrees to determine eligibility for potential Medical Assistance Only (MAO) clients appropriate for CCSP, to determine the amount of MAO client cost share liability, and to transmit this information to the CCSP case manager.

In conjunction with DMA, Division of Program management, Office of Aging and DFCS will develop and coordinate an appropriate vendor authorization payment system.

DFCS agrees to provide training for MAO Specialists.

DPH agrees to provide assessment teams comprised of a registered nurse and social worker. The attending Physician on the assessment team shall provide input verbally or through the provision of written medical data.



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**RELATIONS WITH STATE HEALTH AND VOCATIONAL REHABILITATION AGENCIES AND  
TITLE V GRANTEES**

DPH agrees to reassess clients as determined through standards and procedures established in conjunction with the office of Aging and DMA, Division of Program Management, to determine the appropriateness of community care and the level of services needed if the client remains in the community.

DPH agrees to maintain and distribute the Program Policies and Procedures Manual for assessment teams. Any revision to these manuals must be submitted to OA and DMA, Division of Program Management, for review and approval.

The Office of Aging (OA) agrees to visit each service provider facility, where necessary, to assess physical conditions and compliance with established standards.

The OA agrees to provide technical assistance, training seminars and training packages for providers as determined necessary.

The OA agrees to arrange for the limits of services and containment of costs through the case management function. The case management' function will be carried out through contracts with lead agencies.

The OA agrees to develop and update the Program Policies and Procedures Manuals for home and community-based waiver services provided under the Community Care Services Program. DMA will distribute these manuals.

The OA, in conjunction with DMA, agrees to coordinate a prior approval and prepayment review system to authorize services above the monthly limit but not to exceed the annual limit. This includes form changes, policies, procedures, system edits, etc.

The OA, in cooperation with DPH, agrees to provide to Program Management information needed to complete federal reports for 2176 waived services, i.e., HCFA 371 & 372.

The OA agrees to assist Program Management with the provision of information for all federal and state program assessments.

The OA agrees to submit to Program Management a monthly report reflecting program statistics regarding service utilization.

The OA agrees to provide Program Management with copies of the client Assessment Instrument (CAI) and the Provider Notification Form (PNF) when either form changes.

The OA, in conjunction with DMA, agrees to establish standards and requirements for provider participation.

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**RELATIONS WITH STATE HEALTH AND VOCATIONAL REHABILITATION AGENCIES AND  
TITLE V GRANTEES**

DMA Program Management agrees to maintain, through DMA's Fiscal Agent, an automated case management client file.

DMA Administration agrees to prepare and submit to the OA a quarterly statement of expenditures by recipient, service provider and major service type.

Program Management agrees to provide to OA a monthly list of enrolled home and community-based service providers.

Program Management agrees to conduct utilization reviews for Community Care Services Program recipients and to provide written reports on UR findings.

DMA agrees to establish reasonable reimbursement rates for the provision of Community Care Services and to provide OA with up-to-date reimbursement rates for all enrolled and approved CSP providers.

Program Management agrees to work jointly with the OA on the development of policies and procedures for the Community Care Services Program. OA will involve DPH as appropriate.

Program Management agrees to notify OA in writing of any changes in related policy and regulation requirements needing incorporation into policy manuals. OA will notify DPH of changes as appropriate.

**Community Mental Health and Mental Retardation Area Programs**

Division of Mental Health and Mental Retardation (DMH/MR) agrees to conduct certification and re-certification reviews for mental health/mental retardation and substance abuse (MH/MR/SA) services rendered by Area Programs. Upon completion of each on-site review, DMH/MR will provide DMA with a summary of Area Program compliance with Federal regulations and DHR/DMA policy. The summary shall identify areas of non-compliance. A subsequent summary shall be forwarded to DMA on a quarterly basis which documents action taken to correct previously identified areas of non-compliance, and the certification status of the Area Programs review.

DMH/MR agrees to continue a utilization review program. Reports and analyses of these data shall be forwarded to DMA.

DMH/MR agrees to provide initial and on-going training for the staff who conduct the certification reviews for outpatient MH/MR/SA services and for staff who monitor and supervise the utilization review program.

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**RELATIONS WITH STATE HEALTH AND VOCATIONAL REHABILITATION AGENCIES AND  
TITLE V GRANTEES**

DMH/MR agrees to coordinate and supervise the implementation of provisions contained in DMA's Policies and Procedures for Outpatient MH/MR/SA Services and the DMH/MR's Policy Memorandum 40-01 and Quality Assurance Standards Manual Document, and DMH/MR's minimum requirements for area MH/MR Programs.

DMH/MR agrees to provide sufficient professional staff in the Office of Quality Assurance.

DMH/MR agrees to assure that all providers participating in the Community MH/MR/SA services program will prepare cost reports annually.

MH/MR agrees to appoint state office representatives to serve on an interdivisional committee.

DMH/MR agrees to work jointly with DMA in the development of policies and procedures for community MH/MR/SA services.

DMA agrees to reimburse area programs at rates approved by the Board of Medical Assistance.

Program Management agrees to provide area programs with manuals and manual revisions in a timely fashion.

Program Management agrees to work jointly with DMH/MR in the development of policies and procedures for community MH/MR/SA services.

Program Management agrees to hold interdivisional committee meetings with state office representatives of MH/MR.

Long-Term Care Services

DMH/MR agrees to be responsible for developing long-term care plan for ICF-MR residential services; monitoring the facilities for federal and state standards compliance; developing and providing in-service training and staff development for current ICF-MR facilities and facilities that wish to join the program; coordinating DMH/MR activities with the Office of Regulatory Services; and for obtaining statistics from the Georgia Medical Care Foundation regarding MH/MR recipients in long-term care facilities.

DMA, Division of Program Management, agrees to reimburse long-term care facilities for services provided MH/MR recipients according to rates approved by the Board of Medical Assistance.

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**RELATIONS WITH STATE HEALTH AND VOCATIONAL REHABILITATION AGENCIES AND  
TITLE V GRANTEES****Rehabilitation Services**

DHR, Division of Rehabilitation Services (DRS) agrees to provide Vocational Rehabilitation applicants eligible for Medical Assistance with notification of services provided under the Medical Assistance Program, and to refer Vocational Rehabilitation applicants under twenty-one (21) years of age to the EPSDT Program.

DMA, Program Management, agrees to provide DRS with literature which explains the EPSDT Program and the advantages of participation in it for distribution to vocational rehabilitation applicants under 21 years of age.

DRS and DMA agrees to furnish, on request, information concerning prevailing rates of payment for services.

**Reimbursement**

DHR and DMA agree that this is a cost reimbursement contract. DHR agrees to provide the state portion of matching funds necessary to receive Federal Financial Participation (FFP). DHR agrees that reimbursable costs will be determined in accordance with applicable provisions of 45 CFR Part 74, "Administration of Grants" and the approved DHR Cost Allocation Plan filed pursuant to such regulations. The reimbursable cost is for administrative and support services required under this Contract.

DHR agrees that the applicable provisions of 45 CFR Part 74 shall govern the administration of funds under this contract and that DHR will observe and adhere to such requirements as detailed in Part 74, Subparts A, B, C, D, F, G, H, O, P and Q.

DHR agrees to submit financial statements detailing the costs incurred by DHR in carrying out the administrative provisions of this contract. Such financial statements shall be submitted within sixty (60) days after the end of each calendar quarter and shall indicate the particular service by the type and applicable FFP rate. DHR will ensure that charges for Skilled Professional Medical Personnel (SPMP) included in financial statements will be in accordance with federal regulations regarding FFP for SPMP activities.

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**RELATIONS WITH STATE HEALTH AND VOCATIONAL REHABILITATION AGENCIES AND  
TITLE V GRANTEES**

DMA agrees to pay DHR the applicable FFP percentage of each service, with the exception of services provided under the Community Care Services Program, covered by this Contract as provided in the State Medicaid Plan and as detailed on the financial statement described in the previous paragraph.

DMA agrees to submit financial statements to DHR detailing the payments made to providers for services rendered under the Community Care Services Program. Such financial statements shall be submitted within sixty (60) days after the end of each calendar quarter and shall be in a mutually agreed upon format.

DHR agrees to pay DMA the non-federal share of costs as detailed on the financial statement described in the previous paragraph. DHR agrees to notify DMA of any payments included on this financial statement for which services are not authorized. Unauthorized payments will be credited to DHR promptly upon notification. DMA may recoup unauthorized payments from providers.

Any disallowance of FFP by the Health Care Finance Administration is the ultimate responsibility of DMA; however, DHR is responsible for all disallowances resulting from failure to comply with rules, regulations, policies and procedures, etc., relative to the terms of this administrative agreement. DMA will notify DHR promptly of any audits, financial reviews, etc., relative to DHR responsibilities under this agreement. DMA will provide draft findings and recommendations to DHR with adequate time for input before DMA's response, to assure both agencies' concerns and comments are addressed. DHR will respond promptly when notified by DMA. Financial responsibility for any repayments, sanctions, etc., will be determined on a case by case basis, depending on the circumstances and state budgetary requirements and restrictions.

Disallowance by the Health Care Finance Administration relative to areas where DHR is functioning as a service provider will be handled by DMA in the same manner as that of any other Medicaid service provider.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **GEORGIA**

LIENS AND ADJUSTMENTS OR RECOVERIES

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1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

The State may place a lien on the member's home when there is not a reasonable expectation that the member will return home and when none of the following persons are living in the home:

- (a) The member's spouse;
- (b) A child under twenty-one (21) years of age;
- (c) A disabled child of any age; or
- (d) A sibling with an equity interest in the home who has lived in the home for at least one (1) year before the member entered the nursing home.

The Department shall notify the member and the personal representative, if applicable, of its determination that the member is permanently institutionalized and not reasonably expected to return home and its intent to file a lien on member's real property. Notice must include an explanation of liens and their effect on an individual's ownership of real property. The notice must also state that imposing a lien does not mean the individual will lose their home. A lien may not be filed less than thirty-one (31) days from the date of the notice to the member and before any hearing process has been completed, if a hearing is requested.

A member of his or her designee may, within thirty (30) days after receipt of notice request an administrative hearing under this rule. A member is deemed to have received notice within five (5) days from the date of the notice. Administrative hearings and appeals by Medicaid members are governed by the procedure and time limits set in Georgia Administrative Comprehensive Chapter §290-1-1-.01. Only one (1) appeal shall be afforded on behalf of a member, for each notice received. The member or his/her representative bears the burden of proof in proving that the member is not permanently institutionalized. The administrative law judge shall make the determination that an individual can or cannot reasonably be expected to be discharged from the institution.

The Department or its designee shall file a notice of lien with the recorder of the county in which the real property subject to the lien is located. The notice shall be filed prior to the member's death and shall include the following:

- (a) Name and place of residence of the real property subject to the lien; and
- (b) Legal description of the real property subject to the lien.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **GEORGIA**

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The Department shall file one (1) copy of the notice of lien with the local DFCS office in the county in which the real property is located. The county in which the real property is located shall retain a copy of the notice with the county office's records. The Department or its designee shall provide one (1) copy of the notice of lien to the member or the member's authorized representative, if applicable, whose real property is affected.

The lien continues from the date of filing until the lien is satisfied, released or expires. From the date on which the notice of lien is recorded in the office of the county recorder, the notice of lien:

- (a) Constitutes due notice against the member or member's estate for any amount recoverable under this article; and
- (b) Gives a specific lien in favor of the Department on the Medicaid member's interest in the real property.

The State may not place a lien on an individual's home if anyone of the following individuals are living in the home:

- (a) The member's spouse;
- (b) The member's child under twenty-one (21) years of age;
- (c) The member's blind or disabled child of any age as defined in §1614 of the Act;
- (d) The member's brother or sister who has an equity interest in the home and who has been in the member's home for at least one year immediately before the member's admission to a nursing home.

The Department has the authority to release any lien placed upon the property of an individual deemed permanently institutionalized should that person be discharged and return to a non-institutional home environment. The Department shall release a lien obtained under this rule within thirty (30) days after the Department receives notice that the member is no longer institutionalized and is living in his or her home. If the real property subject to the lien is sold, the office shall release its lien at the closing and the lien shall attach to the net proceeds of the sale.

**"Permanently institutionalized"** means residing in a nursing facility or intermediate care facility for the mentally retarded and developmentally disabled for 6 consecutive months or more.

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR §433.36(f):

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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The son or daughter has resided in the home at least two (2) years immediately before the member's admission to the institution. The member's sibling has resided in the residence at least one (1) year prior to the member's entrance to a nursing home. The son, daughter or sibling must provide the State with acceptable documentation that is clear and convincing evidence to prove residency and equity interest such as receipts, mortgage statements, bills, mail forwarded to member's address, and no other known residence for that sibling, son or daughter during that time frame. The sibling, son, or daughter has the burden of proof in all administrative reviews and/or hearings.

3. The State defines the terms below as follows:

**"Estate"** means all real and personal property under the probate code. Estate also includes real property passing by reason of joint tenancy, right of survivorship, life estate, survivorship, trust, annuity, homestead or any other arrangement. The estate also includes a life estate interest and excess funds from a burial trust or contract, promissory notes, cash, and personal property.

**"Individual's home"** means true, fixed and permanent home and principal establishment to which whenever absent, the individual has the intention of returning to his domicile.

**"Equity interest in the home"** means value of the property that the individual holds legal interest in to beyond the amount owed on it in mortgages and liens.

**"Residing in the home for at least one or two years"** Means the principal place of residence.

**"On a continuous basis"** means that the qualifying relative lived with the member in the member's residence as his or her principal place of residence without any breaks in the time frame.

**"Discharge from the medical institution and return home"** means that in order to be a qualifying discharge the member must be dismissed from the nursing institution and/or facility for at least thirty (30) days. Also, the member's personal effects and bed must be released at the same time of his/her discharge.

**"Lawfully residing"** means permissive use by the owner/power of attorney and the law.



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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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4. The state defines undue hardship as follows:

**“Undue hardship”** means (1) The asset to be recovered is the sole income-producing asset of the Medicaid beneficiary's heirs; or (2) The recovery of the assets would result in the heirs becoming eligible for governmental public assistance based on need and/or medical assistance programs.

5. The following procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective:

Procedures-

- The creditor's claim contains information on the right to apply for an undue hardship waiver.
- The personal representative completes a request for Undue Hardship Waiver within 30 days of the creditor's claim being filed, enclosed supporting documentation and forwards it to the Department for an evaluation on whether to grant a waiver. If a waiver is granted, recovery may be terminated or the Department may compromise by delaying recovery until the death of the eligible heir. In determining whether an undue hardship exists, the following criteria will be used:
  - (a) The asset to be recovered is a income producing farm of one or more of the heirs and the annual gross income is limited to \$25,000 or less; or
  - (b) The recovery of assets would result in the applicant becoming eligible for governmental public assistance based on need and/or medical assistance programs.
- Heirs who disagree with the Department's denial may file for an administrative appeal within 30 days of the notice of denial.
- The heirs have the burden of proof in all administrative reviews and/or hearings.

6. The State defines cost-effective as follows (include methodology/thresholds used to determine cost-effectiveness):

- The State employs the following methodology in determining if recovery is cost effective. The regulations of estate recovery mandate that we must pay years support for the family, funeral expense up to five thousand dollars (\$5000.00), necessary expenses of administration, and unpaid taxes prior to any claims for Medicaid. In addition, the State must pay the third party administrator of the estate recovery program's collection expenses and pay a special assistant attorney general to handle these claims in Probate Court. Estates valued at \$25,000 or less are exempt from estate recovery because it is not cost effective for the state to pursue recovery.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **GEORGIA**

7. The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):
- At application and during re-determination the applicant or the member is notified of the estate recovery program.
  - Potential recovery cases are identified by data matches, newspaper clipping services, and referrals received from, probate courts, nursing facilities and local county offices.
  - After death of the member, a Notice of Intent to File a Claim Against the Decedent's Estate is forwarded to the member's representative or the representative's attorney. In addition, a questionnaire is forwarded requesting information about a surviving spouse, a child under the age of 21, a blind or disabled child, any real property, and the administration of the estate.
  - If all the criteria to pursue estate recovery is met, upon the estate being opened, the Department files a Creditor's Claim for the total amount of medical assistance paid on the deceased member's behalf.
  - If an estate is not opened, the State may recoup funds through the member's bank account. The administrator of the program may present an affidavit to a financial institution requesting that the financial institution release account proceeds to recover the cost of services correctly provided to a member. The affidavit shall include the following information:
    - (a) The name of the decedent;
    - (b) The name of any person who gave notice that the decedent was a Medicaid member and that person's relationship to the decedent;
    - (c) The name of the financial institution;
    - (d) The account number;
    - (e) A description of the claim for estate recovery;
    - (f) The amount of funds to be recovered.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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A financial institution shall release account proceeds to the administrator of the program if all of the following conditions apply:

- (a) The decedent held an account at the financial institution that was in the decedent's name only;
- (b) No estate has been, and it is reasonable to assume that no estate will be, opened for the decedent;
- (c) The decedent has no outstanding debts known to the administrator of the program;
- (d) The financial institution has received no objections or has determined that no valid objections to release proceeds have been received.

If proceeds have been released pursuant to this section and the Department receives notice of a valid claim to the proceeds that has a higher priority under O.C.G.A. §53-7-40 than the claim of this section, the Department may refund the proceeds to the financial institution or pay them to the person or government entity with the claim.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

STATE: \_\_\_\_\_

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A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a) (1) through (5) and (7) of the Act.

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Service and Basis for Determination	Type of Charge			
	Deduct.	Coins	Co-pay.	Amount
Outpatient non-emergency visits			X	\$ 3.00

---

A co-payment study was conducted within Georgia and a comparison study with other states was completed. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

TN No. 93-29  
Supersedes TN No. 85-24  
Approval Date 3-10-94  
Effective Date 7-1-93

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

STATE: GEORGIA

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A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

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Service and Basis for Determination	Type of Charge			Amount
	Deduct.	Coins	Co-pay.	
Oral Maxillofacial Surgery Services			X	\$ 2.00

---

A co-payment study was conducted by the Georgia Office of Planning and Budget and the department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as co-payment.

**STATE PLAN UNDER TITLE XIX OF NE SOCIAL SECURITY ACT**

STATE: GEORGIA

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A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a) (1) through (5) and (7) of the Act.

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Service and Basis for Determination	Type of Charge			Amount
	Deduct.	Coins	Co-pay.	
Nurse practitioners evaluation and management office visits			X	2.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**STATE: GEORGIA**

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A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

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Service and Basis for Determination	Type of Charge			
	Deduct.	Coins	Co-pay.	Amount
Durable Medical Equipment			X	\$ 3.00
Durable Medical Supplies and Rentals			X	1.00

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A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor it was unreasonable that they be asked to pay a percentage of their income as a co-payment.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**STATE: GEORGIA**

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A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

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Service and Basis for Determination	Type of Charge			Amount
	Deduct.	Coins	Co-pay.	
Orthotics and Prosthetic Services			X	\$ 3.00

---

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor it was unreasonable that they be asked to pay a percentage of their income as a co-payment.



**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**STATE: GEORGIA**

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A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

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Service and Basis for Determination	Deduct.	Type of Charge		Amount
		Coins	Co-pay.	
Home Health Services			X	\$ 3.00

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A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

STATE: GEORGIA

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A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

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Service and Basis for Determination	Deduct.	Type of Charge		Amount
		Coins	Co-pay.	
Non-Emergency Transportation			X	\$ 1.00

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A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard CO- payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co- payment.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

STATE: GEORGIA

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A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

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Service and Basis for Determination	Deduct.	Type of Charge		Amount
		Coins	Co-pay.	
Physicians and Podiatrists Evaluation and Management office visits			X	\$2.00
Ophthalmology Service visits			X	2.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard CO- payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co- payment.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

STATE: **GEORGIA**

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A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

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Service and Basis for Determination	Deduct.	Type of Charge		Amount
		Coins	Co-pay.	
Optometric evaluation and management office visits			X	\$ 1.00

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A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard CO- payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co- payment.

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**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905 (a) (1) through (5) and (7) of the Act.

The co-payment structure was established to administer the Preferred Drug List program. Copayments listed below are applicable to drug identified as "non-preferred" only. Preferred branded drug, as well as, preferred generic drug have a co-pay of \$0.50.

Type of Charge				
Service and Basis For Determination	Deduct.	Coins	Co-pay.	Amount
Pharmacy Services			X	
	<u>Cost to State</u>	<u>Co-Payment</u>		
	\$10.00 or less	\$0.50 co-payment		
	\$10.01 to \$25.00	\$1.00 co-payment		
	\$25.01 to \$50.00	\$2.00 co-payment		
	\$50.01 or more	\$3.00 co-payment		

Recipients under age twenty-one (21), pregnant women, institutionalized individuals, hospice care, QMB dual eligible, and Breast and Cervical Cancer Program participant recipients are not required to pay this co-payment. Emergency services, family planning services, are also exempt from this co-payment.

Copayments are based on the maximum allowable charges as described in CFR 447.54 (2) non-institutional services.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

STATE: GEORGIA

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A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

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Service and Basis for Determination	Deduct.	Type of Charge		Amount
		Coins	Co-pay.	
Ambulatory Surgical Centers			X	\$3.00
Rural Health Centers			X	2.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard CO- payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co- payment.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

STATE: GEORGIA

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A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

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Service and Basis for Determination	Deduct.	Type of Charge		Amount
		Coins	Co-pay.	
Federally Qualified Health Centers [ Community Health Center Services (CHC) ]			X	\$2.00

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard CO- payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co- payment.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**STATE: GEORGIA**

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A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act.

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Service and Basis for Determination	Deduct.	Type of Charge		Amount
		Coins	Co-pay.	
Inpatient Hospital Services			x	\$12.50

---

Recipients affected by the co-payment are limited to adult recipients 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, and hospice care recipients are not required to pay this co-payment. Emergency services and family planning services received by Medicaid recipients do not require a co-payment.

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

- B. The method used to collect cost sharing charges for categorically needy Individuals:

Providers are responsible for collecting the cost sharing charges from individuals.

The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

- C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Providers accept the recipients' word as to their ability to pay the co-payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

- D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53 (b) are described below:

Exclusions are determined by edits and audits of the claims payment system.

- E. Cumulative maximums on charges:

State policy does not provide for cumulative maximums.

Cumulative maximums have been established as described below:

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

STATE: \_\_\_\_\_

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A. The following charges are imposed on the medically needy for services:

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Service and Basis for Determination	Type of Charge			Amount
	Deduct.	Coins	Co-pay.	
Non-Emergency outpatient services (visits)			X	\$ 3.00

---

A co-payment study was conducted within Georgia and a comparison study with other states was completed. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

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**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

STATE: GEORGIA

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A. The following charges are imposed on the medically needy for services:

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Service and Basis for Determination	Type of Charge			
	Deduct.	Coins	Co-pay.	Amount
Oral Maxillofacial Surgery Services			X	\$2.00

---

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

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Effective Date 7/1/94

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

STATE: GEORGIA

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A. The following charges are imposed on the medically needy for services:

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Service and Basis for Determination	Deduct.	Type of Charge		Amount
		Coins	Co-pay.	
Nurse practitioners evaluation and management office visits			X	2.00

---

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

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TN NO. 94-019  
Supersedes  
TN No. New

Approval Date FEB 03 1995

Effective Date 7-1-94

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

STATE: GEORGIA

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A. The following charges are imposed on the medically needy for services:

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Service and Basis for Determination	Deduct.	Type of Charge		Amount
		Coins	Co-pay.	
Durable Medical Equipment			X	\$3.00
Durable Medical Supplies and Rentals			X	1.00

---

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

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Effective Date 7-1-94

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

STATE: GEORGIA

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A. The following charges are imposed on the medically needy for services:

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Service and Basis for Determination	Deduct.	Type of Charge		Amount
		Coins	Co-pay.	
Orthotics and Prosthetics Services			X	\$3.00

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A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

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TN NO. 94-021  
Supersedes  
TN No. New

Approval Date FEB 03 1995

Effective Date 7-1-94

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

STATE: GEORGIA

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A. The following charges are imposed on the medically needy for services:

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Service and Basis for Determination	Deduct.	Type of Charge		Amount
		Coins	Co-pay.	
Home Health Services			X	\$3.00

---

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

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TN NO. 94-022  
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Approval Date 2/7/95

Effective Date 7/1/94



**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

STATE: GEORGIA

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A. The following charges are imposed on the medically needy for services:

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Service and Basis for Determination	Deduct.	Type of Charge		Amount
		Coins	Co-pay.	
Non-Emergency Transportation			X	\$1.00

---

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

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TN NO. 94-023  
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TN No. New

Approval Date 2/7/95

Effective Date 7/1/94

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

STATE: GEORGIA

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A. The following charges are imposed on the medically needy for services:

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Service and Basis for Determination	Deduct.	Type of Charge		Amount
		Coins	Co-pay.	
Physicians and Podiatrists Evalua- tion and Management office visits			X	\$2.00
Ophthalmology Service visits			X	2.00

---

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

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TN NO. 94-018  
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**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**STATE: GEORGIA**

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A. The following charges are imposed on the medically needy for services:

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Service and Basis for Determination	Deduct.	Type of Charge		Amount
		Coins	Co-pay.	
Optometric evaluation and management office visits			X	\$ 1.00

---

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

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TN NO. 94-024  
Supersedes  
TN No. New

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Effective Date 7-01-94

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

A. The following charges are imposed on the medically needy for services:

The co-payment structure was established to administer the Preferred Drug List program. Copayments listed below are applicable to drug identified as “non-preferred” only. Preferred branded drug, as well as, preferred generic drug have a co-pay of \$0.50.

Service and Basis For Determination	Type of Charge			
	Deduct.	Coins	Co-pay	Amount
Pharmacy Services			X	
		<u>Cost to State</u>	<u>Co-Payment</u>	
		\$10.00 or less	\$0.50 co-payment	
		\$10.01 to \$25.00	\$1.00 co-payment	
		\$25.01 to \$50.00	\$2.00 co-payment	
		\$50.01 or more	\$3.00 co-payment	

Recipients under age twenty-one (21), pregnant women, institutionalized individuals, hospice care, QMB dual eligible, and Breast and Cervical Cancer Program participant recipients are not required to pay this co-payment. Emergency services, family planning services, are also exempt from this co-payment.

Copayments are based on the maximum allowable charges as described in CFR 447.54 (2) non-institutional services.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**STATE: GEORGIA**

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A. The following charges are imposed on the medically needy for services:

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Service and Basis for Determination	Deduct.	Type of Charge		Amount
		Coins	Co-pay.	
Ambulatory Surgical Centers			X	\$3.00
Rural Health Centers			X	2.00

---

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**STATE: GEORGIA**

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A. The following charges are imposed on the medically needy for services:

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Service and Basis for Determination	Deduct.	Type of Charge		Amount
		Coins	Co-pay.	
Federally Qualified Health Centers [Community Health Center Services (CHC) ]			X	\$2.00

---

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

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TN NO. 94-031  
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Effective Date 7/1/94

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**STATE: GEORGIA**

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A. The following charges are imposed on the medically needy for services:

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Service and Basis for Determination	Deduct.	Type of Charge		Amount
		Coins	Co-pay.	
Inpatient Hospital Services			X	\$12.50

---

Recipients affected by the co-payment are limited to adult recipients 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, and hospice care recipients are not required to pay this co-payment. Emergency services and family planning services received by Medicaid recipients do not require a co-payment.

A co-payment study was conducted by the Georgia Office of Planning and Budget and the Department of Medical Assistance. This study was conducted within Georgia and a comparison study with other states was also completed. The standard co-payment amount for services was determined by applying the maximum co-payment amounts specified in 42 CFR 447.54(a) and (b) to the agency's average or typical payment for that service. The study indicated that persons who receive SSI, SSD, and other state assistance would not suffer undue hardship, nor was it unreasonable that they be asked to pay a percentage of their income as a co-payment.

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TN NO. 94-036  
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TN No. New

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Effective Date 7/1/94

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:                     GEORGIA                    

- B. The method used to collect cost sharing charges for medically needy  
Individuals:

Providers are responsible for collecting the cost sharing charges from  
individuals.

The agency reimburses providers the full Medicaid rate for services  
and collects the cost sharing charges from individuals.

- C. The basis for determining whether an individual is unable to pay the charge,  
and the means by which such an individual is identified to providers, is described below:

Providers accept the recipients' word as to their ability to pay the co-payment.



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:                     GEORGIA                    

- D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53 (b) are described below:

The exclusions are determined by edits and audits of the claims payment system.

- E. Cumulative maximums on charges:

State policy does not provide for cumulative maximums.

Cumulative maximums have been established as described below:



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

C. State or local funds under other programs are used to pay for premiums:

Yes

No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

**NONE**

\*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

Optional Sliding Scale Premiums Imposed on  
Qualified Disabled and Working Individuals

- A. The following method is used to determine the monthly premium imposed on Qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

**NONE**

- B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

**NONE**

\*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

C. State or local funds under other programs are used to pay for premiums:

Yes

No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

**NONE**

\*Description provided on attachment.

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METHODS AND STANDARDS FO RESTABLISHING PAYMENT RATES  
INPATIENT SERVICES

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I. Cost finding and 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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TN No.: 13-006

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METHODS AND STANDARDS FO REESTABLISHING PAYMENT RATES  
INPATIENT SERVICES

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

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METHODS AND STANDARDS FO RESTABLISHING 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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METHODS AND STANDARDS FO RESTABLISHING PAYMENT RATES  
INPATIENT SERVICES

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 purposes 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. Audit Program

The Department shall be responsible for the performance of desk reviews. The Department shall:

- a. Determine the audit scope and format.
- b. Contract annually for the performance of desk and focus reviews
- c. Ensure all audits are performed in accordance with Professional 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 of Georgia.

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METHODS AND STANDARDS FO RESTABLISHING 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.

3. 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.

4. 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.

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METHODS AND STANDARDS FO RESTABLISHING PAYMENT RATES  
INPATIENT SERVICES

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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.

For admissions on and after January 1, 2019, the prospective rates are developed using the following data sources:

- Base Claims Data: Claims Data for CY 2016
- Cost Data: DSH Survey Data filed for the FY 2018 DSH Payment Calculation and Medicare Cost Reports for Hospital FYE 2016 when DSH data is not available.
- Medicaid Inpatient Utilization Rate (MIUR): DSH Survey Data filed for the FY 2018 DSH Payment Calculation and Medicare Cost Reports for Hospital FYE 2016 when DSH data is not available.
- Direct Graduate Medical Education (GME):
  - Number of Residents: CY 2016 GME Survey FTE Counts as reported by the hospitals that received GME funding from Georgia Medicaid prior to January 1, 2019 from Georgia Medicaid and projected FY 2019 FTE Counts for new GME programs.

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METHODS AND STANDARDS FO RESTABLISHING PAYMENT RATES  
INPATIENT SERVICES

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- Medicaid Allocation Ratio (MAR): DSH Survey Data filed for the FY 2018 DSH Payment Calculation and Medicare Cost Reports for Hospital FYE in 2016 when DSH data is not available.
- Indirect Medical Education (IME):
  - Number of Residents: CY 2016 GME Survey FTE Counts as reported by the hospitals that received GME funding from Georgia Medicaid prior to January 1, 2019 from Georgia Medicaid and projected FY 2019 FTE Counts for new GME programs.
  - Number of Beds: Medicare Cost Reports for Hospital FYE 2016.

For admissions on and after January 1, 2019, the prospective payment model will be updated annually on July 1 as follows:

- Direct GME allocations will be updated using the most recent resident counts and MAR data.
- IME factors will be updated using the most recent resident counts and bed count data.
- All hospital CCRs will be updated using the most recent cost 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 6b 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 6b for example.

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METHODS AND STANDARDS FO RESTABLISHING PAYMENT RATES  
INPATIENT SERVICES

**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-on	\$ 408.02	DRG Outlier Threshold	\$33,786.42
GME Add-on per case	\$ 422.07	Outlier Payment %	0.893
<b>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)</b>			
Non-Outlier DRG Payment per case calculation:			
1	Base Rate	\$ 4,879.72	
2	DRG weight	<u>0.8078</u>	
3	Base rate DRG	\$ 3,941.84	(line 1x line 2) = Hospital Specific Base Rate times DRG Relative Rate
4	Capital Add-on	\$ 408.02	
5	GME Add-on per case	\$ 422.07	
6	Non Outlier DRG Payment	\$ 4,771.93	(line 3+line 4 + line 5)
<b>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)</b>			
Outlier DRG Payment per case calculation:			
1	\$ 4,879.72	Base Rate	
2	<u>0.8078</u>	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	<u>0.231</u>	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	\$ <u>0.8930</u>	Outlier Payment Percentage	
9	\$ 37,736.54	(line 7 x line 8)	
10	\$ 408.02	Capital Add-on per case	
11	\$ <u>422.07</u>	GME Add-on per case	
12	\$ <u>42,508.47</u>	(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 pages 9 through 10a for detail on the specific MIUR and IME calculations. Refer to pages 12 through 13 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 6c 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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METHODS AND STANDARDS FO RESTABLISHING PAYMENT RATES  
INPATIENT SERVICES

**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		<u>101.48%</u>	
4	Adjusted Base Rate	\$	5,875.89 (Line 1 X Line 2 X Line 3)	
5	Stop-Loss/Stop-Gain Adjustment		<u>101.35%</u>	
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)	\$	<u>5,400.79</u> (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		<u>0.231</u>	
4	Estimated Cost of Claim	\$	51,975.00 (Line 2 x Line 3)	
5	DRG Outlier Threshold	\$	<u>44,299.82</u>	
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		<u>0.893</u>	
9	Eligible Outlier Payment	\$	<u>41,590.77</u> (Line 7 x Line 8)	
10	Total DRG Payment with Outlier	\$	46,991.56 (Line 1 + Line 9)	

For Admissions on and after January 1, 2019:

The Hospital Specific Base Rate will include adjustments for each hospital's Medicaid Inpatient Utilization Rate (MIUR), Indirect Medical Education (IME) if applicable, Peer Group Add-On Amount if applicable, and a stop-loss/stop-gain adjustment if applicable.

The Hospital Specific Base Rate is calculated as: [(Statewide Base Rate) x (1 +MIUR Factor) x (1 + IME Factor)) + (Peer Group Add-On Amount)] x (1 + Stop-Loss/Stop Gain Adjustment)

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Non-Outlier DRG Per Case Payment = Hospital Specific Base Rate x DRG Weight

Outlier DRG Per Case Payment = {[(Allowable Charges x Hospital Specific Cost-to-Charge Ratio) - DRG Outlier Threshold] x Outlier Payment Percentage} + Non-Outlier DRG Per Case Payment

For Admissions on and after January 1, 2019

Examples of Non-Outlier and Outlier DRG Per Case Payments

Hospital Data:		DRG Data:	
Statewide Base Rate	\$ 5,310.99	DRG Number	313 (Chest Pain)
MIUR Factor	6%	DRG Relative Weight	0.7477
IME Factor	1.48%	DRG Outlier Threshold	\$30,000.00
Peer Group Add-On Amount	\$0		
Stop-Loss/Stop-Gain Adjustment	1.35%		
Hospital Specific Cost-to-Charge Ratio (CCR)	0.231		

**Example 1: Calculation of the Hospital Specific Base Rate**

Hospital Specific Base Rate = [((Statewide Base Rate) x (1 + MIUR Factor) x (1 + IME Factor)) + (Peer Group Add-On Amount)] x (1 + Stop-Loss/Stop-Gain Adjustment)

1.	Statewide Base Rate	\$5,310.99
2.	MIUR Factor+1	106.00%
3.	IME Factor+1	101.48%
4.	Peer Group Add-On Amount	\$0.00
5.	Stop-Loss/Stop-Gain Adjustment + 1	<u>101.35%</u>
6.	Hospital Specific Base Rate	\$5,790.09 ((Line 1 x Line 2 x Line 3) + Line 4) x Line 5

**Example 2: Calculation of Non-Outlier DRG Per Case Payment**

Non-Outlier DRG Per Case Payment = Hospital Specific Base Rate x DRG Weight

1.	Hospital Specific Base Rate	\$5,790.09
2.	DRG Weight (Chest Pain)	<u>0.7477</u>
3.	Non-Outlier DRG Per Case Payment	\$4,329.25 (Line 1 x Line 2)

**Example 3: Calculation of Outlier DRG Per Case Payment**

Outlier DRG Per Case Payment = {[(Allowable Charges x Hospital Specific Cost-to-Charge Ratio) - DRG Outlier Threshold] x Outlier Payment Percentage} + Non-Outlier DRG Per Case Payment

1.	Allowable Charges	\$225,000.00
2.	Hospital Specific CCR	<u>0.231</u>
3.	Estimated Cost of the Claim	\$51,975.00 (Line 1 x Line 2)
4.	DRG Outlier Threshold	<u>\$30,000.00</u>
5.	Estimated Cost Above Threshold	\$21,975.00 (Line 3 - Line 4)
	**Qualifies for Outlier Payment Only if Estimated Cost of the Claim is Above the DRG Outlier Threshold**	
6.	Outlier Payment Percentage	<u>0.893</u>
7.	Outlier Payment Amount	\$19,623.68 (Line 5 x Line 6)
8.	Non-Outlier DRG Per Case Payment	<u>\$4,329.25</u>
9.	Outlier DRG Per Case Payment	\$23,952.93 (Line 7 + Line 8)

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C. Discussion of Payment Components

1. Base Rates

For admissions before January 1, 2019:

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.

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.

**Specialty Peer Group Base Rates**

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, 2019:

All hospitals are assigned to one of two peer groups in order to develop a hospital specific base rate that best matches payments to costs for hospitals that provide similar services. The two hospital peer groups are: statewide and pediatric.

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Hospitals in the statewide peer group have hospital specific base rates calculated from the statewide base rate with adjustments for Medicaid utilization (MIUR), medical education (IME) if applicable, and a stop-loss/stop-gain factor if applicable.

Hospitals in the pediatric peer group have hospital specific base rates calculated from the statewide base rate with adjustments for Medicaid utilization (MIUR), medical education (IME) if applicable, the Pediatric Peer Group Add-On Amount, and a stop-loss/stop-gain factor if applicable.

The statewide base rate is the average cost of claims in the base data for hospitals in the statewide peer group, adjusted for budget neutrality.

The Pediatric Peer Group Add-On Amount is the difference between the average cost of claims in the pediatric peer group, adjusted for budget neutrality, and the average cost of claims in the statewide peer group, adjusted for budget neutrality.

The stop-loss/stop-gain factor adjusts hospital specific base rates such that the hospital does not experience a loss due to the rebasing and does not experience a gain greater than 4.01% due to the rebasing.

### 2. Hospital Provider Fee Add-On Amount

For admissions on or after July 1, 2013 through June 30, 2025:

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.

### 3. Calculation of the Capital Add-on Amount

For admissions before July 1, 2015, 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.

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

For admissions before July 1, 2015, 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.

### 5. 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 that were in place for admissions before July 1, 2015 is 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 (a)) by total capital costs from the cost report (Item (b)).
- (d) Determine the capital CCR by dividing the Medicaid allocation of capital costs (Item (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 (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 (a)) by total capital from surveys (Item (d)).
- (i) Determine the survey rate of increase by dividing Item (h) by item (e).
- (j) Calculate the Capital Add-On Amount by multiplying Item (f) by one plus Item (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 (a)) by total GME costs from the cost report (Item (b)).
- (d) Determine the GME CCR by dividing the Medicaid allocation of GME costs (Item (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 (e)) by the Medicaid discharges from the base year. This will yield the Medicaid GME amount per discharge.

6. Indirect Medical Education

For admissions on and after July 1, 2015, 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.

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7. 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 (b) minus Worksheet S-3, Column 2, Line 13).
- (d) Calculate ratio of interns & residents to beds by dividing the total interns & residents - full time equivalents (Item (a)) by the total number of inpatient beds (Item (c)).
- (e) Use the CMS Medicare formula in place on July 1 2015 to determine Indirect Medical Education Factor:  $1.35 * ([1 + \text{ratio of interns \& residents to bed (item (d))}]^{0.405} - 1)$ .

For admissions on or after January 1, 2019, the IME calculation methodology is as follows:

- (a) Calculate the total FTE residents.
- (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 (b) minus Worksheet S-3, Column 2, Line 13).
- (d) Calculate ratio of residents to beds by dividing the total FTE residents (Item (a)) by the total number of inpatient beds (Item (c)).
- (e) Use the CMS Medicare formula in place on July 1 2015 to determine Indirect Medical Education Factor:  $1.35 * ([1 + \text{ratio of interns \& residents to bed (Item (d))}]^{0.405} - 1)$ .

8. 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.

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- (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 (c)) divided by total inpatient days (Item (b)).

For admissions on or after January 1, 2019, the MIUR factor is calculated as follows

- (a) For facilities completing DSH surveys:
  1. Determine total Medicaid inpatient days from DSH Survey Pt. II, Sec. H, Line 18.
  2. Determine total inpatient days from DSH Survey Pt. II, Sec. G, Line 18.
  3. Calculate MIUR from total Medicaid inpatient days (Step 1) divided by total inpatient days (Step 2).
- (b) For facilities without DSH surveys:
  1. 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.
  2. Determine total inpatient days from Medicare cost report Worksheet S-3, Part I, Column 8, Line 14
  3. Calculate MIUR from Medicaid days (Step 1) divided by total inpatient days (Step 2).

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. The MIUR bands are as follows:

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

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D. Special Payment Provisions

## 1. Graduate Medical Education (GME) Supplemental Payments

Effective July 1, 2015 through December 31, 2018, 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

Effective January 1, 2019, hospitals with accredited GME programs receive a Graduate Medical Education Supplemental Payment. GME supplemental payments are made in quarterly installments. The annual amount of each GME supplemental payment is determined as follows:

- (a) Determine the number of FTE residents.
- (b) Determine the Medicaid Allocation Ratio (MAR). For facilities with DSH surveys, the Medicaid Allocation Ratio is Total Medicaid Hospital Revenue divided by Net Hospital Revenue. For facilities without DSH surveys, the Medicaid Allocation Ratio is Total Medicaid Inpatient Cost (Medicare Cost Report Worksheet E-3, Part VII, Title XIX, Line 1.00, Column 1.00) divided by Total Inpatient and Outpatient Cost (Medicare Cost Report Worksheet B, Part I, Line 118, Column 24).
- (c) Determine the hospital's base GME funding as follows: \$49,000 X (FTE resident count determined in step (a)) x (MAR determined in step (b))
- (d) Hospitals with FTE residents in the residency programs listed below will receive additional funding above the base funding allocation.
  - a. Family Medicine: \$33,000/FTE Resident
  - b. OB/GYN: \$33,000/FTE Resident
  - c. General Pediatrics: \$28,500/FTE Resident
  - d. Pediatric Specialty Programs: \$13,500/FTE Resident
  - e. General Surgery: \$10,000/FTE Resident

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## 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. For dates of admissions on or after January 1, 2019, new facilities will be reimbursed at the statewide base rate.

## 3. 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. 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. For dates of admissions on or after January 1, 2019, out-of-state enrolled facilities will be reimbursed at the statewide base rate and the Georgia statewide average of cost-to-charge ratios.

## 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.2.

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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. For admissions on and after January 1, 2016, the grouper used to classify cases into DRG categories will be TRICARE Grouper version 33.0. For admissions on and after January 1, 2019, the grouper used to classify cases into DRG categories will be TRICARE Grouper version 35.0. The grouper used to assign claims to DRG categories, as well as the corresponding DRG weights and threshold amounts, may be updated periodically.

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.

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 pages 6b and 6c 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

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

J. Payment in Full

I. 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.

Rural Hospital Newborn Delivery Program

Effective for deliveries occurring between July 1, 2016 and June 30, 2017, an additional payment of \$250 per newborn delivery will be made to hospitals in rural counties with populations less than 35,000.

Effective for deliveries occurring between July 1, 2017 and June 30, 2018, the additional payment per newborn delivery will increase by \$500, resulting in a total additional payment of \$750 per newborn delivery for hospitals in rural counties with populations less than 35,000.

Effective for deliveries occurring on and after July 1, 2018, the additional payment per newborn delivery will increase by \$250, resulting in a total additional payment of \$1,000 per newborn delivery for hospitals in rural counties with populations less than 35,000.

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Beginning July 1, 2014, the Inpatient Upper Payment Limit Demonstration will exclude organ acquisition cost in the calculation of the Medicare Cost to Charge Ratio.

- D. Should the aggregate of Section IV rate payment adjustments and calculated supplemental payments in paragraph (B) exceed the available inpatient upper payment limit for hospitals in the private hospital subclass, payment per each supplemental payment type in paragraph (B) will be proportionately adjusted to ensure supplemental payments do not exceed the available inpatient upper payment limit gap calculated in Section IV-Other Rate Adjustments.
- E. Payments are equal to the inpatient UPL gap calculated in Section IV - Other Rate Adjustments less Section IV rate adjustment payments and paragraph (B) Access to Care Payments. Hospitals in the private subclass shall receive a payment equal to a uniform percentage increase applied to annual inpatient hospital Medicaid fee-for-service payments derived from the Medicaid MMIS inpatient fee-for-service date of service claims data and updated annually with the most recent information available as of July 1st of each fiscal year. The percentage increase will be equal to the remaining pool amount divided by the total annual inpatient hospital Medicaid fee-for-service payments for the private hospital subclass.
- F. Supplemental payments shall be paid in four installments within the state fiscal year.
- G. Hospital payments made under this section, when combined with other payments made under the state plan shall not exceed the limit specified in 42 CFR § 447.271 and 42 CFR § 447.272.
- H. The total funds that will be paid to each hospital will be included in the calculation of disproportionate share limits as described in Section III.B.3.

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES  
INPATIENT HOSPITAL SERVICES**

Citation

42 CFR 447, 434,438, and 1902(a)(4), 1902(a)(6), and 1903

**Payment Adjustment for Provider Preventable Conditions (PPC)**

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19(A)

  X   Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

TN No.: 11-005

Supersedes

TN No.: NEW

Approval Date JUN 19 2012

Effective Date: June 30, 2012

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES  
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Payment for Hospital Acquired Conditions:

Effective June 30, 2012 and in accordance with Title XIX of the Social Security Act - Sections 1902, 1903 and 42 CFRs 434, 438, and 447, Medicaid will make no payment to providers for services related to Provider Preventable Conditions (PPC) which includes Healthcare Acquired Condition (HCAC) and Never Events (NE).

In accordance with GA State Plan, Attachment 3.1-A, Page 1, Hospital Services payments are allowed except for the following conditions outlined below.

The above effective date and after, for all Medicaid patients, requests for Diagnosis Related Groups (DRGs) attributable to Present on Admission (POA) conditions will be reimbursed for allowable charges. Peer Review Organization (PRO) review for Present on Admission (POA) is not required.

Provider Preventable Conditions (PPC), which includes Healthcare Acquired Condition (HCAC), with diagnose codes with Y or W, or as defined by CMS, will be considered in the DRG calculation. Conversely, any diagnoses codes with N or U, or as defined by CMS, will not be considered in the DRG calculation. Provider Preventable Conditions (PPC) will not be approved by the Peer Review Organization (PRO). Providers must identify and report PPC occurrences.

Never Events (NE) are defined by the National Coverage Determination (NCD) manual for Inpatient Hospitals and practitioners, and these providers will be required to report NEs. Never Events (NE) for Inpatient Hospital claims will bill separate claims using by Bill Type 110 or as designated by the National Uniform Bill Committee for a non-payment/zero claim. The non-covered Bill Type 110 must have one of the ICD-9 diagnosis codes.

- E876.5 – Performance of wrong operation (procedure) on correct patient
- E876.6 - Performance of operation (procedure) on patient not scheduled for surgery
- E876.7 -- Performance of correct operation (procedure) on wrong side/body part

The provider may file a separate claim for the same Medicaid recipient with the same dates of service to include the allowable charges for reimbursement. Providers must identify and report NE occurrences.

Prohibition on payments for PPCs, HCACs and NEs shall not result in a loss of access to care or services for Medicaid beneficiaries. This policy applies to all Medicaid reimbursement provisions, contained in 4.19A, including Medicaid supplemental or enhanced payments and Medicaid disproportionate share hospital payments.

TN No.: 11-005

Supersedes

TN No.: NEW

Approval Date JUN 19 2012

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES  
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**Reimbursement of Long Term Acute Care Hospitals and Institutional Rehabilitation Facilities**

For admissions on and after January 1, 2019, Long Term Acute Care Hospitals (LTACHS) and Institutional Rehabilitation Facilities (IRFs) will be reimbursed utilizing a facility specific per diem rate. To qualify for per diem reimbursement, the facility must be permitted as a Long Term Acute Care Hospital or a Rehabilitation Hospital in the state of Georgia.

The facility specific per diem rate will be based on CY 2016 historical claims submitted for Georgia Medicaid recipients. Charges on each historical claim shall be converted to estimated costs by applying the hospital specific cost to charge ratio from each hospital's submitted cost report. The historical claims costs and days are summarized to calculate the facility-specific per diem cost and the LTACH and IRF average per diem cost.

LTACHS and IRFs will be placed into one of two peer groups based on ownership status: (1) State Owned Peer Group and (2) Non-State Owned Peer Group.

LTACHS and IRFs in the Non-State Owned Peer Group will have a facility-specific per diem rate set at 80.02% of the facility's CY 2016 Medicaid claims cost. LTACHS and IRFs in the State Owned Peer Group will have a facility-specific per diem rate set at 100% of the facility's CY 2016 Medicaid claims cost.

LTACH and IRF facilities that enroll in Georgia Medicaid on or after January 1, 2019 will receive payment under an average per diem rate.

The per diem rate for newly enrolled LTACHs in the Non-State Owned Peer Group will be set at 80.02% of average LTACH CY 2016 Medicaid claims costs. The per diem rate for newly enrolled LTACHs in the State Owned Peer Group will be set at 100% of average LTACH CY 2016 Medicaid claims costs.

The per diem rate for newly enrolled IRFs in the Non-State Owned Peer Group will be set at 80.02% of average IRF CY 2016 Medicaid claims costs. The per diem rate for newly enrolled IRFs in the State Owned Peer Group will be set at 100% of average IRF CY 2016 Medicaid claims costs.

Qualifying LTACHS and IRFs are eligible to receive the Hospital Provider Fee Add-On Amount as described in Attachment 4.19-A, Section II, Subsection (C)(2).

Out-of-state LTACHs and IRFs will be reimbursed under the Inpatient Perspective Payment System (IPPS), as described in Attachment 4.19-A, Section II, Subsection (D)(3).

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 METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

## III. Disproportionate Share Hospitals (DSH)

A. Eligibility

Effective for DSH payment adjustments made on or after December 1, 2007, hospitals that are eligible to receive DSH payment adjustments under federal DSH criteria per Social Security Act Section 1923(d) will be eligible to receive an allocation of available DSH funds.

## Federal Criteria:

1. The hospital has a Medicaid inpatient utilization rate of at least 1%; AND
2. The hospital has at least two (2) obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid recipients. This requirement does not apply to a hospital of which the inpatients are predominately individuals under 18 years of age or to hospitals which did not offer non-emergency obstetric services to the general population as of December 22, 1987. In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. For rural hospitals subject to a federal requirement to provide obstetric services, as an alternative to determining whether deliveries are provided at the hospital, the Department will consider the following factors:
  - a. The hospital must have two or more physicians with staff privileges that are:
    - Enrolled in the Medicaid program;
    - Credentialed to provide OB services at the hospital in family practice, general practice, or obstetrics; and
    - Located within 25 miles of the hospital or in an office in the hospital network or must attest to attendance at the hospital on some routine basis; and
  - a. The hospital must be able to provide at least one obstetric service that is currently covered by Medicaid and appropriate to be provided in a hospital-based setting

For federal DSH criteria, a hospital will be considered a rural hospital if a hospital's county is not in a Metropolitan Statistical Area, as defined by the United States Office of Management and Budget, OR is a county having a population of less than 35,000 according to the United States decennial census; provided, however, that for counties which contain a military base or installation, the military personnel and their dependents living in such county shall be excluded from the total population of that county.

B. Allocation Methodology

Effective for DSH payment adjustments made on or after December 1, 2007, the following methodology will be used for determining payment amounts:

1. For each federal fiscal year, the amount of funds available for DSH payments will be determined based on the state's federal allotment and required state matching contribution.
2. Hospitals that meet federal DSH eligibility criteria will be eligible to receive an allocation of available DSH allotment funds.
3. The maximum amount of DSH payments (i.e., DSH Limit) for each hospital will be the hospital's loss incurred for services provided to Medicaid and uninsured patients. Medicaid patients will be defined as patients enrolled in either in-state or out-of-state Medicaid fee-for-service or in-state or out-of-state Medicaid Managed Care Organization



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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

(MCO) as their primary or non-primary insurance. Medicaid costs will be determined by applying total per diem costs to Medicaid covered inpatient days and total ratios of cost to charges to Medicaid inpatient and outpatient charges grouped by cost center. The patient day and charge amounts will be determined by Medicaid and Medicaid MCO HS&R reports of paid claims or internal hospital records, while per diem costs and ratios of cost to charges will be determined by available 2552 cost reports. Medicaid payments will include actual claim payments related to Medicaid days and charges, from Medicaid, Medicaid MCOs, Medicare, Medicare Advantage plans, third party insurance, patient payments, the portion of Medicare cost report settlements applicable to Medicare crossover payments, non-claim based Medicaid, Medicaid MCO, and Medicare payments related to inpatient and outpatient hospital services, outpatient settlement estimates and non-DSH rate adjustments. Uninsured costs will be determined by applying the uninsured days and charges reported on the DSH data survey to the same per diems and cost to charge ratios used to calculate Medicaid costs. Uninsured payments will include patient payments received on uninsured services accounted for on a cash basis. The DSH data surveys will also be used to determine amounts received for services provided to uninsured patients. DSH data surveys are conducted annually and subject to desk reviews and onsite reviews of supporting documentation, as warranted.

4. The amount of funds available for DSH payments will be allocated among eligible hospitals. Total available DSH funds will be divided into two pools:
  - Pool 1- For FY 2008 DSH payments, Pool 1 will be equivalent to \$53,735,261 and used in the calculation of DSH allocations for small, rural hospitals. For DSH payments after FY 2008, Pool 1 would change relative to changes in the state's federal DSH allotment as compared to the FY 2008 state DSH allotment;
  - Pool 2 - For FY 2008 DSH payments, Pool 2 will be equivalent to \$347,439,065 and used in the calculation of the DSH allocations for all other, eligible hospitals. For DSH payments after FY 2008, Pool 2 would change relative to changes in the state's federal DSH allotment as compared to the FY 2008 state DSH allotment.
  
5. Each hospital's DSH limit is subject to the following DSH limit adjustments for all location purposes:
  - a. For hospitals receiving Upper Payment Limit(UPL) rate adjustments, the allocation basis will be increased by the amount of any intergovernmental transfer or certified public expenditure on behalf of the hospital.
  - b. For hospitals receiving rate adjustment payments related to medical education, neonatal services or services provided under contract with the Georgia Department of Human Resources, the allocation basis will be increased by the amount of such rate adjustments.
  
6. The department will utilize the following steps to determine the amount each hospital is eligible to receive in DSH payments.
  - a. Step 1: Determine the adjusted DSH limit(as determined in section (III)(B)(5)) as a percentage of total cost for each hospital.
  - b. Step 2: For each hospital, multiply the hospital-specific percentage determined in Step 1 by the hospital's adjusted DSH limit. For private hospitals, the outcome of this calculation will be multiplied by the rate of federal matching funds for Medicaid benefit payments.
  - c. Step 3: For each hospital, divide the hospital-specific amount identified in Step 2 by the aggregate "step 2" amount derived from all hospitals in the applicable pool, as defined in section (III)(B)(4), which will result in a hospital-specific allocation factor.
  - d. Step 4: Apply the hospital's allocation factor calculated in Step 3 to the total amount of DSH funds available in the applicable pool, as defined in section (III)(B)(4). This will result in the hospital's DSH payment. Should the DSH payment amount calculated for a hospital exceed the

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES**

hospital's DSH limit, as determined in section (III)(B)(3), the excess amount will be redistributed to the remaining hospitals in the applicable allocation pool.

7. To mitigate significant increases and decreases in hospital-specific DSH payments as compared to state fiscal year 2007, the following adjustments will be applied for the allocation of DSH funds:
  - Maximum DSH allocations for all hospitals are set at 75% of their specific adjusted DSH limits; however, for facilities ineligible for DSH payment adjustments prior to December 1, 2007 but newly eligible under the criteria specified in section A above or facilities who did not receive a DSH payment prior to December 1, 2007, their maximum DSH allocation factor, as calculated in Section (III)(B)(6), step 2, effective January 1, 2013 is limited to 75% of the calculated amount.
  - Final DSH payment amounts for all other hospitals reflects 100% of the allocation calculation based on the methodology specified in section (III)(B)(6).
  - Effective July 1, 2013 the maximum DSH allotment for all hospital are set at 75% as calculated in section (III)(B)(6).
8. For private hospitals that meet the eligibility requirements of Section (III)(A) and meet Social Security Act Section 1923(b) criteria, allocations payments will be made at 100% of calculated allocation amounts as determined by steps 1 through 7 of Section (III)(B). For private hospitals that meet the eligibility requirements of Section (III)(A) but do not meet Social Security Act Section 1923(b) criteria, allocation payments will be made at 100% of calculated allocation amounts as determined by steps 1 through 7 of Section (III)(B).
9. The state share of DSH payment amounts for state governmental and non-state governmental hospitals will come from intergovernmental transfers made on behalf of or by the hospital.

For allocation of 2010 DSH funds, provider eligibility and DSH limit calculations will be based on information available from hospital fiscal years ending in 2007; for hospitals not in operation during 2007, data for 2008 may be used. For allocation of DSH funds after 2010, eligibility and DSH limit calculations will be based on the most recent year for which comparable data would be available.

Audit of Disproportionate Share Payments:

As required by Section 1923(j) of the Social Security Act related to auditing and reporting of disproportionate share hospital payments, the Division of Medical Assistance will implement procedures to comply with the Disproportionate Share Hospital Payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009, to ensure that the hospital specific DSH limits have not been exceeded.

Any funds recouped as a result of audits or other corrections shall be redistributed to other eligible hospitals within the state, provided each hospital remains below their hospital specific DSH limit. Funds shall be redistributed to hospitals within the pools, as identified in (III)(B)(4) above, for which funds were recouped. There couped funds within each pool shall be redistributed to the governmental facilities that are still below their hospital specific DSH limit. The funds shall be allocated to those hospitals based on their allocation factor that was derived in (III)(B)(6)(b) above. If the redistribution causes a hospital to exceed their hospital specific DSH limit those excess funds will be redistributed using the same methodology until all funds are expended.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
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IV. Other Rate Adjustments

Upper Payment Limit Rate Adjustments

For payments made for services provided on or after July 1, 2005, the following types of hospitals will be eligible for rate payment adjustments:

- State government-owned or operated facilities;
- Non-State government owned or operated facilities;
- Federally defined Critical Access hospitals;
- Hospitals designated by the Georgia Department of Human Resources as Regional Perinatal Centers;
- Hospitals providing the following program services for the Georgia Department of Human Resources: AIDS Clinic, Poison Control Center, Genetics/Sickle Cell Screening and Maternal and Infant Health Services; and
- Hospitals participating in selected residency grant programs administered by the Georgia Board for Physician Workforce.

The rate adjustment payments are intended to provide supplemental funding for Medicaid services to these facilities that need sufficient funds for their commitments to meet the healthcare needs of all members of their communities and to ensure that these facilities receive financial support for their participation in programs vital to the state's healthcare infrastructure.

The rate payment adjustments will be subject to federal upper payment limits. For the appropriate groupings of State government-owned or operated facilities, non-State government owned or operated facilities and all other facilities, aggregate rate adjustment payments available without exceeding upper payment limits will be determined by measuring the difference between:

- Amounts paid for services provided to Medicaid patients and
- Estimated payment amounts for such services if payments were based on Medicare payment principles. Either cost-based determined in accordance with 42 CFR 413s or based on Medicare Prospective payment methods determined in accordance with 42 CFR 412.

Comparisons of amounts paid for services provided to Medicaid patients and estimated payment amounts for such services if payments were based on Medicare payment principles will also be made for each facility to determine facility-specific rate adjustment payments. If an individual facility cannot be paid a portion of its full rate adjustment payment due to a facility-specific charge limit, this rate adjustment amount can be

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
INPATIENT SERVICES

allocated to other facilities that are eligible to receive additional rate adjustment payments without exceeding facility-specific charge limits. These rate payment adjustments will be made on a monthly, quarterly or annual basis and will be determined in a manner that will not duplicate compensation provided from payments for individual patient claims.

A sample of how a rate adjustment payment is calculated is presented on the following page.

Line	Field Description	Comments	XYZ Hospital
1	base period report period beginning date		9/1/2003
2	base period report period ending date		8/31/2004
3	HS&R processing date for Medicaid data		9/6/2005
4	adjustment factor (if period not equal to 1 year)		1
5	Medicaid inpatient claims paid at amount > 0:		
6	covered charges	From HS&R	3,949,268
7	payments	From HS&R	1,828,506
8	annual covered charges	From HS&R	3,949,268
9	annual payments	From HS&R	1,828,506
10			
	Cost of Medicaid Services	Worksheets C, Part 1 and D-1, Part II	1,661,931
11			
	Covered Charges for Medicaid Services	Worksheets C, Part 1 and D-1, Part II	3,725,000
12	inpatient CCR	Line 14 / Line 9	0.446156

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
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	annual cost of services	Line 4 X Line 6 X Line 12	1,761,990
13			
15	<u>adjustment factors</u>		
16			
	claim completion		1
17			
18	inflation		1.073852
19	volume allowance		1.014000
20	combined adjustment factors	Line 17 X Line 18 X Line 19	1.088886
21	supplemental inpatient rate adjustments		0
22	adjusted annual charges	Line 4 X Line 6 X Line 20	4,300,302
23	adjusted Medicaid payments	Line 4 X Line 9 X Line 20	1,991,034
24	adjusted cost of services	Line 13 X Line 20	1,918,606
25	total Medicaid payments	Line 21 + Line 23	1,991,034

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
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26	DRG differential		1.176249
27	adjusted Medicare-based annual payments	Line 23 X Line 26	2,341,952
28	UPL estimate	Line 27 - Line 25	350,918

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
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Supplemental Payments for Inpatient Child and Adolescent Behavioral Health Units

Effective on and after July 1, 2019, the Department will make an annual supplemental payment to acute care hospitals that have inpatient child and adolescent behavioral health units. The annual supplemental payments will be made after all claims have been received and validated for the state fiscal year end. The supplemental payment will provide additional reimbursement to eligible hospitals, bringing the total Medicaid payments for inpatient mental health services provided by the units to the equivalent of \$750 per covered day.

The following acute care hospitals with inpatient child and adolescent behavioral health units will be eligible to receive the annual supplemental payment:

- Donalsonville Hospital, Inc.
- Northeast Georgia Medical Center
- Saint Francis Hospital
- Tanner Medical Center Villa Rica

The supplemental payment for each eligible hospital shall be calculated as follows:

(1) Calculate the total amount paid by Georgia Medicaid to the eligible hospital for fee-for-service inpatient claims in which the hospital rendered services to a child under 18 years old and the claim was assigned to one of the diagnosis related groups (DRGs) listed below. The claims data to be utilized in the first state fiscal year (SFY) of the program will be claims incurred during SFY 2018. The claims data utilized in each subsequent year of the program will be updated by one state fiscal year.

- |  |  |
|--|--|
| • 880 Acute Adjustment Reaction and Psychosocial Dysfunction | • 884 Organic Disturbances and Intellectual Disability |
| • 881 Depressive Neuroses                                    | • 885 Psychoses  |
| • 882 Neuroses Except Depressive                             | • 886 Behavioral and Developmental Disorders           |
| • 883 Disorders of Personality and Impulse Control           | • 887 Other Mental Disorder Diagnoses                  |

(2) Calculate the total covered days for the claims identified in step (1).

(3) Multiply the covered days from step (2) by \$750.

(4) Subtract the amount calculated in step (1) from the amount calculated in step (3) to determine the supplemental payment.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-  
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V. Other Information

A. Payment Assurance

The State will pay each hospital for services provided in accordance with the requirements of the Georgia Title XIX State Plan and applicable State and Federal rules and regulations. The payment amount shall be determined for each hospital according to the standards and methods set forth in the Georgia Title XIX inpatient Hospital Reimbursement Plan.

Hospitals will continue to submit claims as they have in the past. All requirements for documented services and charges will remain in effect, and all screens for completeness will continue. Hospital claims will be subject to post-payment review. The Department will be requesting information from the hospitals to substantiate the necessity and appropriateness of services rendered. Any denials for lack of medical necessity, documentation, or other reasons will result in recoupment of monies paid to the provider. A reduced rate for less than acute care is not applicable nor required.

Unlike a per diem or percent of charges system, this reimbursement plan does not provide incentives for prolonging a patient's stay. If a patient remains in the hospital beyond the time of medical necessity, the effect is to reduce the daily reimbursement rate.

B. Provider Participation

This plan is designed to assure adequate participation of hospitals in the Medicaid Program, the availability of hospital services of high quality to recipients, and services within which are comparable to those available to the general public.

C. Swing-bed Services

1. Reimbursement Methodology

Swing-bed providers will be reimbursed a prospective rate per patient day which will be \$295 per covered day. The per diem rate covers the cost of certain routine services as described in Attachment 3.1 A, page 1c-3 of the Plan. Ancillary services such as laboratory, radiology, and certain prescription drugs must be billed and reimbursed separately under the appropriate Medicaid program. For example, radiology

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-  
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services provided in the outpatient department of the hospital should be billed as outpatient hospital services. Providers must bill on a monthly basis.

Medicaid will reimburse the Medicare Part A coinsurance for skilled level care of swing bed services provided to Medicaid/Medicare recipients.

Medicaid reimbursement will be reduced by the amount of the recipient's liability (patient income). Patient income is established by the county DFACS office and is the dollar amount shown on Form DMA-59, or the dollar amount shown on Form DMA-286 if the recipient has Medicaid/Medicare coverage. The patient's income is deducted in full from the Medicaid reimbursement rate until the income has been exhausted.

## 2. Cost Report and Cost Settlement

There will not be a year-end cost settlement process for the swing-bed services program. In addition, there is no swing-bed services cost report. Medicaid Swing-Bed program data should not be included in the Medicaid Hospital program cost report settlement data. The Medicaid routine swing-bed days should be excluded from the hospital's Medicaid routine days on Worksheet D-1, Part I of the cost report.

### D. Public Process

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

### E. Revisions

The plan will be revised as operating experience data are developed and need for changes is necessary in accordance with Federal and State regulations. If it is found that there are insufficient controls on utilization transfers or cost, or if the Department determines that a different reimbursement methodology is warranted, the Department maintains its right to discontinue this system upon appropriate public notice of the proposed change.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR  
OTHER TYPES OF CARE OR SERVICE

W. Inpatient Psychiatric Facility Services (Psychiatric Residential Treatment Facility Services)

For claims with dates of service July 1, 2008 through December 31, 2018, Psychiatric Residential Treatment Facilities (PRTFs) will be reimbursed at provider specific prospective rates based on 2006, or more recently available cost reports, not to exceed the maximum amount of \$370 per day (the cap). PRTFs will be reimbursed at a provider-specific, prospective per diem rate based on allowable costs as reported on the provider's Fiscal Year 2006, or more recent, cost reports filed with the Department of Community Health (DCH).

Effective January 1, 2019, PRTFs will be reimbursed at provider specific prospective rates based on 2017, or more recently available cost reports, not to exceed maximum amount of \$407 per day (the cap). PRTFs will be reimbursed at a provider-specific, prospective per diem rate based on allowable costs as reported on the provider's Fiscal Year 2017, or more recent, cost reports filed with the DCH.

To ensure sufficient access and provider stability, in the event that a PRTF's provider specific rate as calculated utilizing its most recent cost report decreases by more than 25% from its prior rate, DCH will reimburse the PRTF at its prior rate.

Effective January 1, 2019, for members with a co-occurring diagnosis of autism, PRTFs will be reimbursed at prospective rates based on 2017, or more recently available cost reports, not to exceed the maximum amount of \$440 per day (the cap). PRTFs will be reimbursed at a prospective per diem rate based on allowable costs as reported on the Fiscal Year 2017, or more recent, cost reports filed with the DCH Annual reporting of audited allowable costs and utilization data adjusted to 90% of licensed capacity is used to find the program specific per-diem costs. DCH will apply the utilization standard of 90% of operational capacity for those PRTFs demonstrating appropriate staff to child ratios as described in Section 600.5.B. of the provider manual (Part II: Policies and Procedures for Psychiatric Residential Treatment Facilities).

Reimbursement is set at the lesser of cost or approved rate cap. These rates will be trended for inflation to the mid-point of each rate year (State fiscal year), based on the CMS Hospital Market Basket (Global Insight's Health Care Cost Service, Fourth Quarter Forecast for each rate year). Rates for PRTFs that do not have 2017, or more recent, cost reports reflective of the provision of PRTF services will be based on the median rate of other PRTF providers then in effect and shall not exceed the \$407 per day. These initial rates will be subject to cost settlement and will be established as the lesser of the cost-settled rate or the cap.

New PRTF providers may submit per diem rate proposals based on budgeted estimates so long as these estimates are no greater than the median of rates then in effect and shall not exceed the cap. Upon notice of the provider specific rate, providers will have 30 days to appeal their new rates based on the submission of an amended cost report.

PRTFs shall submit a cost report annually using a uniform cost report form prescribed by DCH and supported by the facilities most recent certified financial audit. Cost reports are used as the basis for rate setting as well as establishing documentary support for federal reimbursement.

The definitions for allowable and unallowable costs and expenditures for federal claiming are based on federal criteria. Cost principles defining allowability for non-governmental entities follow Medicare reimbursement principles in the CMS Provider Reimbursement Manual (PRM 15-I). Allocation of reasonable costs to the program shall be supported by approved methodology and documentation retained by the reporting agency.

Cost reports are subject to federal and state audit.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR  
OTHER TYES OF CARE OR SERVICE

<b>Program Name:</b>	XYZ - Residential Care Facility
<b>Program Vendor Number</b>	XXXXXX
<b>Program Cost Totals</b>	<b>Cost Report</b>
Personnel - Salaries (pg 2)	\$7,909,494
Personnel - Fringe (pg 2)	\$2,035,789
Personnel - Contract (pg 3)	\$423,660
Indirect (pg 3)	\$5,703,999
Consumables (pg 4)	\$972,609
Occupancy (pg 5)	\$716,116
Travel (pg 5)	\$10,226
Equipment (pg 5)	\$166,899
<b>Total Program Cost per Cost Report</b>	<b>\$17,938,792</b>
Less revenue offsets	\$17,761,462
Per diem Cost	\$284
Program Cost per Audit - ENTER	\$20,366,242
Variance	\$2,427,449
Corp Unallowed (Alloc Depr Added)	\$19,248
Education Costs	\$2,207,540
Personal Client Needs/R&B Costs	\$32,310
Bad Debt	\$119,109
Public Relations	\$23,693
Off Set Admin Income	\$25,549
Total Expense Variance:	\$2,427,449
<b>Program Revenue Totals</b>	<b>Cost Report</b>
USDA	\$177,330
Other Federal	\$0
DFCS	\$14,302,150
DFCS OTHER	\$0
DJJ	\$2,671,657
Mental Health	\$0
MAAC	\$0
Other Public	\$3,488,489
Private	\$0
<b>Total Program Revenue per Cost Report</b>	<b>\$20,639,626</b>
Program Revenues per Audit - ENTER	\$20,665,175
Variance	\$25,549
Admin Income Offset	\$9,187
Admin. Income Offset	\$16,362
Total Revenue Variance:	\$25,549

EXHIBIT C.1  
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0		Outlier Threshold	Relative Weight
1	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	\$61,798.67	6.0437
2	CRANIOTOMY FOR TRAUMA AGE >17	\$62,585.79	6.1050
3	CRANIOTOMY AGE 0-17	\$77,862.51	4.4117
4	SPINAL PROCEDURES	\$26,418.82	2.0091
5	EXTRACRANIAL VASCULAR PROCEDURES	\$28,462.91	2.5409
6	CARPAL TUNNEL RELEASE	\$26,418.82	2.0091
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	\$26,418.82	2.0091
8	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	\$26,418.82	2.0091
9	SPINAL DISORDERS & INJURIES	\$83,636.65	7.8905
10	NERVOUS SYSTEM NEOPLASMS WCO	\$32,511.50	1.6731
11	NERVOUS SYSTEM NEOPLASMS W/O CC	\$26,418.82	2.0091
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	\$36,432.93	2.1164
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	\$26,418.82	2.0091
14	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	\$35,333.37	2.4431
15	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS	\$20,184.06	1.0671
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	\$26,418.82	2.0091
17	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	\$26,418.82	2.0091
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	\$20,184.06	1.2496
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	\$20,184.06	0.8823
20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	\$40,860.94	2.4677
21	VIRAL MENINGITIS	\$20,184.06	0.7989
22	HYPERTENSIVE ENCEPHALOPATHY	\$26,418.82	2.0091
23	NONTRAUMATIC STUPOR & COMA	\$26,418.82	2.0091
24	SEIZURE & HEADACHE AGE >17 W CC	\$20,184.06	1.2143
25	SEIZURE & HEADACHE AGE >17 W/O CC	\$20,184.06	0.9447
26	SEIZURE & HEADACHE AGE 0-17	\$20,184.06	0.7985
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	\$26,418.82	2.0091
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	\$26,418.82	2.0091
29	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	\$26,418.82	2.0091
30	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	\$24,477.14	1.1600
31	CONCUSSION AGE >17 W CC	\$26,418.82	2.0091
32	CONCUSSION AGE >17 W/O CC	\$26,418.82	2.0091
33	CONCUSSION AGE 0-17	\$26,418.82	2.0091
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	\$40,763.32	2.0865
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	\$26,418.82	2.0091
36	RETINAL PROCEDURES	\$ 161,018.72	1.6637
37	ORBITAL PROCEDURES	\$20,184.06	1.2509
38	PRIMARY IRIS PROCEDURES	\$20,184.06	1.2509
39	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	\$20,184.06	1.2509
40	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	\$20,184.06	1.2509
41	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	\$20,184.06	1.2509
42	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	\$20,184.06	1.2509
43	HYPHEMA	\$20,184.06	1.2509
44	ACUTE MAJOR EYE INFECTIONS	\$20,184.06	0.5625
45	NEUROLOGICAL EYE DISORDERS	\$20,184.06	1.2509

EXHIBIT C.1  
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
46 OTHER DISORDERS OF THE EYE AGE >17 W CC	\$20,184.06	1.2509
47 OTHER DISORDERS OF THE EYE AGE >17 W/O CC	\$20,184.06	1.2509
48 OTHER DISORDERS OF THE EYE AGE 0-17	\$20,184.06	1.2509
49 MAJOR HEAD & NECK PROCEDURES	\$20,184.06	1.1831
50 SIALOADENECTOMY	\$20,184.06	1.1831
51 SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	\$20,184.06	1.1831
52 CLEFT LIP & PALATE REPAIR	\$20,184.06	1.1831
53 SINUS & MASTOID PROCEDURES AGE >17	\$20,184.06	1.1831
54 SINUS & MASTOID PROCEDURES AGE 0-17	\$20,184.06	1.1831
55 MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	\$20,184.06	1.1831
56 RHINOPLASTY	\$20,184.06	1.1831
57 T&A PROC, EXCEPT TONSILLECTOMY & OR ADENOIDECTOMY ONLY, AGE	\$20,184.06	1.1831
58 T&A PROC, EXCEPT TONSILLECTOMY & OR ADENOIDECTOMY ONLY, AGE	\$20,184.06	1.1831
59 TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	\$20,184.06	1.1831
60 TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	\$20,184.06	1.1831
61 MYRINGOTOMY W TUBE INSERTION AGE >17	\$20,184.06	1.1831
62 MYRINGOTOMY W TUBE INSERTION AGE 0-17	\$20,184.06	1.0377
63 OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	\$40,547.62	2.5659
64 EAR, NOSE, MOUTH & THROAT MALIGNANCY	\$20,184.06	1.1831
65 DYSEQUILIBRIUM	\$20,184.06	1.1831
66 EPISTAXIS	\$20,184.06	1.1831
67 EPIGLOTTITIS	\$20,184.06	1.1831
68 OTITIS MEDIA & URI AGE >17 W CC	\$20,184.06	0.7417
69 OTITIS MEDIA & URI AGE >17 W/O CC	\$20,184.06	0.6325
70 OTITIS MEDIA & URI AGE 0-17	\$20,184.06	0.5118
71 LARYNGOTRACHEITIS	\$20,184.06	0.5941
72 NASAL TRAUMA & DEFORMITY	\$20,184.06	1.1831
73 OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	\$20,184.06	1.1831
74 OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	\$20,184.06	1.1831
75 MAJOR CHEST PROCEDURES	\$60,166.66	4.9188
76 OTHER RESP SYSTEM O.R. PROCEDURES W CC	\$55,402.40	3.6667
77 OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	\$29,180.85	1.4834
78 PULMONARY EMBOLISM	\$20,184.06	2.2006
79 RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	\$31,971.46	2.2529
80 RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	\$20,184.06	1.2499
81 RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	\$39,596.15	1.8729
82 RESPIRATORY NEOPLASMS	\$20,184.06	1.8003
83 MAJOR CHEST TRAUMA W CC	\$29,180.85	1.4834
84 MAJOR CHEST TRAUMA W/O CC	\$29,180.85	1.4834
85 PLEURAL EFFUSION W CC	\$20,184.06	1.5472
86 PLEURAL EFFUSION W/O CC	\$29,180.85	1.4834
87 PULMONARY EDEMA & RESPIRATORY FAILURE	\$51,274.11	2.7129
88 CHRONIC OBSTRUCTIVE PULMONARY DISEASE	\$20,184.06	1.3590
89 SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	\$20,184.06	1.4810
90 SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	\$20,184.06	1.0153

EXHIBIT C.1  
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
91 SIMPLE PNEUMONIA & PLEURISY AGE 0-17	\$20,184.06	0.7169
92 INTERSTITIAL LUNG DISEASE W CC	\$20,184.06	1.3253
93 INTERSTITIAL LUNG DISEASE W/O CC	\$29,180.85	1.4834
94 PNEUMOTHORAX W CC	\$20,184.06	1.5038
95 PNEUMOTHORAX W/O CC	\$20,184.06	0.8020
96 BRONCHITIS & ASTHMA AGE >17 W CC	\$20,184.06	1.0341
97 BRONCHITIS & ASTHMA AGE >17 W/O CC	\$20,184.06	0.8192
98 BRONCHITIS & ASTHMA AGE 0-17	\$20,184.06	0.7255
99 RESPIRATORY SIGNS & SYMPTOMS W CC	\$38,026.59	1.4193
100 RESPIRATORY SIGNS & SYMPTOMS W/O CC	\$20,184.06	0.7076
101 OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	\$22,288.55	1.4014
102 OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	\$20,184.06	0.6364
103 HEART TRANSPLANT	\$27,861.56	1.8842
104 CARDIAC VALVE PROCEDURES W CARDIAC CATH	\$92,117.34	11.2066
105 CARDIAC VALVE PROCEDURES W/O CARDIAC CATH	\$77,284.78	8.5732
106 CORONARY BYPASS W CARDIAC CATH	\$39,027.30	6.4173
107 CORONARY BYPASS W/O CARDIAC CATH	\$45,343.68	5.3786
108 OTHER CARDIOTHORACIC PROCEDURES	\$115,008.44	8.1418
110 MAJOR CARDIOVASCULAR PROCEDURES W CC	\$89,288.39	6.5028
111 MAJOR CARDIOVASCULAR PROCEDURES W/O CC	\$24,611.96	3.3711
112 PERCUTANEOUS CARDIOVASCULAR PROCEDURES	\$20,846.83	2.5982
113 AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	\$59,626.01	4.1308
114 UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	\$20,184.06	2.2415
115 PERM CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK	\$27,861.56	1.8842
116 OTH PERM CARDIAC PACEMAKER IMPLANT OR AICD LEAD OR GENERATOR	\$108,547.62	4.0352
117 CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	\$27,861.56	1.8842
118 CARDIAC PACEMAKER DEVICE REPLACEMENT	\$27,861.56	1.8842
119 VEIN LIGATION & STRIPPING	\$27,861.56	1.8842
120 OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	\$41,165.25	2.7375
121 CIRCULATORY DISORDERS W AMI & C.V. COMP DISCH ALIVE	\$20,184.06	2.0019
122 CIRCULATORY DISORDERS WAMI W/O C.V. COMP DISCH ALIVE	\$20,184.06	1.8347
123 CIRCULATORY DISORDERS WAMI, EXPIRED	\$27,861.56	1.8842
124 CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	\$24,495.16	1.7892
125 CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DI	\$20,184.06	1.6272
126 ACUTE & SUBACUTE ENDOCARDITIS	\$27,861.56	1.8842
127 HEART FAILURE & SHOCK	\$20,184.06	1.2750
128 DEEP VEIN THROMBOPHLEBITIS	\$20,184.06	1.1252
129 CARDIAC ARREST, UNEXPLAINED	\$27,861.56	1.8842
130 PERIPHERAL VASCULAR DISORDERS W CC	\$20,184.06	1.3445
131 PERIPHERAL VASCULAR DISORDERS W/O CC	\$22,177.21	1.0046
132 ATHEROSCLEROSIS W CC	\$20,184.06	1.1203
133 ATHEROSCLEROSIS W/O CC	\$27,861.56	1.8842
134 HYPERTENSION	\$20,184.06	0.8440
135 CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	\$27,861.56	1.8842
136 CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	\$27,861.56	1.8842

EXHIBIT C.1  
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
137 CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	\$27,861.56	1.8842
138 CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	\$20,184.06	1,1653
139 CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	\$20,184.06	0.7655
140 ANGINA PECTORIS	\$20,184.06	0.9114
141 SYNCOPE & COLLAPSE W CC	\$20,184.06	0.8962
142 SYNCOPE & COLLAPSE W/O CC	\$20,184.06	0.7040
143 CHEST PAIN	\$20,184.06	0.8921
144 OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	\$51,420.26	1.9821
145 OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	\$27,861.56	1.8842
146 RECTAL RESECTION W CC	\$20,184.06	1.6640
147 RECTAL RESECTION W/O CC	\$20,184.06	1.6640
148 MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	\$74,674.48	5.4835
149 MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	\$20,184.06	2.1626
150 PERITONEAL ADHESIOLYSIS W CC	\$65,412.09	4.0322
151 PERITONEAL ADHESIOLYSIS W/O CC	\$20,184.06	1.5674
152 MINOR SMALL & LARGE BOWEL PROCEDURES W CC	\$20,184.06	1.6640
153 MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	\$20,184.06	1.7735
154 STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	\$75,654.77	5.5624
155 STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	\$20,184.06	2.2487
156 STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	\$47,377.59	2.0053
157 ANAL & STOMAL PROCEDURES W CC	\$20,184.06	1.6640
158 ANAL & STOMAL PROCEDURES W/O CC	\$20,184.06	1.1318
159 HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	\$20,184.06	1.9993
160 HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	\$20,184.06	1.4504
161 INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	\$20,184.06	1.6640
162 INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	\$20,184.06	1.6640
163 HERNIA PROCEDURES AGE 0-17	\$20,184.06	1.6640
164 APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	\$35,536.38	3.0764
165 APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	\$20,184.06	1.6640
166 APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	\$20,184.06	1.5733
167 APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	\$20,184.06	1.1659
168 MOUTH PROCEDURES W CC	\$20,184.06	1.1831
169 MOUTH PROCEDURES W/O CC	\$20,184.06	1.1831
170 OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	\$20,184.06	1.6640
171 OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	\$20,184.06	1.6640
172 DIGESTIVE MALIGNANCY W CC	\$29,325.15	1.9166
173 DIGESTIVE MALIGNANCY W/O CC	\$20,184.06	1.6640
174 G.I. HEMORRHAGE W CC	\$20,184.06	1.3616
175 G.I. HEMORRHAGE W/O CC	\$20,184.06	0.8550
176 COMPLICATED PEPTIC ULCER	\$31,921.87	1.4590
177 UNCOMPLICATED PEPTIC ULCER W CC	\$20,184.06	1.0245
178 UNCOMPLICATED PEPTIC ULCER W/O CC	\$20,184.06	0.8030
179 INFLAMMATORY BOWEL DISEASE	\$29,339.19	1.6516
180 G.I. OBSTRUCTION W CC	\$20,184.06	1.1615
181 G.I. OBSTRUCTION W/O CC	\$20,184.06	0.6998



EXHIBIT C.1  
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
182 ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	\$20,184.06	0.9784
183 ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O C	\$20,184.06	0.8620
184 ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	\$20,184.06	0.4725
185 DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	\$20,184.06	1.1831
186 DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-1	\$20,184.06	1.1831
187 DENTAL EXTRACTIONS & RESTORATIONS	\$20,184.06	1.1831
188 OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	\$38,375.83	1.6346
189 OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	\$20,184.06	1.6640
190 OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	\$20,184.06	1.6640
191 PANCREAS, LIVER & SHUNT PROCEDURES W CC	\$89,212.86	6.8823
192 PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	\$20,184.06	2.1599
193 BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. WC	\$20,184.06	2.1599
194 BILIARY TRACT PROC EXCEPT ONLY CHOLECYST WOR W/O C.D.E. W/O	\$20,184.06	2.1599
195 CHOLECYSTECTOMY W C.D.E. W CC	\$27,013.59	2.9647
196 CHOLECYSTECTOMY W C.D.E. W/O CC	\$20,184.06	2.1599
197 CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	\$41,763.60	3.1077
198 CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	\$20,184.06	1.6949
199 HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	\$20,184.06	2.1599
200 HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	\$20,184.06	2.1599
201 OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	\$20,184.06	2.1599
202 CIRRHOSIS & ALCOHOLIC HEPATITIS	\$30,259.17	1.9225
203 MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	\$20,798.37	1.6636
204 DISORDERS OF PANCREAS EXCEPT MALIGNANCY	\$23,062.55	1.3223
205 DISORDERS OF LIVER EXCEPT MALIG,CIRR, ALC HEPA W CC	\$29,013.98	1.6204
206 DISORDERS OF LIVER EXCEPT MALIG,CIRR, ALC HEPA W/O CC	\$20,184.06	2.1599
207 DISORDERS OF THE BILIARY TRACT W CC	\$20,184.06	1.2958
208 DISORDERS OF THE BILIARY TRACT W/O CC	\$20,184.06	0.8116
209 MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMIT	\$20,184.06	3.7027
210 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE > 17 W CC	\$25,174.40	2.7308
211 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	\$20,184.06	2.2398
212 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	\$20,184.06	2.0071
213 AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDER	\$20,184.06	1.4485
216 BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	\$20,184.06	1.4485
217 WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS	\$49,376.34	3.8545
218 LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC	\$20,184.06	2.3265
219 LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O	\$20,184.06	1.8071
220 LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0-17	\$20,184.06	1.6391
223 MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC WC	\$20,184.06	1.5628
224 SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	\$20,184.06	1.3474
225 FOOT PROCEDURES	\$20,184.06	1.5180
226 SOFT TISSUE PROCEDURES W CC	\$20,184.06	1.4485
227 SOFT TISSUE PROCEDURES W/O CC	\$20,184.06	1.4322
228 MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC	\$20,184.06	1.4485
229 HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC. W/O CC	\$20,184.06	1.4485
230 LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	\$20,184.06	1.4485

EXHIBIT C.1  
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
231 LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEM	\$27,444.19	2.0810
232 ARTHROSCOPY	\$20,184.06	1.4485
233 OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	\$20,184.06	1.4485
234 OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	\$20,184.06	2.6611
235 FRACTURES OF FEMUR	\$20,184.06	1.1647
236 FRACTURES OF HIP & PELVIS	\$20,184.06	1.4485
237 SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	\$20,184.06	1.4485
238 OSTEOMYELITIS	\$29,864.75	1.8614
239 PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNA	\$28,440.97	1.7804
240 CONNECTIVE TISSUE DISORDERS W CC	\$44,293.09	1.8289
241 CONNECTIVE TISSUE DISORDERS W/O CC	\$20,184.06	1.4485
242 SEPTIC ARTHRITIS	\$20,184.06	1.4485
243 MEDICAL BACK PROBLEMS	\$20,184.06	1.0289
244 BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	\$20,184.06	1.4485
245 BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	\$20,184.06	1.4485
246 NON-SPECIFIC ARTHROPATHIES	\$20,184.06	1.4485
247 SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	\$20,184.06	1.4485
248 TENDONITIS, MYOSITIS & BURSITIS	\$20,184.06	1.4485
249 AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	\$20,184.06	1.4485
250 FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	\$20,184.06	1.4485
251 FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	\$20,184.06	1.4485
252 FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	\$20,184.06	1.4485
253 FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	\$20,184.06	1.4485
254 FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	\$20,184.06	1.4485
255 FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	\$20,184.06	1.4485
256 OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	\$20,184.06	1.4485
257 TOTAL MASTECTOMY FOR MALIGNANCY W CC	\$20,184.06	1.5351
258 TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	\$20,184.06	1.4023
259 SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	\$20,184.06	1.1936
260 SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	\$20,184.06	1.1936
261 BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISIO	\$20,184.06	1.6911
262 BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	\$20,184.06	1.1936
263 SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	\$65,491.23	4.1509
264 SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	\$20,184.06	1.1936
265 SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W	\$20,184.06	1.1936
266 SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W	\$20,184.06	1.6914
267 PERIANAL & PILONIDAL PROCEDURES	\$20,184.06	1.1936
268 SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	\$20,184.06	1.1936
269 OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	\$39,081.73	2.5615
270 OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	\$21,346.72	1.2069
271 SKIN ULCERS	\$28,528.84	1.6467
272 MAJOR SKIN DISORDERS W CC	\$20,184.06	1.1936
273 MAJOR SKIN DISORDERS W/O CC	\$20,184.06	1.1936
274 MALIGNANT BREAST DISORDERS W CC	\$20,184.06	1.1936
275 MALIGNANT BREAST DISORDERS W/O CC	\$20,184.06	1.1936

EXHIBIT C.1  
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
276 NON-MALIGANT BREAST DISORDERS	\$20,184.06	0.7779
277 CELLULITIS AGE >17 W CC	\$20,184.06	1.2077
278 CELLULITIS AGE >17 WO CC	\$20,184.06	0.8399
279 CELLULITIS AGE 0-17	\$20,184.06	0.6267
280 TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	\$20,184.06	1.1936
281 TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	\$20,184.06	1.1936
282 TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	\$20,184.06	1.1936
283 MINOR SKIN DISORDERS W CC	\$20,184.06	1.1936
284 MINOR SKIN DISORDERS W/O CC	\$20,184.06	1.1936
285 AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDE	\$20,184.06	1.9338
286 ADRENAL & PITUITARY PROCEDURES	\$20,184.06	1.9338
287 SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDE	\$20,184.06	1.9338
288 O.R, PROCEDURES FOR OBESITY	\$20,184.06	1.9338
289 PARATHYROID PROCEDURES	\$20,184.06	1.9338
290 THYROID PROCEDURES	\$20,184.06	1.4509
291 THYROGLOSSAL PROCEDURES	\$20,184.06	1.9338
292 OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	\$20,184.06	1.9338
293 OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	\$20,184.06	1.9338
294 DIABETES AGE >35	\$20,184.06	0.9921
295 DIABETES AGE 0-35	\$20,184.06	0.7919
296 NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	\$20,184.06	1.2206
297 NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	\$20,184.06	0.7521
298 NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	\$20,184.06	0.5487
299 INBORN ERRORS OF METABOLISM	\$20,184.06	1.9338
300 ENDOCRINE DISORDERS W C	\$20,184.06	1.9338
301 ENDOCRINE DISORDERS W/O CC	\$20,184.06	1.9338
302 KIDNEY TRANSPLANT	\$20,184.06	1.2201
303 KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	\$29,975.18	3.5893
304 KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	\$48,262.60	2.9291
305 KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	\$20,184.06	1.8184
306 PROSTATECTOMY W CC	\$20,184.06	1.2201
307 PROSTATECTOMY W/O CC	\$20,184.06	1.2201
308 MINOR BLADDER PROCEDURES W CC	\$20,184.06	1.2201
309 MINOR BLADDER PROCEDURES W/O CC	\$20,184.06	1.2201
310 TRANSURETHRAL PROCEDURES W CC	\$20,184.06	1.8149
311 TRANSURETHRAL PROCEDURES W/O CC	\$27,901.51	1.3809
312 URETHRAL PROCEDURES, AGE >17 W CC	\$20,184.06	1.2201
313 URETHRAL PROCEDURES, AGE >17 W/O CC	\$20,184.06	1.2201
314 URETHRAL PROCEDURES, AGE 0-17	\$20,184.06	1.2201
315 OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	\$52,455.61	2.7267
316 RENAL FAILURE	\$24,112.77	1.5255
317 ADMIT FOR RENAL DIALYSIS	\$20,184.06	1.2201
318 KIDNEY & URINARY TRACT NEOPLASMS W CC	\$20,184.06	1.2201
319 KIDNEY & URINARY TRACT NEOPLASMS W/O CC	\$20,184.06	1.2201
320 KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	\$20,184.06	1.0176

EXHIBIT C.1  
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
321 KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	\$20,184.06	0.7323
322 KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	\$20,184.06	0.6313
323 URINARY STONES W CC, &/OR ESW LITHOTRIPSY	\$20,184.06	1.1927
324 URINARY STONES W/O CC	\$20,184.06	0.7690
325 KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	\$20,184.06	1.2201
326 KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	\$25,714.73	1.2201
327 KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	\$20,184.06	1.2201
328 URETHRAL STRICTURE AGE >17 W CC	\$20,184.06	1.2201
329 URETHRAL STRICTURE AGE >17 W/O CC	\$20,184.06	1.2201
330 URETHRAL STRICTURE AGE 0-17	\$20,184.06	1.2201
331 OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	\$20,184.06	1.3303
332 OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	\$20,184.06	1.2201
333 OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	\$20,184.06	1.2201
334 MAJOR MALE PELVIC PROCEDURES W CC	\$20,184.06	1.3392
335 MAJOR MALE PELVIC PROCEDURES W/O CC	\$20,184.06	1.3392
336 TRANSURETHRAL PROSTATECTOMY W CC	\$20,184.06	1.3392
337 TRANSURETHRAL PROSTATECTOMY W/O CC	\$20,184.06	1.3392
338 TESTES PROCEDURES, FOR MALIGNANCY	\$20,184.06	1.3392
339 TESTES PROCEDURES, NON-MALIGNANCY AGE >17	\$20,184.06	1.3392
340 TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	\$20,184.06	1.3392
341 PENIS PROCEDURES	\$20,184.06	1.3392
342 CIRCUMCISION AGE >17	\$20,184.06	1.3392
343 CIRCUMCISION AGE 0-17	\$20,184.06	1.3392
344 OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	\$20,184.06	1.3392
345 OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	\$20,184.06	1.3392
346 MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	\$20,184.06	1.3392
347 MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	\$20,184.06	1.3392
348 BENIGN PROSTATIC HYPERTROPHY W CC	\$20,184.06	1.3392
349 BENIGN PROSTATIC HYPERTROPHY W/O CC	\$20,184.06	1.3392
350 INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	\$20,184.06	1.3392
351 STERILIZATION, MALE	\$20,184.06	1.3392
352 OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	\$20,184.06	1.3392
353 PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	\$20,184.06	1.5474
354 UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	\$20,184.06	1.5474
355 UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	\$20,184.06	1.3154
356 FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	\$20,184.06	1.3010
357 UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	\$20,184.06	1.5474
358 UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	\$20,184.06	1.7649
359 UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	\$20,184.06	1.3242
360 VAGINA, CERVIX & VULVA PROCEDURES	\$20,184.06	1.4014
361 LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	\$20,184.06	1.5957
362 ENDOSCOPIC TUBAL INTERRUPTION	\$20,184.06	1.5474
363 D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	\$20,184.06	1.5474
364 D&C, CONIZATION EXCEPT FOR MALIGNANCY	\$20,184.06	1.5474
365 OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	\$25,211.73	2.0063

EXHIBIT C.1  
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
366 MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	\$20,184.06	1.5474
367 MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	\$20,184.06	1.5474
368 INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	\$20,184.06	0.7523
369 MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	\$20,184.06	0.7065
370 CESAREAN SECTION W CC	\$20,184.06	1,1532
371 CESAREAN SECTION W/O CC	\$20,184.06	0.9167
372 VAGINAL DELIVERY W COMPLICATING DIAGNOSES	\$20,184.06	0.7216
373 VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	\$20,184.06	0.4935
374 VAGINAL DELIVERY W STERILIZATION &/OR D&C	\$20,184.06	0.7278
375 VAGINAL DELIVERY WO.R. PROC EXCEPT STERIL &/OR D&C	\$20,184.06	1.4350
376 POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	\$20,184.06	0.7408
377 POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	\$20,184.06	1.4350
378 ECTOPIC PREGNANCY	\$20,184.06	1.3542
379 THREATENED ABORTION	\$20,184.06	0.7743
380 ABORTION W/O D&C	\$20,184.06	0.7584
381 ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	\$20,184.06	1.0604
382 FALSE LABOR	\$20,184.06	0.5475
383 OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	\$20,184.06	0.6420
384 OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	\$20,184.06	0.7382
391 NORMAL NEWBORN	\$20,184.06	0.3113
392 SPLENECTOMY AGE >17	\$20,184.06	2.0784
393 SPLENECTOMY AGE 0-17	\$20,184.06	2.0784
394 OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	\$20,184.06	2.0784
395 RED BLOOD CELL DISORDERS AGE >17	\$22,451.37	1.2974
396 RED BLOOD CELL DISORDERS AGE 0-17	\$26,481.29	0.8955
397 COAGULATION DISORDERS	\$26,019.43	1.4898
398 RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	\$20,184.06	1.4906
399 RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	\$20,184.06	0.7090
400 LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	\$28,935.87	2.6931
401 LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	\$28,935.87	2.6931
402 LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	\$28,935.87	2.6931
403 LYMPHOMA & NON-ACUTE LEUKEMIA W CC	\$43,255.29	2.4971
404 LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	\$28,935.87	2.6931
405 ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	\$28,935.87	2.6931
406 MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	\$28,935.87	2.6931
407 MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/OC	\$28,935.87	2.6931
408 MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	\$28,935.87	2.6931
409 RADIOTHERAPY	\$28,935.87	2.6931
410 CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	\$20,184.06	1.6163
411 HISTORY OF MALIGNANCY W/O ENDOSCOPY	\$28,935.87	2.6931
412 HISTORY OF MALIGNANCY W ENDOSCOPY	\$28,935.87	2.6931
413 OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	\$28,935.87	2.6931
414 OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	\$28,935.87	2.6931
415 O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	\$69,817.77	4.8915
416 SEPTICEMIA AGE >17	\$29,426.16	2.1843

EXHIBIT C.1  
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
417 SEPTICEMIA AGE 0-17	\$20,184.06	0.8200
418 POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	\$20,184.06	1,1284
419 FEVER OF UNKNOWN ORIGIN AGE >17 W CC	\$20,184.06	1.2345
420 FEVER OF UNKNOWN ORIGIN AGE »17 W/O CC	\$20,184.06	1.3211
421 VIRAL ILLNESS AGE >17	\$20,184.06	0.9821
422 VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	\$20,184.06	0.5818
423 OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	\$20,184.06	.1.3211
424 O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	\$20,184.06	1.7737
425 ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTIO	\$20,184.06	0.8558
426 DEPRESSIVE NEUROSES	\$20,184.06	0.5772
427 NEUROSES EXCEPT DEPRESSIVE	\$20,184.06	0.5856
428 DISORDERS OF PERSONALITY & IMPULSE CONTROL	\$20,184.06	0.7563
429 ORGANIC DISTURBANCES & MENTAL RETARDATION	\$20,758.55	1.0048
430 PSYCHOSES	\$20,184.06	0.7590
431 CHILDHOOD MENTAL DISORDERS	\$20,184.06	0.7855
432 OTHER MENTAL DISORDER DIAGNOSES	\$20,184.06	1.7737
433 ALCOHOU DRUG ABUSE OR DEPENDENCE, LEFT AMA	\$20,184.06	0.5653
434 ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W CC	\$20,184.06	0.9478
436 ALC/DRUG DEPENDENCE W REHABILITATION THERAPY	\$20,184.06	0.5653
437 ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY	\$20,184.06	0.5653
439 SKIN GRAFTS FOR INJURIES	\$20,184.06	1.4422
440 WOUND DEBRIDEMENTS FOR INJURIES	\$20,184.06	1.4422
441 HAND PROCEDURES FOR INJURIES	\$20,184.06	1.4422
442 OTHER O.R. PROCEDURES FOR INJURIES W CC	\$20,184.06	1.4422
443 OTHER O.R. PROCEDURES FOR INJURIES W/O CC	\$20,184.06	1.4422
444 TRAUMATIC INJURY AGE >17 W CC	\$20,184.06	1.4422
445 TRAUMATIC INJURY AGE >17 W/O CC	\$20,184.06	1.4422
446 TRAUMATIC INJURY AGE 0-17	\$20,184.06	1.4422
447 ALLERGIC REACTIONS AGE >17	\$20,184.06	1.4422
448 ALLERGIC REACTIONS AGE 0-17	\$20,184.06	1.4422
449 POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	\$20,184.06	1.2205
450 POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	\$20,184.06	0.6900
451 POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	\$20,184.06	0.6794
452 COMPLICATIONS OF TREATMENT W CC	\$20,184.06	1.4422
453 COMPLICATIONS OF TREATMENT W/O CC	\$20,184.06	1.4422
454 OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	\$20,184.06	1.4422
455 OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	\$20,184.06	1.4422
456 BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	\$25,714.73	2.7891
457 EXTENSIVE BURNS W/O O.R. PROCEDURE	\$25,714.73	2.7891
458 NON-EXTENSIVE BURNS W SKIN GRAFT	\$25,714.73	2.7891
459 NON-EXTENSIVE BURNS W WOUND DEBRIDEMENT OR OTHER O.R. PROC	\$25,714.73	2.7891
460 NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	\$20,184.06	0.9266
461 O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	\$20,184.06	1.0507
462 REHABILITATION	\$20,184.06	1.0507
463 SIGNS & SYMPTOMS W CC	\$20,184.06	1.1670

EXHIBIT C.1  
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

CHAMPUS DRG V15.0	Outlier Threshold	Relative Weight
464 SIGNS & SYMPTOMS W/O CC	\$20,184.06	1.0507
465 AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	\$20,184.06	1.0507
466 AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	\$20,184.06	1.0507
467 OTHER FACTORS INFLUENCING HEALTH STATUS	\$20,184.06	0.5626
468 EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	\$80,629.31	4.6159
469 PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	\$0.00	0.0000
470 UNGROUPABLE	\$0.00	0.0000
471 BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	\$20,184.06	1.4485
472 EXTENSIVE BURNS W O.R. PROCEDURE	\$25,714.73	2.7891
473 ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	\$28,935.87	2.6931
475 RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	\$94,403.18	6.5415
476 PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	\$122,705.06	17.6221
477 NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	\$49,385.67	2.6508
478 OTHER VASCULAR PROCEDURES W CC	\$39,172.80	3.5051
479 OTHER VASCULAR PROCEDURES W/O CC	\$22,812.11	2.4340
480 LIVER TRANSPLANT	\$122,705.06	17.6221
481 BONE MARROW TRANSPLANT	\$122,705.06	17.6221
482 TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES	\$72,582.56	6.1506
483 TRACHEOSTOMY EXCEPT FOR FACE, MOUTH & NECK DIAGNOSES	\$350,066.39	28.2892
484 CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	\$54,816.16	7.8370
485 LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICA	\$54,816.16	7.8370
486 OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	\$105,421.92	8.0937
487 OTHER MULTIPLE SIGNIFICANT TRAUMA	\$76,041.04	4.7193
488 HIV W EXTENSIVE O.R. PROCEDURE	\$32,707.96	5.0614
489 HIV W MAJOR RELATED CONDITION	\$30,733.50	1.9373
490 HIV W OR W/O OTHER RELATED CONDITION	\$20,184.06	1.3451
491 MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMIT	\$20,184.06	2.5348
492 CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	\$20,184.06	1.3222
493 LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	\$32,574.73	2.4226
494 LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	\$20,184.06	1.8354
495 LUNG TRANSPLANT	\$122,705.06	17.6221
496 COMBINED ANERIOR/POSTERIOR SPINAL FUSION	\$20,184.06	1.4485
497 SPINAL FUSION W CC	\$36,012.23	3.9098
498 SPINAL FUSION W/O CC	\$26,957.14	2.7781
499 BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	\$27,201.74	2.2196
500 BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	\$20,184.06	1.5310
501 KNEE PROCEDURES W PDX OF INJECTION W CC	\$20,184.06	1.4485
502 KNEE PROCEDURES W/O PDX OF INJECTION W CC	\$20,184.06	1.4485
503 KNEE PROCEDURES W/O PDX OF INJECTION	\$20,184.06	1.8229
600 NEONATE, DIED W/IN ONE DAY OF BIRTH	\$45,842.85	2.7771
601 NEONATE, TRANSFERRED <5 DAYS OLD	\$45,842.85	2.7771
602 NEONATE, BIRTHWT <750G, DISCHARGED ALIVE	\$294,222.93	33.4792
603 NEONATE, BIRTHWT <750G, DIED	\$45,842.85	2.7771
604 NEONATE, BIRTHWT 750-999G, DISCHARGED ALIVE	\$227,166.35	23.2690
605 NEONATE, BIRTHWT 750-999G, DIED	\$45,842.85	2.7771

State: GeorgiaEXHIBIT C.1  
OUTLIER THRESHOLDS AND RELATIVE WEIGHTS

	Outlier Threshold	Relative Weight
CHAMPUS DRG V15.0		
606 NEONATE, BIRTHWT 1000-1499G, W SIGNIF OR PROC, DISCHARGED AL	\$45,842.85	2.7771
607 NEONATE, BIRTHWT 1000-1499G, W/O SIGNIF OR PROC, DISCHARGED	\$83,622.83	9.1723
608 NEONATE, BIRTHWT 1000-1499G, DIED	\$45,842.85	2.7771
609 NEONATE, BIRTHWT 1500-1999G, W SIGNIF OR PROC, W MULT MAJOR	\$45,842.85	2.7771
610 NEONATE, BIRTHWT 1500-1999G, W SIGNIF OR PROC, W/O MULT MAJO	\$45,842.85	2.7771
611 NEONATE, BIRTHWT 1500-1999G, W/O SIGNIF OR PROC, W MULT MAJO	\$65,956.78	5.9042
612 NEONATE, BIRTHWT 1500-1999G, W/O SIGNIF OR PROC, W MAJOR PRO	\$34,542.84	3.2809
613 NEONATE, BIRTHWT 1500-1999G, W/O SIGNIF OR PROC, W MINOR PRO	\$36,176.70	3.0819
614 NEONATE, BIRTHWT 1500-1999G, W/O SIGNIF OR PROC, W OTHER PRO	\$20,184.06	1.4459
615 NEONATE, BIRTHWT 2000-2499G, W SIGNIF OR PROC, W MULT MAJOR	\$45,842.85	2.7771
616 NEONATE, BIRTHWT 2000-2499G, W SIGNIF OR PROC, W/O MULT MAJO	\$45,842.85	2.7771
617 NEONATE, BIRTHWT 2000-2499G, W/O SIGNIF OR PROC, W MULT MAJO	\$45,842.85	2.7771
618 NEONATE, BIRTHWT 2000-2499G, W/O SIGNIF OR PROC, W MAJOR PRO	\$27,021.73	2.2471
619 NEONATE, BIRTHWT 2000-2499G, W/O SIGNIF OR PROC, W MINOR PRO	\$21,309.04	1.6406
621 NEONATE, BIRTHWT 2000-2499G, W/O SIGNIF OR PROC, W OTHER PRO	\$20,184.06	0.8152
622 NEONATE, BIRTHWT >2499G, W SIGNIF OR PROC, W MULT MAJOR PROB	\$238,491.52	14.9230
623 NEONATE, BIRTHWT >2499G, W SIGNIF OR PROC, W/O MULT MAJOR PR	\$45,842.85	2.7771
624 NEONATE, BIRTHWT >2499G, W MINOR ABDOM PROCEDURE	\$45,842.85	2.7771
626 NEONATE, BIRTHWT >2499G, W/O SIGNIF OR PROC, W MULT MAJOR PR	\$89,270.70	3.1168
627 NEONATE, BIRTHWT >2499G, W/O SIGNIF OR PROC, W MAJOR PROB	\$21,726.34	1.3444
628 NEONATE, BIRTHWT >2499G, W/O SIGNIF OR PROC, W MINOR PROB	\$20,184.06	0.8309
630 NEONATE, BIRTHWT >2499G, W/O SIGNIF OR PROC, W OTHER PROB	\$20,184.06	0.6062
631 BPD AND OTH CHRONIC RESPIRATORY DISEASES ARISING IN PERINATA	\$29,180.85	1.4834
632 OTHER RESPIRATORY PROBLEMS AFTER BIRTH	\$29,180.85	1.4834
633 MULTIPLE, OTHER AND UNSPECIFIED CONGENITAL ANOMALIES, W CC	\$20,184.06	1.0507
634 MULTIPLE, OTHER AND UNSPECIFIED CONGENITAL ANOMALIES, W/O CC	\$20,184.06	1.0507
635 NEONATAL AFTERCARE FOR WEIGHT GAIN	\$45,842.85	2.7771
636 NEONATAL DIAGNOSIS, AGE > 28 DAYS	\$45,842.85	2.7771
900 ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT AGE <= 21	\$20,184.06	0.6124
901 ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT AGE > 21	\$20,184.06	0.6186

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Supersedes

TN No: NewApproval Date 02/28/07Effective Date: 01/01/07



State: Georgia

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –  
INPATIENT PSYCHIATRIC FACILITY SERVICES  
(PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES)

Y. Inpatient Psychiatric Facility Services (Psychiatric Residential Treatment Facility)

Effective January 1, 2007, Psychiatric Residential Treatment Facilities (PRTFs) will be reimbursed at provider specific prospective rate:

- PRTF per diem rates are based on allowable costs and patient days as reported on the provider's Fiscal Year 2005 cost reports filed with the Department of Community Health.
- PRTF per diem rates from the FY 2005 cost reports will be trended for inflation to January 1, 2007 based on the CMS Hospital Market Basket (Global Insight's Health Care Cost Service, Second Quarter 2006 Forecast, and Table 6.3).
- PRTF rates will be subject to a maximum capped amount of \$299.80 based on the current rate paid to the Therapeutic Residential Intervention Services (TRIS) Level 6 providers for treatment and room and board
- Rates for new PRTF providers are set at the median total allowable costs as determined from the FY 2005 cost reports and trended for inflation to January 1, 2007 based on the CMS Hospital Market Basket (Global Insight's Health Care Cost Service, Second Quarter 2006 Forecast, and Table 6.3).
- Upon notice of the provider-specific per diem rate, providers will have 30 days to appeal their new rates, based on the submission of an amended cost report for Fiscal Year 2005.

Cost information will be submitted annually using a uniform cost report form prescribed by the Department and supported by the facility's most recent certified financial audit.

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

A. Ambulance Services

Payment for covered services shall not exceed the lower of:

- (a) The provider's submitted charge; or
- (b) The statewide maximum allowable rate in effect on the date of service.

The maximum allowable amount is derived from Medicare's maximum allowable reimbursement rates for non-hospital based ambulance services. The maximum rates are 90% of the CY2002 Medicare fee schedule for Locality 01 for Medicaid-covered procedure codes in the Emergency Ambulance Services (EAS) program. Fee schedule rates for public and private providers of ambulance services are the same and the state does not subdivide or sub classify its payment rates based on whether the provider is a public or private entity/provider. Annual or periodic adjustments will be made and such adjustments will be reflected in the fee schedule that is made available to the providers and public.

B. Emergency Air Ambulance

Emergency air ambulance covered services consist of fixed wing air ambulance and rotary wing air ambulance. The reimbursement rate for fixed wing air ambulance is determined by obtaining three estimates from Air Ambulance providers who provide fixed wing transports. These estimates include the base rate plus loaded mileage which will equal the cost to provide the transport. The three estimates are compared to the transportation provider's submitted charge. Payment for covered services will be the lower of the three estimates or the provider's submitted charge.

The reimbursement rate for rotary wing is determined by obtaining three estimates from Air Ambulance providers who provide rotary wing transport. These estimates include the base rate plus loaded mileage plus \$750 which equals the cost to provide the transport. (The \$750 payment is included as the cost for all medical personnel when a critical care flight is approved). The three estimates are compared to the transportation provider's submitted charge. Payment for covered services will be the lower of the three estimates or the provider's submitted charge.

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**(ii). Rotary Wing**

The reimbursement rate for rotary wing is determined by comparing the following pre-determined rates and choosing the lessor:

1. Providers submitted charges
2. Loaded miles x \$16.00 = sum + \$2,573.00
3. \$3,300 fixed rate

Loaded miles are defined as the mileage incurred from the pickup of an eligible member to the member's arrival at the destination. Unloaded trips and mileage are not reimbursable. The rates stated above include the base rate plus loaded mileage which equals the cost to provide the transportation.

**Telemedicine Based Services**

- A. Originating Sites (HCPCS Q3014): Originating site means the location of an eligible Medicaid beneficiary at the time the service being furnished via a telecommunications system occurs. Originating sites are reimbursed at 84.645% of the 2012 Medicare fee schedule.
- B. Distant Site Practitioners: Distant site means the site at which the physician or practitioner delivering the service is located at the time the service is provided via a telecommunications system. Distant Site Practitioners shall be reimbursed according to the same methodology as if the visit occurred in person. Ambulances are not authorized to provide distant site services.

**Effective Date Fee Schedule language:**

“Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of telemedicine emergency ambulance. The agency's fee schedule rate was set as of April 22, 2016 and is effective for services provided on or after that date. All rates are published on the Georgia MMIS website, <https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Fee%20Schedules/tabId/56/Default.aspx>.

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

B. Services Provided

a. Family Planning Services

84.645% of the January 1, 2000 Medicare fee schedule is being used as the statewide maximum allowable amount for initial, annual, and follow-up family planning visits using covered CPT codes (99211 through 99215 and 99204). Reimbursement rates for contraceptive supplies, including intrauterine devices and hormonal implants, are the lesser of the provider's usual and customary charge; the average sales price plus 6% as defined January 1<sup>st</sup> of each year or average sales price plus 6% upon the drug's initial availability in the marketplace whichever is later; or average wholesale price minus 11% for drugs that do not have an average sales price until such time the average sales price plus 6% pricing becomes available. Reimbursement rates for clinical laboratory and anatomical pathology services are the lesser of the laboratory's usual and customary charge or the statewide maximum allowable amount. There is no cost settlement.

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TN No.: 07-004

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

### **C. Community Behavioral Health Rehabilitation Services**

Effective for services provided on or after July 1, 2009, providers of Community Behavioral Health Rehabilitation Services (CBHRS) will be reimbursed at fee for service rates based on:

- Practitioner type;
- Service costs (salaries, fringe benefits, allocable direct and appropriate indirect costs);
- Location of services (in-clinic and out-of-clinic) and productivity factors;

State-developed fee schedule rates are the same for both governmental and private providers of all community mental health services. The fee schedule and any annual/periodic adjustments to the fee schedule are published in provider correspondence and policy manuals available at <https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabid/54/Default.aspx>.

CBHRS are primarily billed and rated for reimbursement utilizing the most discreet procedure code. Some services and the associated treatment modalities, however, are more appropriately clinically correlated to the most comprehensive procedure code. Utilizing a comprehensive code in effect bundles a set of discreet codes. CBHRS that bundle a set of codes in this way are: Substance Abuse/Addictive Disease Intensive Outpatient Services, Crisis Stabilization Unit Services, and Assertive Community Treatment. As an example, the discreet codes representing each of the following services when billed independently including Behavioral Health Assessment & Service Plan Development, Diagnostic Assessment, Psychiatric Treatment, Nursing Assessment & Care, Community Support, Individual Outpatient Services, Group Outpatient Services, and Family Outpatient Services are combined to represent a program service such as Substance Abuse Intensive Outpatient Services and billed at an hourly rate under a single comprehensive code.

Detail on each of the factors involved in the CBHRS reimbursement methodology is described below (practitioner type, service costs (direct and indirect) and including location of service delivery and productivity rates). The fee schedule for Community Behavioral Health Rehabilitation Services as reflected in the policy manual is grouped

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by service type to correspond with the section 3.1-A of the Georgia Medicaid Plan. In addition, provider qualifications are detailed in section 3.1-A.

#### Practitioner Type

Practitioner types are grouped into levels consistent with specific credentials and ranges of salaries. Salary data was derived from the May 2007 Occupational Employment and Wage Estimates for Georgia from the United States Department of Labor's Bureau of Labor Statistics and revalidated using the 2010 Standard Occupational Classification System. The Practitioner Types are generally classified below by the following levels:

- Level 1: Physician, Psychiatrist
- Level 2: Licensed Practitioners of healthcare and behavioral health (highly trained and specialized [or specialty skilled] salary scale): Includes practitioners such as Psychologists, Physician's Assistants, Nurse Practitioners, Clinical Nurse Specialists/PMHs, Pharmacists
- Level 3: Licensed/Certified Practitioners of healthcare and behavioral health (highly trained and skilled salary scale): Includes practitioners such as Registered Nurse, Licensed Dietician, Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Certified/Registered Addictions Counselor-II
- Level 4: Associate Licensed and other Certified Practitioner (significantly trained and skilled salary scale): including Licensed Practical Nurse (LPN); Licensed Associate Professional Counselor (LAPC); Licensed Master's Social Worker (LMSW); Licensed Associate And Family Therapist (LAMFT); Certified/Registered Addictions Counselor), Certified Peer Specialist, Trained Paraprofessional or Certified Psychiatric Rehabilitation Professional (CPRP) with Bachelor's degree or higher in the social sciences/helping professions
- Level 5: Non-Licensed, Non-degreed and Trained Paraprofessionals (moderately trained and skilled salary scale): including practitioners such as Certified/Registered Addiction Counselor (CAC-I or Registered Alcohol and Drug Technician), Certified Peer Specialist, Certified Psychiatric Rehabilitation Professional, and Qualified Medication Aide

#### Service Costs

Service costs include practitioner salaries, fringe benefits, allocable direct and appropriate indirect costs and were calculated as follows:

#### *Salaries and Fringe Benefits*

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Using the annual salaries of the practitioners that were included within a level (data source described above), a median salary was calculated for each band. Salaries are increased by 41.71% to account for employee fringe benefits.

*Allocable Direct and Appropriate Indirect Costs*

The Community Behavioral Health Rehabilitation Services rates also take into account costs that are directly allocable to individual practitioners and indirectly allocable to the enrolled facilities/agencies for which the individual practitioners are employed.

Allocable direct costs include those costs which are critical to the practitioner in providing treatment services to the individual. These costs include:

- Program clinical supervisors and support staff
- Staff training costs
- Staff mileage and vehicle costs
- Telephone costs
- Office supplies
- Computer costs
- Office space allocated to staff providing MRO services
- Liability/malpractice insurance

Indirect costs include:

- Management personnel costs (CEO, Medical Director, CFO)
- Support staff personnel costs such as human resources, payroll, quality improvement/accreditation, procurement, billing, accounting, information system technicians
- Management information system costs such as billing and general ledger accounting systems
- Occupancy costs not directly allocated to programs
- Professional costs such as audits and legal fees.

CBHRS FFP is not available for:

- a. room and board services;
- b. educational, vocational and job training services;
- c. habilitation services;
- d. services to inmates in public institutions as defined in 42 CFR §435.1010;
- e. services to individuals residing in institutions for mental diseases as described in 42 CFR §435.1010 (except in situations in which an individual in an IMD for psychiatric treatment and stabilization needs transition and planning support from a CBHRS-enrolled provider prior to the planned and documented discharge);
- f. recreational and social activities, or
- g. services that must be covered elsewhere in the state Medicaid plan.

Based on data received through surveys of a large sample of agencies currently providing Community Behavioral Health Rehabilitation Services in multiple states, average allocable direct and indirect cost factors were calculated as a percentage of direct personnel costs. These costs were then calculated for each service and for each applicable practitioner level. All of these cost components were summed to yield an annual cost for the service for the particular practitioner level. Due to the large difference between the median annual salaries in Level 1 (physicians/psychiatrists) and the other levels, it was necessary to adjust the support and administrative factors applied to the highest level versus the other levels so that the support and administrative costs associated with the highest levels were not over-inflated. This was accomplished by adjusting the direct and indirect cost factors according to the proportion of personnel costs in an average agency accounted for by the top level versus the other four practitioner levels. The overall direct services cost factor is 39% and indirect is 15%. Once the factors were adjusted to account for the disparity between physician salaries and the other levels the cost factors became 19% for direct costs and 7% for indirect costs for Level 1 and 45% for direct costs and 17% indirect costs for the remaining four levels.

Once the total cost of a service for a practitioner at a particular level was calculated, the cost was distributed to billable time for staff providing CBHRS in the following manner:

- Total hours were reduced by the average paid time off for vacation, holiday and sick time to yield available time per practitioner per year.
- Productivity factors were established based on the CBHRS requirements for the service: national and state experience with the amount of billable time that can be expected over the course of an average week or month; consideration of travel time required for a community-based service in a large, rural state; time associated with missed appointments; and staff time required for chart documentation, record-keeping, supervision, training, meetings and other administrative activities.

*Location of Services (In-Clinic and Out-of-Clinic) and Associated Productivity Factors*

Except as noted below, for services provided in clinic locations the targeted productivity is 60-70% of available hours depending on the service and practitioner. Productivity factors were set at 70% for in-clinic services provided by physicians and for all medication administration services and 60% for most other in-clinic services. Except as noted otherwise below for out-of-clinic services, the productivity time was 45-55% of available hours, with physician and medication administration services calculated using the 55% factor and most other out-of-clinic service rates calculated using the 50% factor. In addition, the following adjustments were made: productivity factors were reduced by 5% for services provided in a group setting to account for additional documentation time; productivity for Level 3 professionals for most services was also reduced by 5% to account for the required supervisory responsibilities of these



licensed staff (e.g. RNs, LPCs, LCSWs) that reduce the amount of time available for direct billable services; productivity for Intensive Family Intervention team members was set at 45% to account for additional time required for team meetings and contacts in which two team members are providing services in conjunction but only one is billing. Available hours times (x) the productivity factor yields (=) billable hours for each service for each practitioner level/band, and the total program costs (salary, fringe, direct and indirect costs) are then divided by billable time to arrive at a unit rate.

*Program-Specific Costs*

With respect to Assertive Community Treatment, the State Mental Health Agency, as designated by law and on behalf of the State Medicaid agency, will require that the entity furnish to the Medicaid agency on an annual basis the following:

- a. data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate; and
- b. cost information by practitioner type and by type of service actually delivered within the service unit.

The Medicaid Agency will base future rates on information obtained from the providers.

With respect to Community Living Supports (CLS), there are four intensity levels of service delivery. No rate includes any room and/or board. Rates use the detail stated earlier in this document specific to Practitioner Costs and Service Costs as a base and then are calculated on the assumptions below to create units for each level:

- **CLS Level I** is intensive and provides 24/7/365 awake staff support generally in a licensed community-living setting (in no case exceeding 16 beds). In order to directly support the individual, there will be a minimum of five hours weekly of skills training, community integration activities, and/or personal services provided to the person if indicated on the individual supports plan. This skills training is provided by one or more Community Living Supports specialists who may be practitioner Level 3, 4 or 5.
- **CLS Level II** is intensive and provides 24/7/365 staff support generally in a licensed community-living setting (in no case exceeding 16 beds). In order to directly support the individual, there will be a minimum of five hours weekly of skills training, community integration activities, and/or personal services provided to the person if indicated on the individual supports plan. This skills training is

provided by one or more Community Living Supports specialists who may be practitioner Level 3, 4 or 5.

- **CLS Level III** is semi-independent support which provides 36 hours per Week staff support generally in a licensed community-living setting (in no case exceeding 16 beds). In order to directly support the individual, there will be a minimum of three hours per week of skills training, community integration activities, and/or personal services provided to the person if indicated on the individual supports plan. This skills training is provided by one or more Community Living Supports specialists who may be practitioner Level 4 or 5.
- **CLS IV** is support to provide a minimum of one face-to-face contact and an average of 10 15-minute units per week of skills training, community integration activities, and/or personal services provided to the person as indicated on the individual supports plan. A Community Living Supports specialist is a practitioner Level 5 operating on 65% productivity and is on call and available to individuals 24/7/365

Description	Procedure Code	Unit	Rate	Max Units per Day.
Practitioner Level 3, Via interactive audio and video telecommunication systems, Child Program	90802 GT HA U3	1 episode	\$ 90.03	2
<b>Psychological Testing - Psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology e.g. MMP, Rorschach, WAIS (per hour of psychologist's or physician's time, both face-to-face with the patient and time interpreting test results and preparing the report)</b>				
Practitioner Level 2, In-Clinic	96101 U2 U6	1 hour	\$ 155.87	5
Practitioner Level 2, Out-of-Clinic	96101 U2 U7	1 hour	\$ 187.04	5
<b>Psychological Testing - Psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology e.g. MMP, Rorschach, WAIS) with qualified healthcare professional interpretation and report, administered by technician, per hour of technician time, face-to-face</b>				
Practitioner Level 3, In-Clinic	96102 U3 U6	1 hour	\$ 120.04	5
Practitioner Level 3, Out-of-Clinic	96102 U3 U7	1 hour	\$ 146.71	5
Practitioner Level 4, In-Clinic	96102 U4 U6	1 hour	\$ 81.18	5
Practitioner Level 4, Out-of-Clinic	96102 U4 U7	1 hour	\$ 97.42	5
<b>Service Area = Crisis Intervention Services</b>				
<b>Crisis Intervention Services</b>				
Practitioner Level 1, In-Clinic	H2011 U1 U6	15 minutes	\$ 58.21	48
Practitioner Level 2, In-Clinic	H2011 U2 U6	15 minutes	\$ 38.97	48
Practitioner Level 3, In-Clinic	H2011 U3 U6	15 minutes	\$ 30.01	48
Practitioner Level 4, In-Clinic	H2011 U4 U6	15 minutes	\$ 20.30	48
Practitioner Level 5, In-Clinic	H2011 U5 U6	15 minutes	\$ 15.13	48
Practitioner Level 1, Out-of-Clinic	H2011 U1 U7	15 minutes	\$ 74.09	48
Practitioner Level 2, Out-of-Clinic	H2011 U2 U7	15 minutes	\$ 46.76	48
Practitioner Level 3, Out-of-Clinic	H2011 U3 U7	15 minutes	\$ 36.68	48
Practitioner Level 4, Out-of-Clinic	H2011 U4 U7	15 minutes	\$ 24.36	48
Practitioner Level 5, Out-of-Clinic	H2011 U5 U7	15 minutes	\$ 18.15	48
<b>Service Area = Psychiatric Treatment</b>				
<b>Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately 20-30 minutes face-to-face with patient with medical evaluation and management services.</b>				
Practitioner Level 1, In-Clinic	90805 U1 U6	20-30 minutes	\$ 97.02	1
Practitioner Level 1, in-Clinic, Child Program	90805 HA U1 U6	20-30 minutes	\$ 97.02	1
Practitioner Level 1, Out-of-Clinic	90805 U1 U7	20-30 minutes	\$ 123.48	1
Practitioner Level 1, Out-of-Clinic, Child Program	90805 HA U1 U7	20-30 minutes	\$ 123.48	1
Practitioner Level 2, In-Clinic	90805 U2 U6	20-30 minutes	\$ 64.95	1
Practitioner Level 2, in-Clinic, Child Program	90805 HA U2 U6	20-30 minutes	\$ 64.95	1
Practitioner Level 2, Out-of-Clinic	90805 U2 U7	20-30 minutes	\$ 77.93	1

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Description	Procedure Code	Unit	Rate	Max Units per Day.
Practitioner Level 2, Out-of-Clinic, Child Program	90805 HA U2 U7	20-30 minutes	\$ 77.93	1
<b>Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately 45-50 minutes face-to-face with patient with medical evaluation and management services.</b>				
Practitioner Level 1, In-Clinic	90807 U1 U6	45-50 minutes	\$ 174.63	1
Practitioner Level 1, In-Clinic, Child Program	90807 HA U1 U6	45-50 minutes	\$ 174.63	1
Practitioner Level 1, Out-of-Clinic	90807 U1 U7	45-50 minutes	\$ 222.26	1
Practitioner Level 1, Out-of-Clinic, Child Program	90807 HA U1 U7	45-50 minutes	\$ 222.26	1
Practitioner Level 2, In-Clinic	90807 U2 U6	45-50 minutes	\$ 116.90	1
Practitioner Level 2, In-Clinic, Child Program	90807 HA U2 U6	45-50 minutes	\$ 116.90	1
Practitioner Level 2, Out-of-Clinic	90807 U2 U7	45-50 minutes	\$ 140.28	1
Practitioner Level 2, Out-of-Clinic, Child Program	90807 HA U2 U7	45-50 minutes	\$ 140.28	1
<b>Pharmacological Management</b>				
Practitioner Level 1, In-Clinic	90862 U1 U6	1 episode	\$ 58.21	1
Practitioner Level 1, In-Clinic, Child Program	90862 HA U1 U6	1 episode	\$ 58.21	1
Practitioner Level 1, Via interactive audio and video telecommunication systems	90862 GT U1	1 episode	\$ 58.21	1
Practitioner Level 1, Via interactive audio and video telecommunication systems, Child Program	90862 GT HA U1	1 episode	\$ 58.21	1
Practitioner Level 1, Out-of-Clinic	90862 U1 U7	1 episode	\$ 74.09	1
Practitioner Level 1, Out-of-Clinic, Child Program	90862 HA U1 U7	1 episode	\$ 74.09	1
Practitioner Level 2, In-Clinic	90862 U2 U6	1 episode	\$ 38.97	1
Practitioner Level 2, In-Clinic, Child Program	90862 HA U2 U6	1 episode	\$ 38.97	1
Practitioner Level 2, Via interactive audio and video telecommunication systems	90862 GT U2	1 episode	\$ 38.97	1
Practitioner Level 2, Via interactive audio and video telecommunication systems, Child Program	90862 GT HA U2	1 episode	\$ 38.97	1
Practitioner Level 2, Out-of-Clinic	90862 U2 U7	1 episode	\$ 46.76	1
Practitioner Level 2, Out-of-Clinic, Child Program	90862 HA U2 U7	1 episode	\$ 46.76	1
<b>Service Area = Nursing Assessment and Care</b>				
Practitioner Level 2, In-Clinic	T1001 U2 U6	15 Minutes	\$ 38.97	16
Practitioner Level 3, In-Clinic	T1001 U3 U6	15 Minutes	\$ 30.01	16
Practitioner Level 4, In-Clinic	T1001 U4 U6	15 Minutes	\$ 20.30	16
Practitioner Level 2, Out-of-Clinic	T1001 U2 U7	15 Minutes	\$ 46.76	16

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Description	Procedure Code	Unit	Rate	Max Units per Day.
Practitioner Level 3, Out-of-Clinic	T1001 U3 U7	15 Minutes	\$ 36.68	16
Practitioner Level 4, Out-of-Clinic	T1001 U4 U7	15 Minutes	\$ 24.36	16
<b>RN Services, up to 15 minutes</b>				
Practitioner Level 2, In-Clinic	T1002 U2 U6	15 Minutes	\$ 38.97	16
Practitioner Level 3, In-Clinic	T1002 U3 U6	15 Minutes	\$ 30.01	16
Practitioner Level 2, Out-of-Clinic	T1002 U2 U7	15 Minutes	\$ 46.76	16
Practitioner Level 3, Out-of-Clinic	T1002 U3 U7	15 Minutes	\$ 36.68	16
<b>LPN/LVN Services, up to 15 minutes</b>				
Practitioner Level 4, in-Clinic	T1003 U4 U6	15 Minutes	\$ 20.30	16
Practitioner Level 4, Out-of-Clinic	T1003 U4 U7	15 Minutes	\$ 24.36	16
<b>Health and Behavior Assessment, Face-to-Face with the Patient, Initial Assessment</b>				
Practitioner Level 2, in-Clinic	96150 U2 U6	15 Minutes	\$ 38.97	16
Practitioner Level 3, in-Clinic	96150 U3 U6	15 Minutes	\$ 30.01	16
Practitioner Level 4, In-Clinic	96150 U4 U6	15 Minutes	\$ 20.30	16
Practitioner Level 2, Out-of-Clinic	96150 U2 U7	15 Minutes	\$ 46.76	16
Practitioner Level 3, Out-of-Clinic	96150 U3 U7	15 Minutes	\$ 36.68	16
Practitioner Level 4, Out-of-Clinic	96150 U4 U7	15 Minutes	\$ 24.36	16
<b>Health and Behavior Assessment, Face-to-Face with the Patient, Reassessment</b>				
Practitioner Level 2, in-Clinic	96151 U2 U6	15 Minutes	\$ 38.97	16
Practitioner Level 3, In-Clinic	96151 U3 U6	15 Minutes	\$ 30.01	16
Practitioner Level 4, In-Clinic	96151 U4 U6	15 Minutes	\$ 20.30	16
Practitioner Level 2, Out-of-Clinic	96151 U2 U7	15 Minutes	\$ 46.76	16
Practitioner Level 3, Out-of-Clinic	96151 U3 U7	15 Minutes	\$ 36.68	16
Practitioner Level 4, Out-of-Clinic	96151 U4 U7	15 Minutes	\$ 24.36	16
<b>Health and Wellness Supports (Behavioral Health Prevention Education Service Delivery of Services With Target Population To Affect Knowledge, Attitude And/Or Behavior)</b>				
Practitioner Level 2, In-Clinic	96151 U2 U6	15 Minutes	\$ 38.97	16
Practitioner Level 3, In-Clinic	H0025 U3 U6	15 Minutes	\$ 30.01	6
Practitioner Level 4, In-Clinic	96151 U4 U6	15 Minutes	\$ 20.30	16
Practitioner Level 2, Out-of-Clinic	96151 U2 U7	15 Minutes	\$ 46.76	16
Practitioner Level 3, Out-of-Clinic	H0025 U3 U7	15 Minutes	\$ 36.68	6
Service Area = Detoxification Services				
<b>Alcohol and/or drug services, Ambulatory Detoxification</b>				
Practitioner Level 2, In-Clinic	H0014 U2 U6	15 Minutes	\$ 38.97	32
Practitioner Level 3, in-Clinic	H0014 U3 U6	15 Minutes	\$ 30.01	32
Practitioner Level 4, In-Clinic	H0014 U4 U6	15 Minutes	\$ 20.30	32
<b>Alcohol and/or drug services; Sub-acute Detoxification (Residential Addiction Program Outpatient)</b>				
Level I	H0012 TF	1 day	\$ 31.34	1

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Description	Procedure Code	Unit	Rate	Max Units per Day.
Level II	H0012 TG	1 day	\$ 38.58	1
<b>Alcohol and/or drug services; Acute Detoxification (Residential Addiction Program Outpatient)</b>				
Level III	H0013	1 day	\$209.22	1
<b>Service Area = Individual Outpatient Services</b>				
<b>Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately 20-30 minutes face-to-face with patient</b>				
Practitioner Level 2, in-Clinic	90804 U2 U6	20-30 minutes	\$ 64.95	2
Practitioner Level 3, in-Clinic	90804 U3 U6	20-30 minutes	\$ 50.02	2
Practitioner Level 4, in-Clinic	90804 U4 U6	20-30 minutes	\$ 33.83	2
Practitioner Level 5, in-Clinic	90804 U5 U6	20-30 minutes	\$ 25.21	2
Practitioner Level 2, Out-of-Clinic	90804 U2 U7	20-30 minutes	\$ 77.93	2
Practitioner Level 3, Out-of-Clinic	90804 U3 U7	20-30 minutes	\$ 61.13	2
Practitioner Level 4, Out-of-Clinic	90804 U4 U7	20-30 minutes	\$ 40.59	2
Practitioner Level 5, Out-of-Clinic	90804 U5 U7	20-30 minutes	\$ 30.25	2
<b>Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately 45-50 minutes face-to-face with patient</b>				
Practitioner Level 2, In-Clinic	90806 U2 U6	45-50 minutes	\$ 116.90	2
Practitioner Level 3, In-Clinic	90806 U3 U6	45-50 minutes	\$ 90.03	2
Practitioner Level 4, in-Clinic	90806 U4 U6	45-50 minutes	\$ 60.89	2
Practitioner Level 5, In-Clinic	90806 U5 U6	45-50 minutes	\$ 45.38	2
Practitioner Level 2, Out-of-Clinic	90806 U2 U7	45-50 minutes	\$ 140.28	2
Practitioner Level 3, Out-of-Clinic	90806 U3 U7	45-50 minutes	\$ 110.04	2
Practitioner Level 4, Out-of-Clinic	90806 U4 U7	45-50 minutes	\$ 73.07	2
Practitioner Level 5, Out-of-Clinic	90806 U5 U7	45-50 minutes	\$ 54.46	2
<b>Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately 75-80 minutes face-to-face with patient</b>				

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Description	Procedure Code	Unit	Rate	Max Units per Day.
Practitioner Level 2, in-Clinic	90808 U2 U6	75-80 minutes	\$ 194.84	2
Practitioner Level 3, In-Clinic	90808 U3 U6	75-80 minutes	\$ 150.05	2
Practitioner Level 4, In-Clinic	90808 U4 U6	75-80 minutes	\$ 101.48	2
Practitioner Level 5, In-Clinic	90808 U5 U6	75-80 minutes	\$ 75.64	2
Practitioner Level 2, Out-of-Clinic	90808 U2 U7	75-80 minutes	\$ 233.80	2
Practitioner Level 3, Out-of-Clinic	90808 U3 U7	75-80 minutes	\$ 183.39	2
Practitioner Level 4, Out-of-Clinic	90808 U4 U7	75-80 minutes	\$ 121.78	2
Practitioner Level 5, Out-of-Clinic	90808 U5 U7	75-80 minutes	\$ 90.76	2
<b>Individual psychotherapy, interactive, using play equipment, physical devises, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately <u>20-30 minutes face-to-face with patient</u></b>				
Practitioner Level 2, in-Clinic	90810 U2 U6	20-30 minutes	\$ 64.95	2
Practitioner Level 3, in-Clinic	90810 U3 U6	20-30 minutes	\$ 50.02	2
Practitioner Level 4, in-Clinic	90810 U4 U6	20-30 minutes	\$ 33.83	2
Practitioner Level 5, In-Clinic	90810 U5 U6	20-30 minutes	\$ 25.21	2
Practitioner Level 2, Out-of-Clinic	90810 U2 U7	20-30 minutes	\$ 77.93	2
Practitioner Level 3, Out-of-Clinic	90810 U3 U7	20-30 minutes	\$ 61.13	2
Practitioner Level 4, Out-of-Clinic	90810 U4 U7	20-30 minutes	\$ 40.59	2
Practitioner Level 5, Out-of-Clinic	90810 U5 U7	20-30 minutes	\$ 30.25	2
<b>Individual psychotherapy, interactive, using play equipment, physical devises, language Interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately <u>45-50 minutes face-to-face with patient</u></b>				
Practitioner Level 2, In-Clinic	90812 U2 U6	45-50 minutes	\$ 116.90	2
Practitioner Level 3, In-Clinic	90812 U3 U6	45-50 minutes	\$ 90.03	2
Practitioner Level 4, In-Clinic	90812 U4 U6	45-50 minutes	\$ 60.89	2
Practitioner Level 5, In-Clinic	90812 U5 U6	45-50 minutes	\$ 45.38	2

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Description	Procedure Code	Unit	Rate	Max Units per Day.
Practitioner Level 2, Out-of-Clinic	90812 U2 U7	45-50 minutes	\$ 140.28	2
Practitioner Level 3, Out-of-Clinic	90812 U3 U7	45-50 minutes	\$ 110.04	2
Practitioner Level 4, Out-of-Clinic	90812 U4 U7	45-50 minutes	\$ 73.07	2
Practitioner Level 5, Out-of-Clinic	90812 U5 U7	45-50 minutes	\$ 54.46	2
<b>Individual psychotherapy, interactive, using play equipment, physical devises, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75-80 minutes face-to-face with patient</b>				
Practitioner Level 2, In-Clinic	90814 U2 U6	75-80 minutes	\$ 194.84	2
Practitioner Level 3, In-Clinic	90814 U3 U6	75-80 minutes	\$ 150.05	2
Practitioner Level 4, In-Clinic	90814 U4 U6	75-80 minutes	\$ 101.48	2
Practitioner Level 5, In-Clinic	90814 U5 U6	75-80 minutes	\$ 75.64	2
Practitioner Level 2, Out-of-Clinic	90814 U2 U7	75-80 minutes	\$ 233.80	2
Practitioner Level 3, Out-of-Clinic	90814 U3 U7	75-80 minutes	\$ 183.39	2
Practitioner Level 4, Out-of-Clinic	90814 U4 U7	75-80 minutes	\$ 121.78	2
Practitioner Level 5, Out-of-Clinic	90814 U5 U7	75-80 minutes	\$ 90.76	2
<b>Service Area - Family Outpatient Services</b>				
<b>Family - Behavioral health counseling and therapy (without client present)</b>				
Practitioner Level 2, in-Clinic	U0004 HS U2 U6	15 minutes	\$ 38.97	16
Practitioner Level 3, in-Clinic	H0004 HS U3 U6	15 minutes	\$ 30.01	16
Practitioner Level 4, In-Clinic	H0004 HS U4 U6	15 minutes	\$ 20.30	16
Practitioner Level 5, In-Clinic	H0004 HS U5 U6	15 minutes	\$ 15.13	16
Practitioner Level 2, Out-of-Clinic	H0004 HS U2 U7	15 minutes	\$ 46.76	16
Practitioner Level 3, Out-of-Clinic	H0004 HS U3 U7	15 minutes	\$ 36.68	16
Practitioner Level 4, Out-of-Clinic	H0004 HS U4 U7	15 minutes	\$ 24.36	16
Practitioner Level 5, Out-of-Clinic	H0004 HS U5 U7	15 minutes	\$ 18.15	16
<b>Family -- Behavioral health counseling and therapy (with client present)</b>				
Practitioner Level 2, In-Clinic	HO004 HR U2 U6	15 minutes	\$ 38.97	16
Practitioner Level 3, In-Clinic	H0004 HR U3 U6	15 minutes	\$ 30.01	16
Practitioner Level 4, In-Clinic	H0004 HR U4 U6	15 minutes	\$ 20.30	16
Practitioner Level 5, In-Clinic	HO004 HR U5 U6	15 minutes	\$ 15.13	16

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Description	Procedure Code	Unit	Rate	Max Units per Day.
Practitioner Level 2, Out-of-Clinic	H0004 HR U2 U7	15 minutes	\$ 46.76	16
Practitioner Level 3, Out-of-Clinic	H0004 HR U3 U7	15 minutes	\$ 36.68	16
Practitioner Level 4, Out-of-Clinic	H0004 HR U4 U7	15 minutes	\$ 24.36	16
Practitioner Level 5, Out-of-Clinic	H0004 HR U5 U7	15 minutes	\$ 18.15	16
<b>Family Psychotherapy without the patient present (appropriate license required)</b>				
Practitioner Level 2, In-Clinic	90846 U2 U6	15 minutes	\$ 38.97	16
Practitioner Level 3, In-Clinic	90846 U3 U6	15 minutes	\$ 30.01	16
Practitioner Level 4, in-Clinic	90846 U4 U6	15 minutes	\$ 20.30	16
Practitioner Level 5, in-Clinic	90846 U5 U6	15 minutes	\$ 15.13	16
Practitioner Level 2, Out-of-Clinic	90846 U2 U7	15 minutes	\$ 46.76	16
Practitioner Level 3, Out-of-Clinic	90846 U3 U7	15 minutes	\$ 36.68	16
Practitioner Level 4, Out-of-Clinic	90846 U4 U7	15 minutes	\$ 24.36	16
Practitioner Level 5, Out-of-Clinic	90846 U5 U7	15 minutes	\$ 18.15	16
<b>Conjoint Family Psychotherapy with the patient present (appropriate license required)</b>				
Practitioner Level 2, in-Clinic	90847 U2 U6	15 minutes	\$ 38.97	16
Practitioner Level 3, In-Clinic	90847 U3 U6	15 minutes	\$ 30.01	16
Practitioner Level 4, In-Clinic	90847 U4 U6	15 minutes	\$ 20.30	16
Practitioner Level 5, In-Clinic	90847 U5 U6	15 minutes	\$ 15.13	16
Practitioner Level 2, Out-of-Clinic	90847 U2 U7	15 minutes	\$ 46.76	16
Practitioner Level 3, Out-of-Clinic	90847 U3 U7	15 minutes	\$ 36.68	16
Practitioner Level 4, Out-of-Clinic	90847 U4 U7	15 minutes	\$ 24.36	16
Practitioner Level 5, Out-of-Clinic	90847 U5 U7	15 minutes	\$ 18.15	16
<b>Family - Skills training and development</b>				
Practitioner Level 4, in-Clinic, without client present	H2014 HS U4 U6	15 minutes	\$ 20.30	16
Practitioner Level 5, In-Clinic, without client present	H2014 HS U5 U6	15 minutes	\$ 15.13	16
Practitioner Level 4, Out-of-Clinic, without client present	H2014 HS U4 U7	15 minutes	\$ 24.36	16
Practitioner Level 5, Out-of-Clinic, without client present	H2014 HS U5 U7	15 minutes	\$ 18.15	16
Practitioner Level 4, In-Clinic, with client present	H2014 HR U4 U6	15 minutes	\$ 20.30	16
Practitioner Level 5, In-Clinic, with client present	H2014 HR U5 U6	15 minutes	\$ 15.13	16
Practitioner Level 4, Out-of-Clinic, with client present	H2014 HR U4 U7	15 minutes	\$ 24.36	16
Practitioner Level 5, Out-of-Clinic, with client present	H2014 HR U5 U7	15 minutes	\$ 18.15	16
<b>Service Area = Group Outpatient Services</b>				
<b>Group - Behavioral health counseling and therapy</b>				

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Description	Procedure Code	Unit	Rate	Max Units per Day.
Practitioner Level 2, In-Clinic	H0004 HQ U2 U6	15 minutes	\$ 8.50	20
Practitioner Level 3, in-Clinic	H0004 HQ U3 U6	15 minutes	\$ 6.60	20
Practitioner Level 4, In-Clinic	H0004 HQ U4 U6	15 minutes	\$ 4.43	20
Practitioner Level 5, In-Clinic	H0004 HQ U5 U6	15 minutes	\$ 3.30	20
Practitioner Level 2, Out-of-Clinic	H0004 HQ U2 U7	15 minutes	\$ 10.39	20
Practitioner Level 3, Out-of-Clinic	H0004 HQ U3 U7	15 minutes	\$ 8.25	20
Practitioner Level 4, Out-of-Clinic	H0004 HQ U4 U7	15 minutes	\$ 5.41	20
Practitioner Level 5, Out-of-Clinic	H0004 HQ U5 U7	15 minutes	\$ 4.03	20
Practitioner Level 2, In-Clinic, Multi-family group, with client present	H0004 HQ HR U2 U6	15 minutes	\$ 8.50	20
Practitioner Level 3, In-Clinic, Multi-family group, with client present	H0004 HQ HR U3 U6	15 minutes	\$ 6.60	20
Practitioner Level 4, in-Clinic, Multi-family group, with client present	H0004 HQ HR U4 U6	15 minutes	\$ 4.43	20
Practitioner Level 5, in-Clinic, Multi-family group, with client present	H0004 HQ HR U5 U6	15 minutes	\$ 3.30	20
Practitioner Level 2, Out-of-Clinic, Multi-family group, with client present	H0004 HQ HR U2 U7	15 minutes	\$ 10.39	20
Practitioner Level 3, Out-of-Clinic, Multi-family group, with client present	H0004 HQ HR U3 U7	15 minutes	\$ 8.25	20
Practitioner Level 4, Out-of-Clinic, Multi-family group, with client present	H0004 HQ HR U4 U7	15 minutes	\$ 5.41	20
Practitioner Level 5, Out-of-Clinic, Multi-family group, with client present	H0004 HQ HR U5 U7	15 minutes	\$ 4.03	20
Practitioner Level 2, In-Clinic, Multi-family group, without client present	H0004 HQ HS U2 U6	15 minutes	\$ 8.50	20
Practitioner Level 3, in-Clinic, Multi-family group, without client present	H0004 HQ HS U3 U6	15 minutes	\$ 6.60	20
Practitioner Level 4, in-Clinic, Multi-family group, without client present	H0004 HQ HS U4 U6	15 minutes	\$ 4.43	20
Practitioner Level 5, In-Clinic, Multi-family group, without client present	H0004 HQ HS U5 U6	15 minutes	\$ 3.30	20
Practitioner Level 2, Out-of-Clinic, Multi-family group, without client present	H0004 HQ HS U2 U7	15 minutes	\$ 10.39	20
Practitioner Level 3, Out-of-Clinic, Multi-family group, without client present	H0004 HQ HS U3 U7	15 minutes	\$ 8.25	20
Practitioner Level 4, Out-of-Clinic, Multi-family group, without client present	H0004 HQ HS U4 U7	15 minutes	\$ 5.41	20
Practitioner Level 5, Out-of-Clinic, Multi-family group, without client present	H0004 HQ HS U5 U7	15 minutes	\$ 4.03	20
<b>Group Psychotherapy other than of a multiple family group (appropriate license required)</b>				
Practitioner Level 2, In-Clinic	90853 U2 U6	15 minutes	\$ 8.50	20
Practitioner Level 3, in-Clinic	90853 U3 U6	15 minutes	\$ 6.60	20
Practitioner Level 4, In-Clinic	90853 U4 U6	15 minutes	\$ 4.43	20

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Description	Procedure Code	Unit	Rate	Max Units per Day.
Practitioner Level 5, In-Clinic	90853 U5 U6	15 minutes	\$ 3.30	20
Practitioner Level 2, Out-of-Clinic	90853 U2 U7	15 minutes	\$ 10.39	20
Practitioner Level 3, Out-of-Clinic	90853 U3 U7	15 minutes	\$ 8.25	20
Practitioner Level 4, Out-of-Clinic	90853 U4 U7	15 minutes	\$ 5.41	20
Practitioner Level 5, Out-of-Clinic	90853 U5 U7	15 minutes	\$ 4.03	20
<b>Group Skills training and development</b>				
Practitioner Level 4, In-Clinic	H2014 HQ U4 U6	15 minutes	\$ 4.43	20
Practitioner Level 5, In-Clinic	H2014 HQ U5 U6	15 minutes	\$ 3.30	20
Practitioner Level 4, Out-of-Clinic	H2014 HQ U4 U7	15 minutes	\$ 5.41	20
Practitioner Level 5, Out-of-Clinic	H2014 HQ U5 U7	15 minutes	\$4.03	20
Practitioner Level 4, In-Clinic, with Client present	H2014 HQ HR U4 U6	15 minutes	\$ 4.43	20
Practitioner Level 5, in-Clinic, with Client present	H2014 HQ HR U5 U6	15 minutes	\$ 3.30	20
Practitioner Level 4, Out-of-Clinic, with client present	H2014 HQ HR U4 U7	15 minutes	\$ 5.41	20
Practitioner Level 5, Out-of-Clinic, with client present	H2014 HQ HR U5 U7	15 minutes	\$ 4.03	20
Practitioner Level 4, In-Clinic, without client present	H2014 HQ HS U4 U6	15 minutes	\$ 4.43	20
Practitioner Level 5, In-Clinic, without client present	H2014 HQ HS U5 U6	15 minutes	\$ 3.30	20
Practitioner Level 4, Out-of-Clinic, without client present	H2014 HQ HS U4 U7	15 minutes	\$ 5.41	20
Practitioner Level 5, Out-of-Clinic, without client present	H2014 HQ HS U5 U7	15 minutes	\$ 4.03	20
<b>Service Area = Intensive Family Intervention</b>				
<b>Intensive Family Intervention</b>				
Practitioner Level 3, In-Clinic	H0036 U3 U6	15 minutes	\$ 30.01	48
Practitioner Level 4, in-Clinic	H0036 U4 U6	15 minutes	\$ 22.14	48
Practitioner Level 5, In-Clinic	H0036 U5 U6	15 minutes	\$ 16.50	48
Practitioner Level 3, Out-of-Clinic	H0036 U3 U7	15 minutes	\$ 41.26	48
Practitioner Level 4, Out-of-Clinic	H0036 U4 U7	15 minutes	\$ 27.06	48
Practitioner Level 5, Out-of-Clinic	H0036 U5 U7	15 minutes	\$ 20.17	48
<b>Service Area - Medication Administration</b>				
<b>Comprehensive Medication Services</b>				
Practitioner Level 2, In-Clinic	H2010 U2 U6	Per contact	\$ 33.40	1
Practitioner Level 3, In-Clinic	H2010 U3 U6	Per contact	\$ 25.39	1
Practitioner Level 4, In-Clinic	H2010 U4 U6	Per contact	\$ 17.40	1
Practitioner Level 5, In-Clinic	H2010 U5 U6	Per contact	\$ 12.97	1

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Practitioner Level 2, Out-of-Clinic	H2010 U2 U7	Per contact	\$ 42.51	1
Practitioner Level 3, Out-of-Clinic	H2010 U3 U7	Per contact	\$ 33.01	1
Practitioner Level 4, Out-of-Clinic	H2010 U4 U7	Per contact	\$ 22.14	1
<b>Therapeutic, prophylactic or diagnostic injection</b>				
Practitioner Level 2, In-Clinic	96372 U2 U6	Per contact	\$ 33.40	1
Practitioner Level 3, In-Clinic	96372 U3 U6	Per contact	\$ 25.39	1
Practitioner Level 4, in-Clinic	96372 U4 U6	Per contact	\$ 17.40	1
Practitioner Level 2, Out-of-Clinic	96372 U2 U7	Per contact	\$ 42.51	1
Practitioner Level 3, Out-of-Clinic	96372 U3 U7	Per contact	\$ 33.01	1
Practitioner Level 4, Out-of-Clinic	96372 U4 U7	Per contact	\$ 22.14	1
<b>Alcohol, and/or drug services, methadone administration and/or service (provision of the drug by a licensed program)</b>				
Practitioner Level 2, In-Clinic	H0020 U2 U6	Per contact	\$ 33.40	1
Practitioner Level 3, In-Clinic	H0020 U3 U6	Per contact	\$ 25.39	1
Practitioner Level 4, In-Clinic	H0020 U4 U6	Per contact	\$ 17.40	1
<b>Service Area = Psychosocial Rehabilitation</b>				
<b>Psychosocial Rehabilitation</b>				
Practitioner Level 4, Group, In-Clinic	H2017 HQ U4 U6	1 hour	\$ 17.72	5
Practitioner Level 5, Group, In-Clinic	H2017 HQ U5 U6	1 hour	\$ 13.20	5
Practitioner Level 4, Group, Out-of-Clinic	H2017 HQ U4 U7	1 hour	\$ 21.64	5
Practitioner Level 5, Group, Out-of-Clinic	H2017 HQ U5 U7	1 hour	\$ 16.12	5
Practitioner Level 4, in-Clinic	H2017 U4 U6	15 minutes	\$ 20.30	48
Practitioner Level 5, In-Clinic	H2017 U5 U6	15 minutes	\$ 15.13	48
Practitioner Level 4, Out-of-Clinic	H2017 U4 U7	15 minutes	\$ 24.36	48
Practitioner Level 5, Out-of-Clinic	H2017 U5 U7	15 minutes	\$ 18.15	48
<b>Service Area = Community Support Services</b>				
<b>Community Support Services</b>				
Practitioner Level 4, In-Clinic	H2015 U4 U6	15 minutes	\$ 20.30	48
Practitioner Level 5, in-Clinic	H2015 U5 U6	15 minutes	\$ 15.13	48
Practitioner Level 4, Out-of-Clinic	H2015 U4 U7	15 minutes	\$ 24.36	48
Practitioner Level 5, Out-of-Clinic	H2015 U5 U7	15 minutes	\$ 18.15	48
Practitioner Level 4, in-Clinic, Collateral Contact	H2015 UK U4 U6	15 minutes	\$ 20.30	48
Practitioner Level 5, In-Clinic, Collateral Contact	H2015 UK U5 U6	15 minutes	\$ 15.13	48
Practitioner Level 4, Out-of-Clinic, Collateral Contact	H2015 UK U4 U7	15 minutes	\$ 24.36	48
Practitioner Level 5, Out-of-Clinic, Collateral Contact	H2015 UK U5 U7	15 minutes	\$ 18.15	48

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Description	Procedure Code	Unit	Rate	Max Units per Day.
<b>Service Area = Addictive Disease Support Services</b>				
<b>Community Support Services</b>				
Practitioner Level 4, in-Clinic	H2015 HF U4 U6	15 minutes	\$ 20.30	48
Practitioner Level 5, in-Clinic	H2015 HF U5 U6	15 minutes	\$ 15.13	48
Practitioner Level 4, Out-of-Clinic	H2015 HF U4 U7	15 minutes	\$ 24.36	48
Practitioner Level 5, Out-of-Clinic	H2015 HF U5 U7	15 minutes	\$ 18.15	48
Practitioner Level 4, In-Clinic, Collateral Contact	H2015 HF UK U4 U6	15 minutes	\$ 20.30	48
Practitioner Level 5, In-Clinic, Collateral Contact	H2015 HF UK U5 U6	15 minutes	\$ 15.13	48
Practitioner Level 4, Out-of-Clinic, Collateral Contact	H2015 HF UK U4 U7	15 minutes	\$ 24.36	48
Practitioner Level 5, Out-of-Clinic, Collateral Contact	H2015 HF UK U5 U7	15 minutes	\$ 18.15	48
<b>Service Area = Case Management Support Services</b>				
<b>Case Management</b>				
Practitioner Level 4, In-Clinic	T1016 U4 U6	15 minutes	\$ 20.30	24
Practitioner Level 5, In-Clinic	T1016 U5 U6	15 minutes	\$ 15.13	24
Practitioner Level 4, Out-of-Clinic	T1016 U4 U7	15 minutes	\$ 24.36	24
Practitioner Level 5, Out-of-Clinic	T1016 U5 U7	15 minutes	\$ 18.15	24
Practitioner Level 4, In-Clinic, Collateral Contact	T1016 UK U4 U6	15 minutes	\$ 20.30	24
Practitioner Level 5, In-Clinic, Collateral Contact	T1016 UK U5 U6	15 minutes	\$ 15.13	24
Practitioner Level 4, Out-of-Clinic, Collateral Contact	T1016 UK U4 U7	15 minutes	\$ 24.36	24
Practitioner Level 5, Out-of-Clinic, Collateral Contact	T1016 UK U5 U7	15 minutes	\$ 18.15	24
Practitioner Level 4, In-Clinic	T1016 HK U4 U6	15 minutes	\$ 20.30	24
Practitioner Level 5, In-Clinic	T1016 HK U5 U6	15 minutes	\$ 15.13	24
Practitioner Level 4, Out-of-Clinic	T1016 HK U4 U7	15 minutes	\$ 24.36	24
Practitioner Level 5, Out-of-Clinic	T1016 HK U5 U7	15 minutes	\$ 18.15	24
Practitioner Level 4, in-Clinic, Collateral Contact	T1016 HK UK U4 U6	15 minutes	\$ 20.30	24
Practitioner Level 5, in-Clinic, Collateral	T1016 HK UK U5 U6	15	\$ 15.13	24

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Description	Procedure Code	Unit	Rate	Max Units per Day.
Contact		minutes		
Practitioner Level 4, Out-of-Clinic, Collateral Contact	T1016 HK UK U4 U7	15 minutes	\$ 24.36	24
Practitioner Level 5, Out-of-Clinic, Collateral Contact	T1016 HK UK U5 U7	15 minutes	\$ 18.15	24
<b>Service Area = Peer Supports</b>				
<b>Self Help/Peer Services</b>				
Practitioner Level 4, Group, In-Clinic	H0038 HQ U4 U6	1 hour	\$ 17.72	5
Practitioner Level 5, Group, In-Clinic	H0038 HQ U5 U6	1 hour	\$ 13.20	5
Practitioner Level 4, Group, Out-of-Clinic	H0038 HQ U4 U7	1 hour	\$ 21.64	5
Practitioner Level 5, Group, Out-of-Clinic	H0038 HQ U5 U7	1 hour	\$ 16.12	5
Practitioner Level 4, In-Clinic	H0038 U4 U6	15 minutes	\$ 20.30	48
Practitioner Level 5, in-Clinic	H0038 U5 U6	15 minutes	\$ 15.13	48
Practitioner Level 4, Out-of-Clinic	H0038 U4 U7	15 minutes	\$ 24.36	48
Practitioner Level 5, Out-of-Clinic	H0038 U5 U7	15 minutes	\$ 18.15	48
Practitioner Level 4, Group, In-Clinic	H0038 HF HQ U4 U6	1 hour	\$ 17.72	5
Practitioner Level 5, Group, in-Clinic	H0038 HF HQ U5 U6	1 hour	\$ 13.20	5
Practitioner Level 4, Group, Out-of-Clinic	H0038 HF HQ U4 U7	1 hour	\$ 21.64	5
Practitioner Level 5, Group, Out-of-Clinic	H0038 HF HQ U5 U7	1 hour	\$ 16.12	5
Practitioner Level 4, In-Clinic	H0038 HF U4 U6	15 minutes	\$ 20.30	48
Practitioner Level 5, in-Clinic	H0038 HF U5 U6	15 minutes	\$ 15.13	48
Practitioner Level 4, Out-of-Clinic	H0038 HF U4 U7	15 minutes	\$ 24.36	48
Practitioner Level 5, Out-of-Clinic	H0038 HF U5 U7	15 minutes	\$ 18.15	48
<b>Health and Wellness Supports (Behavioral Health Prevention Education Service (Delivery Of Services With Target Population To Affect knowledge, Attitude And/Or Behavior).</b>				
Practitioner Level 4, in-Clinic	H0025 U4 U6	15 minutes	\$ 20.30	6
Practitioner Level 5, In-Clinic	H0025 U5 U6	15 minutes	\$ 15.13	6
Practitioner Level 4, Out-of-Clinic	H0025 U4 U7	15 minutes	\$ 24.36	6
Practitioner Level 5, Out-of-Clinic	H0025 U5 U7	15 minutes	\$ 18.15	6
<b>Service Area = Assertive Community Treatment</b>				
<b>Assertive Community Treatment</b>				
Practitioner Level 1, In-Clinic	H0039 U1 U6	15 minutes	\$ 32.46	60
Practitioner Level 2, in-Clinic	H0039 U2 U6	15 minutes	\$ 32.46	60
Practitioner Level 3, In-Clinic	H0039 U3 U6	15 minutes	\$ 32.46	60
Practitioner Level 4, In-Clinic	H0039 U4 U6	15 minutes	\$ 32.46	60
Practitioner Level 5, In-Clinic	H0039 U5 U6	15 minutes	\$ 32.46	60

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TN No.: 07-004

Description	Procedure Code	Unit	Rate	Max Units per Day.
Practitioner Level 1, Out-of-Clinic	H0039 U1 U7	15 minutes	\$ 32.46	60
Practitioner Level 2, Out-of-Clinic	H0039 U2 U7	15 minutes	\$ 32.46	60
Practitioner Level 3, Out-of-Clinic	H0039 U3 U7	15 minutes	\$ 32.46	60
Practitioner Level 4, Out-of-Clinic	H0039 U4 U7	15 minutes	\$ 32.46	60
Practitioner Level 5, Out-of-Clinic	H0039 U5 U7	15 minutes	\$ 32.46	60
Practitioner Level 1, Via interactive audio and video telecommunication systems	H0039 GT U1	15 minutes	\$ 32.46	60
Practitioner Level 1, Via interactive audio and video telecommunication systems	H0039 GT U2	15 minutes	\$ 32.46	60
Practitioner Level 3, Group, In-Clinic	H0039 HQ U3 U6	15 minutes	\$ 6.60	20
Practitioner Level 4, Group, In-Clinic	H0039 HQ U4 U6	15 minutes	\$ 4.43	20
Practitioner Level 5, Group, In-Clinic	H0039 HQ U5 U6	15 minutes	\$ 3.30	20
Multidisciplinary Team Meeting	H0039 HT	15 minutes	\$ 0.00	60
Practitioner Level 3, In-Clinic	H0039 TN U3 U6	15 minutes	\$ 30.01	60
Practitioner Level 4, In-Clinic	H0039 TN U4 U6	15 minutes	\$ 20.30	60
Practitioner Level 5, In-Clinic	H0039 TN U5 U6	15 minutes	\$ 15.13	60
Practitioner Level 3, Out-of-Clinic	H0039 TN U3 U7	15 minutes	\$ 36.68	60
Practitioner Level 4, Out-of-Clinic	H0039 TN U4 U7	15 minutes	\$ 24.36	60
Practitioner Level 5, Out-of-Clinic	H0039 TN U5 U7	15 minutes	\$ 18.15	60
<b>Service Area = Community Living Supports</b>				
Level I	H0019 TG	1 day	\$ 99.23	1
Level II	H0019 TF	1 day	\$ 64.13	1
Level III	H0019	1 day	\$ 46.43	1
Level IV	H2021	15 minutes	\$ 13.96	10
<b>Service Area = Task-Oriented Services</b>				
Practitioner Level 4, Out-of-Clinic	H2025 U4 U7	15 minutes	\$ 24.36	8
Practitioner Level 5, Out-of-Clinic	H2025 U5 U7	15 minutes	\$ 18.15	8

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With respect to Assertive Community Treatment, the State Mental Health Agency, as designated by law and on behalf of the State Medicaid agency, will require that the entity furnish to the Medicaid agency on an annual basis the following:

- a. data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate; and
- b. cost information by practitioner type and by type of service actually delivered within the service unit.

The Medicaid Agency will base future rates on information obtained from the providers.

With respect to Community Living Supports (CLS), there are four intensity levels of service delivery. No rate includes any room and/or board. Rates use the detail stated earlier in this document specific to Practitioner Costs and Service Costs as a base and then are calculated on the assumptions below to create units for each level:

- **CLS Level I** is intensive and provides 24/7/365 awake staff support generally in a licensed community-living setting (in no case exceeding 16 beds). In order to directly support the individual, there will be a minimum of five hours weekly of skills training, community integration activities, and/or personal services provided to the person if indicated on the individual supports plan. This skills training is provided by one or more Community Living Supports specialists who may be practitioner Level 3, 4 or 5.
- **CLS Level II** is intensive and provides 24/7/365 staff support generally in a licensed community-living setting in no case exceeding 16 beds). In order to directly support the individual, there will be a minimum of five hours weekly of skills training, community integration activities, and/or personal services provided to the person if indicated on the individual supports plan. This skills training is provided by one or more Community Living Supports specialists who may be practitioner Level 3, 4 or 5.
- **CLS Level III** is semi-independent support which provides 36 hours per week staff support generally in a licensed community-living setting (in no case exceeding 16 beds). In order to directly support the individual, there will be a minimum of three hours per week of skills training, community integration activities, and/or personal services provided to the person if indicated on the individual supports plan. This skills training is provided by one or more Community Living Supports specialists who may be practitioner Level 4 or 5.
- **CLS IV** is support to provide a minimum of one face-to-face contact and an average of 10 15-minute units per week of skills training, community integration activities, and/or personal services provided to the person as indicated on the individual supports plan. A Community Living Supports specialist is a practitioner Level 5 operating on 65% productivity and is on call and available to consumers 24/7/365.



D. Graduate Medical Education Payments for Community Service Boards

Community Service Boards (CSBs) with Graduate Medical Education (GME) programs that are accredited by the Accreditation Council for Graduate Medical Education (ACGME) will be eligible to receive GME supplemental payments. The annual amount of each eligible CSB's GME payments will be calculated as follows:

- (1) Determine the Percentage of the CSB Claims Attributable to Medicaid in the previous fiscal year.
- (2) Multiply the percentage of the CSB claims attributable to Medicaid by the total GME annual expenses for the current fiscal year.
- (3) Divide the last four state fiscal years average CSB annual Medicaid claim count into the GME expenses reimbursable by Medicaid.
- (4) This amount is the per claim GME add-on amount.

**Fee-For-Service Ground Ambulance Upper Payment Limit (UPL) Supplemental Payment Program**

Effective with dates of service beginning on January 1, 2020 and thereafter, the Fee-for-Service (FFS) Ground Ambulance Upper Payment Limit (UPL) program will provide supplemental payments for government-owned (hospital affiliated or free-standing) ambulance providers. Participation in the program is voluntary.

Supplemental payments provided by this program are available to compensate eligible ground ambulance providers for ambulance services provided to Medicaid FFS members. The UPL will be based on commercial rate information through the calculation of an average commercial rate (ACR). The ACRs are based upon claims paid by commercial payers to the ambulance provider. Eligible ambulance service providers must complete the required ACR surveys attesting to the commercial rates paid by commercial payers for specific HCPCS codes. This survey is required in order for the State to determine the supplemental payment amount. For specific instructions on reporting commercial payer rates, refer to the ACR survey form located at (<https://dch.georgia.gov/ground-ambulance-upl>).

Supplemental payments shall be calculated and paid annually. Supplemental payments will not be distributed on individual claims as described in other parts of this state plan for ambulance services.

**Eligible Ambulance Service Providers**

Eligible ambulance service providers must be in-state, government owned (hospital affiliated or free standing) ground ambulance providers.

**Average Commercial Rate Survey**

Qualified ambulance providers must complete the Department's ACR survey. Providers are required to attest that the information reported is true, correct, and completed and prepared from the books and records of the provider in accordance with applicable instructions. Providers are required to provide the rates paid by commercial insurers for the specified HCPCS codes. Commercial payers exclude Medicare, Medicare Advantage/HMO, TRICARE, Medicaid, worker's compensation, and auto insurance plans as payers. For specific instructions on reporting commercial payer rates, refer to the ACR survey form located at <https://dch.georgia.gov/ground-ambulance-upl>.

Providers must submit commercial payer rates and supporting documentation for the time period specified in the ACR survey. Commercial payer rates for five commercial payers for each eligible and applicable HCPCS code are required. If a provider has less than five different commercial payers for a HCPCS code for the payment period, four or a minimum of three payer rates will be accepted.

Effective with calculations after August 13, 2021 (using claims with dates of service starting on or after January 1, 2021) the State will calculate a state wide median average for those providers who are unable to provide a minimum of three commercial payer rates.

Supporting documentation must be submitted for each payer rate. Acceptable documentation includes paid remittance advice (RA), explanation of benefits (EOB), or similar approved payment record documenting the allowed payment amount. The documentation must tie to reported payment amounts.

**Payment Methodology**

The supplemental UPL payment amount is equal to the maximum payment amount (or UPL) allowed by CMS less the amount paid in Medicaid claims. The supplemental payment will be issued annually.

**Calculation of Maximum Payment Amount**

1. The maximum payment amount allowed (UPL) will be determined for each provider using calculated ACRs for eligible HCPCS codes and historical Medicaid utilization from paid claims data.
2. For example, the January 2021 payment will be based upon Medicaid FFS utilization period January 1, 2020 – June 30, 2020 and July 2021 payment will be based upon Medicaid FFS utilization period July 1, 2020 - December 31, 2020 and so forth.
3. Providers are required to submit twice a year, their commercial rates for 3-5 commercial payers for HCPCS codes A0425, A0426, A0427, A0428, A0429, A0433, and A0434. These rates will be used to calculate the ACR for each HCPCS code
4. Effective with calculations on are after August 13, 2021, the State will require ground ambulance providers to submit commercial payer rates every two years.
5. For each HCPCS code, the provider's ACR is multiplied by the provider's Medicaid fee for service utilization to arrive at the UPL amount allowed by CMS.

**Formula: Maximum Payment Amount (UPL) – Total Medicaid Payments = Supplemental UPL Payment**

6. The ground ambulance UPL program is based upon specific HCPCS codes.

HCPCS Code	Description
A0425	Mileage
A0426	Advanced Life Support (ALS, Non-Emergency)
A0427	Advanced Life Support (ALS, Level 1, Emergency)
A0428	Basic Life Support (BLS, Non-Emergency)
A0429	Basic Life Support (BLS, Emergency)
A0433	Advanced Life Support, Level 2 (ALS Level 2, Emergency)
A0434	Specialty Care Transport

**Limitations**

1. Supplemental UPL payments are not allowed for ambulance services rendered to managed-care beneficiaries, dually eligible for Medicare and Medicaid beneficiaries or Children's Health Insurance Program (CHIP) beneficiaries.
2. Supplemental UPL payments are not available for treat not transport services.

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3. Supplemental UPL payments are not available for air ambulance services (fixed or rotary wing).
4. Supplemental UPL payments are not available for ambulance telemedicine services.
5. Supplemental UPL payments are not available for Non-Emergency Medical Transportation.
6. Services must be deemed medically necessary.

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 CHIP 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 FY 2000. Those costs will be adjusted to take into account any increase (or decrease) in the scope of services furnished by the RHC during FY2001 for 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 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, 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.

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

If an RHC 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 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.

Effective for dates of services on or after May 15, 2015, RHCs may elect to receive reimbursement for Long Acting Reversible Contraceptives (LARCs) (specifically intrauterine devices and single rod implantable devices) for contraceptive purposes.

Reimbursement for the LARCs shall be made in accordance with the following:

- i. To the extent that the LARCs were purchased under the 340B Drug Pricing Program, the RHC must bill the actual acquisition cost for the device.
- ii. Reimbursement shall be made at the RHC's actual 340B acquisition cost for LARCS purchased through the 340B program. For LARCs not purchased through the 340B program, reimbursement shall be made at the lower of the provider's charges or the rate on the Department's practitioner fee schedule, whichever is applicable.
- iii. Reimbursement is separate from any encounter payment the RHC may receive for LARCs.

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

B. Clinical Services (continued)

4. Dialysis Services

a. Physician Services

The Department will pay physicians the lower of the submitted charge or the statewide monthly capitation payment (MCP) as determined by Medicare. Reimbursement for the MCP is not to exceed the Medicare reimbursement for those services. Physicians will receive the MCP each month for each enrolled patient (member) under their care. Physicians enrolled in this program will receive the MCP for professional services. Professional services include the monthly supervision of medical care, dietetic services, social services and procedures directly related to End Stage Renal Disease.

b. Technical Services

Facilities enrolled in this program will be paid per visit for technical services including routine laboratory work, and the cost of supplies and equipment as described in the policy manual. Facilities will be reimbursed the lower of the submitted charge or the statewide fixed per visit rate. The monthly aggregate of per visit reimbursement not to exceed the monthly aggregate Medicare reimbursement for these services. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of technical dialysis services and the fee schedule and any annual/periodic adjustments to the fee schedule are published in state plan amendments, Georgia Medicaid policy manuals and provider correspondence.

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

c. Dental Services

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

- (1) The dentist's actual charge for the service; or
- (2) The statewide reimbursement rate in effect on the date of service.

Reimbursement will be made on a per procedure basis.

Reimbursement to providers of dental services is made on an established fee schedule not to exceed prevailing charges in the state.

The current reimbursement rates will be based on a percentage of usual and customary reimbursement, not to exceed 100 percent. The usual and customary reimbursement will be determined using regional data on a periodic basis.

Effective with dates of service beginning January 1, 2021 and thereafter, Silver Fluoride Diamine (HCPCS Code D1354) is a covered dental service for Category of Service-Health Check.

Limitations:

Silver Fluoride Diamine (HCPCS Code D1354) is limited to a maximum of two (2) applications per tooth.

Effective with dates of services beginning July 1, 2021 and thereafter, the following reimbursement rate for the following dental codes will increase by 3%.  
D2140 D2150 D2160 D2330 D2331 D2332 D2335 D2393 D2394 D2930 D2931 D3220  
D7111 D7140 D7210.

All dental codes and reimbursement rates can be located in the Part II, Policies and Procedures Manual for Dental Services at the following link:

<https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabld/39/Default.aspx>



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

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions (PPC)

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions (OPPC)

The State identifies the following Other Provider-Preventable Conditions for non-payment under Attachment 4.19-B of this State plan.

X  Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

On and after May 17, 2012, Medicaid will make zero payments to providers for Other Provider-Preventable Conditions which includes Never Events (NE) as defined by the National Coverage Determination (NCD). The Never Events (NE) as defined in the NCD includes Inpatient Hospitals, Outpatient Hospitals, Ambulatory Surgical Centers (ASC) and practitioners, and these providers regardless of the healthcare setting will be required to report NEs. Reimbursement for conditions described above is defined in Attachment 4.19-B, Page 1.002 of this State Plan.

- A. Dates of service beginning on or after May 17, 2012:
  - 1. The claims identified with provider-preventable conditions through the claims payment system will be reviewed.
  - 2. When the review of claims indicates an increase of payment to the provider for an identified provider-preventable condition, the amount for the provider-preventable condition will be excluded from the providers' payment.
- B. No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
- C. Reductions in provider payment may be limited to the extent that the following apply:
  - 1. The identified provider-preventable conditions would otherwise result in an increase in payment.
  - 2. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.
  - 3. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.
- D. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

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

Payment for Hospital Acquired Conditions:

Effective May 17, 2012 and in accordance with Title XIX of the Social Security Act - Sections 1902, 1903 and 42 CFRs 434,438, and 447, Medicaid will make no payment to providers for services related to Provider Preventable Conditions (PPCs) which includes Never Events (NE), Other Provider Preventable Conditions (OPPCs) and Additional Other Provider-Preventable Conditions (AOPPCs).

In accordance with GA State Plan, Attachment 3.1-B payments are allowed except for the following conditions outlined below.

Never Events (NE) are defined by the National Coverage Determination (NCD) manual for Outpatient Hospitals, Ambulatory Surgical Centers (ASC) and practitioners, and these providers will be required to report NEs. Outpatient Hospital claims must bill all non-payment/zero services on the same professional 1500 claim as a separate detail line-entry or as designated by the National Uniform Bill Committee for non-payment. All non-payment services found in claims adjudication from NES, PPCs, and AOPPCs will be subject to post medical records review and recoupment.

The provider may file a professional claim for the same Medicaid recipient with the same dates of service to include the allowable charges for reimbursement. Providers must identify and report NE occurrences. All NEs services will pend for retrospective review.

Prohibition on payments for NE, OPPC, and AOPPC shall not result in a loss of access to care or services for Medicaid beneficiaries. This policy applies to all Medicaid reimbursement provisions contained in 4.19B.

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

Covered Outpatient drugs will be reimbursed based on the established product cost plus a professional dispensing fee. The amount billed should be no more than the usual and customary charge (U&C) to the private pay patient. The following Methodology is used to establish Medicaid Payments:

- 1. Reimbursement for legend and non-legend drugs shall not exceed the lowest of:**
  - (a) The Georgia Maximum Allowable Cost (GMAC) plus a professional dispensing fee
  - (b) The Georgia Estimated Actual Acquisition Cost (GEAC) plus a professional dispensing fee
  - (c) The Federal Upper Limit (FUL) plus a professional dispensing fee
  - (d) The usual and customary charge or the submitted ingredient cost
  - (e) The Select Specialty Pharmacy Rate (SSPR) plus a professional dispensing fee

**DEFINITIONS:**

Georgia Maximum Allowable Cost (GMAC) is the National Average Drug Acquisition Cost (NADAC) data published by the Center for Medicare and Medicaid Services (CMS). If CMS does not publish a NADAC for a covered outpatient drug the Georgia Maximum Allowable Cost (GMAC) reimbursement may be established by the State for selected drugs

Georgia Estimated Actual Acquisition Cost (GEAC) is the Wholesale Acquisition Cost (WAC) as established by the State.

Usual and Customary: The Division defines usual and customary as the lower of the lowest price reimbursed to the pharmacy by other third party payers (including HMO's); or, the lowest price routinely offered to any segment of the general public.

Select Specialty Pharmacy Rate (SSPR) is the Actual Acquisition Cost (AAC) for select specialty pharmaceuticals based on the product dispensed and the State's ability to ensure access to the medication at that reimbursement level.

1.340B Actual Acquisition Drug Pricing is the submitted ingredient cost 340B purchase price but no more than the 340B ceiling price plus a professional dispensing fee. 340B covered entity pharmacies that carve Medicaid into the 340B drug pricing program will be reimbursed no more than the 340B ceiling price plus a professional dispensing fee. 340B covered entities purchasing drugs outside the program will be reimbursed according to the lesser of logic defined in section I. above

2.. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.

3. Professional Dispensing Fee: The reasonable professional dispensing fee is defined as a fee that is incurred at the point of sale or service and pays for costs in excess of the ingredient cost of a covered outpatient drug each time a covered outpatient drug is dispensed. The Medicaid dispensing fee shall be \$10.63 for pharmacies.

4. Clotting Factors will be reimbursed at the lesser of providers U&C, or the Select Specialty Pharmacy Rate plus the PDF, or the WAC plus the PDF.
5. For federal supply schedule (FSS) purchased drugs, their provider agreements will require them to bill at no more than their actual acquisition cost plus the professional dispensing fee. FSS purchased drugs will be reimbursed at no more than the actual acquisition cost plus the professional dispensing fee
6. Drugs acquired at nominal price (outside of 340B or FSS) will be reimbursed at no more than the actual acquisition cost plus the professional dispensing fee.
7. Investigational drugs are not a covered service under Georgia's Medicaid pharmacy program.
8. Pharmacies providing services to Long Term Care beneficiaries will be reimbursed for ingredient cost using the lesser of methodology plus the established professional dispensing fee.

**Provider Administered Drug Reimbursement Methodology:**

The maximum allowable reimbursement for provider administered drugs in an office or outpatient setting, will be reimbursed according to the Average Sales Price (ASP) plus 3%.

Covered provider administered drugs for which CMS does not publish an ASP price will be reimbursed in accordance with the Georgia Estimated Actual Acquisition Cost (GEAC).

7. Appeal Process: On an ongoing basis, providers are allowed to submit a request for reimbursement review.
  - a. Provider submits a Reimbursement Review Request Form
    - i. Provider submits two (2) most recent wholesaler invoices. If this is the first time a provider has dispensed said product within the last three (3) months, then one (1) invoice will be accepted.
    - ii. The Provider will attest to that product is not available to the provider in the market at the published rate.
  - b. The Department will review the invoices and compare to other dispensing providers within a geographical location.
    - i. The Department will work with wholesalers and other providers to discern the availability of the product at the specialty pharmacy reimbursement rate in the marketplace.
    - ii. The Department will identify any other provider in the geographic area that are accepting the specialty pharmacy reimbursement rate and coordinate access to those providers for any affected members.
    - iii. Absent other providers accepting the specialty pharmacy reimbursement rate, the Department will adjust the specialty pharmacy reimbursement rate.
  - c. The provider will be notified within five (5) business days of the determination of the request for Reimbursement Review.
8. Any resulting adjustment in the specialty pharmacy reimbursement rate will be updated in the claims processing system within ten (10) business days of the determination.
2. The dispensing fee for profit and non-profit community pharmacies is based on periodic surveys of pharmacy operating costs including professional salaries and fees, overhead costs and reasonable profit. Between these periodic surveys, the Division, in consultation with the Governor's Office of Planning and Budget, reviews the fee. When appropriate, the fee is adjusted based on an inflation factor. The Medicaid dispensing fee shall be \$4.63 for profit pharmacies and \$4.33 for non-profit pharmacies. The dispensing fee paid by the Division shall be subject to the usual and customary charge as defined by the Division above and shall not exceed the lower of submitted charges.

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

d. Prescribed Drugs (continued)

3. No dispensing fee is allowed to the physician dispensing drugs.
4. Payment for special approved drugs as requested by the prescribing physician is determined as in item 1 above.
5. Prescriptions supporting Medicaid claims must be initiated and recorded in accordance with State and Federal laws. The maximum quantity payable for a prescription or its refill will be one (1)-month supply unless the drug delivery system or package size is such that the smallest dispensable unit provides greater than a one month supply.
6. Effective with the date of service on or after June 1, 2001, the Department will impose a co-payment for each non-preferred drug dispensed to a Medicaid recipient based on the typical payment by the Department for the prescription as follows:

<u>Cost to State</u>	<u>Co-Payment</u>
\$10.00 or less	\$0.50 co-payment
\$10.01 to \$25.00	\$1.00 co-payment
\$25.01 to \$50.00	\$2.00 co-payment
\$50.01 or more	\$3.00 co-payment

Recipients under age twenty-one (21), pregnant women, institutionalized individuals, hospice care, QMB dual eligible, and Breast and Cervical Cancer Program participant recipients are not required to pay this co-payment. Emergency services, family planning services, are also exempt from this co-payment.

The Department will impose a nominal co-payment of \$.50 for each preferred prescribed drug dispensed by the pharmacy.

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

E. Durable Medical Equipment Services

The maximum reimbursement for providers of medical equipment to Medicaid and PeachCare members is limited to the lower of:

- (a) the usual and customary charges for the item; or
- (b) 80% of the 2007 Medicare DME rate for the Atlanta area.

Reimbursement for delivery mileage is limited to 100 miles, one way.

Effective for dates of service July 1, 1994 and after, a \$3.00 recipient co-payment is required on all Durable Medical Equipment and a \$1.00 co-payment for all Durable Medical Equipment Supplies and Rentals.

Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care recipients are exempt from the co-payment. Emergency services and family planning services are also exempt from a co-payment.

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Supersedes

09-003  
94-020

Approved:  
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01-27-10  
07-01-09

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES  
FOR OTHER TYPES OF CARE OR SERVICE

F. HEALTH CHECK (EPSDT) SERVICES

Reimbursement to Health Check (EPSDT) screening providers is based on the lower of submitted charges or the state's maximum allowable rate. Vaccine costs and administration fees are reimbursed separately at established rates dependent on the source of the vaccine. Vaccines provided by the Vaccines for Children (VFC) program have an administration only reimbursement rate as specified in the Part II Policy and Procedure Manual for Health Check. Georgia Medicaid will reimburse for the administration and cost of vaccines purchased outside of the VFC program when used to immunize eligible Medicaid members. Medically necessary non-institutional and institutional services which are not otherwise covered under the State Plan require prior approval and will be reimbursed under the respective program using that program's established reimbursement methodology as described on Supplement 1 to Attachment 4.19-B, Page 1.

For Health Check screenings and tests, the state's maximum allowable rates are published in the Georgia Department of Community Health Policy and Procedure Manual for Health Check and other appropriate Georgia Department of Community Health Policy and Procedure manuals.

Immunizations will be provided per the Department of Community Health's periodicity schedule and recommendations of the Advisory Committee on Immunization Practices (ACIP). The state's maximum allowable rates for immunizations and administration fees are published in the Georgia Department of Community Health Policy and Procedure Manual for Health Check as well as the Georgia Department of Community Health Policy and Procedure Manual for Physician's Injectable Drug List.

Except as otherwise noted in the plan or Part II Policy and Procedure Manual for Health Check Services, state-developed fee schedule rates are the same for both governmental and private providers of EPSDT services. The agency's fee schedule rate was set as of 7/1/2006 and is effective for services provided on or after that date. All rates are published on the [www.ghp.georgia.gov](http://www.ghp.georgia.gov) website.



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

G. HOME HEALTH SERVICES

The Department will reimburse each Home Health Agency a specific rate per visit for covered services. The specific rate per visit is the total of the agency's inflated base rate, any efficiency incentive applicable to the agency, and a supply rate. Base rates, efficiency incentives, and supply rates are subject to ceilings. Rates, incentives, and ceilings are determined as follows:

- (a) Each agency's base rate is calculated using data contained in the as-filed or audited Medicaid cost report for that agency's base period. An inflation percentage is applied to base period date and the resulting inflated base period cost per visit is the agency's base rate. The inflation percentage and base period are set by the Department.
- (b) Each agency is classified into one of the following categories; hospital-based, freestanding urban, and freestanding rural. For each category the 75th percentile of inflated base period cost per visit is determined. This amount is the base rate ceiling for agencies in the category.
- (c) An efficiency incentive may be added to the base rate for an agency as follows:

If an agency's base rate is less than or equal to the base rate ceiling in the agency's category, the difference between the base rate and the ceiling is multiplied by 20%, and the product (not to exceed \$1.76) is added to the base rate. The total of base rate plus incentive shall not exceed the base rate ceiling for the agency's category.
- (d) The supply cost per visit for each agency is based on data contained in the as-filed or audited Medicaid cost report for the agency's base period. An inflation percentage is applied to base-period data to determine each agency's inflated supply cost per visit. The inflation percentage and base period for supply costs are set by the Department. Inflated base period supply costs per visit for each agency are arrayed on a statewide basis and the 75th percentile cost from that array is the supply rate. The supply rate is added to each agency's base rate plus any applicable efficiency incentive.
- (e) The reimbursement rate for each freestanding agency shall not exceed the base rate ceiling for that agency's category plus the supply rate. The reimbursement rate for each hospital-based agency will be calculated as noted in paragraphs (a) through (d), and shall not exceed the maximum rate noted in paragraph (f) below.

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EFFECTIVE 7/1/94  
SUPERSEDES 91-48

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

- (f) For purposes of setting the maximum rate per visit for hospital-based agencies, the Department has established two subcategories: Urban hospital-based and rural hospital-based. The maximum rate per visit for each agency in these subcategories is determined by adding a hospital-based adjustment amount to the freestanding urban and freestanding rural based rate ceilings. The adjustment is calculated as follows:

The mean of the agencies' inflated base period cost per visit will be calculated for each of the subcategories. A percentage of the mean for each subcategory will be calculated and added to the base rate ceiling for the corresponding freestanding urban or rural category, plus the supply rate to establish the maximum rate for hospital-based agencies in that subcategory.

Each hospital-based agency will be reimbursed the lesser of its rate calculated as noted in paragraphs (a) through (d), or the maximum rate per visit for its subcategory.

Assignment to a subcategory is determined according to the criteria outlined in the section labeled classification of agencies.

- (g) Reimbursement rates will be adjusted for home health agencies which provide certain home-delivered services to community-care recipients. The rate adjustment will be calculated using the home health reimbursement methodology in paragraphs (a) through (f) above, and the calculation will include both home health and home delivered services utilization data for the base period.

Reimbursement rates will be adjusted only for those agencies currently enrolled and providing services in the community care home-delivered services program and for which at least nine months of cost and utilization data exists for the base period. Home health agencies which discontinue

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

the provision of home-delivered services will be subject to a reduction in their reimbursement rate.

- (h) Effective for dates of service July 1, 1994 and after, a \$3.00 recipient co-payment is required on all home health visits. Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care recipients are not required to pay the co-payment. Emergency services and family planning services are also exempt from a co-payment.

Cost Reports

Each agency must submit a copy of its as-filed Medicare cost report and a completed Medicaid Cost Data Form (supplied by the Department) to the Department. These documents must be received by the Department within one hundred fifty (150) days after each agency's fiscal year end. If the Medicare and Medicaid reports have not been received after this one hundred fifty (150) day period, a rate reduction of 10% on the current rate will be imposed. This rate reduction will remain in effect through the final day of the month in which the cost information is received. If the information is received after any fraction of a month beyond the one hundred fifty (150) day period, the rate reduction of 10% will be applied for the entire month. If an agency's cost information is not received by the time the Department establishes individual provider rates and determines the percentiles and rate ceilings, that agency will be assigned the lesser of its current rate or the lowest rate in the State for the appropriate category, less applicable incentive, as established by the rate-setting process. If the agency's cost information is received after rates are established, the Department will calculate a based on the

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

information received and retroactively and prospectively adjust the agency's previously assigned rate only if it is greater than the calculated rate. The agency's rate will remain in effect until the next rate adjustment period, as determined by the Department. Failure to submit cost information may result in suspension or termination of the agency from the Medicaid Home Health program.

An agency's Medicaid cost report is subject to review or audit by the Department or its agent(s)-in accordance with HCFA-15 principles of reimbursement and Medicaid policies and procedures. The agency's reimbursement rate will be adjusted (if necessary) for the period for which the rate was effective as a result of the review or audit performed. Percentile and rate ceilings as initially established will not be adjusted based upon subsequent audits. An agency may appeal any audit adjustments and rates resulting therefrom using the administrative review procedures outlined in the home health policy manual.

Nonallowable Costs

Effective for the determination of reasonable costs used in the calculation of rates initially established on and after April 1, 1991, the costs outlined below are nonallowable for Medicaid purposes:

- (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 or 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 expense in excess of the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles; provided, however, such limits 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 transport is nonallowable;
- (f) Fifty percent (50%) of professional dues for national, state, and local associations.

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TRANSMITTAL	91-48
APPROVED	1-28-92
EFFECTIVE	11-1-91
SUPERSEDES	90-2

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

- (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 issuance reviews, 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.
- (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.

Information on these nonallowable costs will be obtained by the Department or its agent at the time of review or audit of the agency.

The agency's reimbursement rate will be adjusted (if necessary) for the period for which the rate was effective as a result of the review or audit performed. Percentile and rate ceilings as initially established will not be adjusted based upon subsequent audits. An agency may appeal any audit adjustments and rates resulting therefrom using the Department's Administrative Review Procedures.

New Agencies

- a) A new agency will be reimbursed a rate equal to the statewide average reimbursement rate for the appropriate category, as of the effective date of enrollment of the new agency. This new agency rate will be reimbursed until a cost report for a base period (minimum nine months) on which an agency-specific rate per visit can be based, is received by the Department. There will not be a cash settlement determination for new agencies.
- b) A new agency is defined as an agency established by the initial issuance of a Certificate of Need (CON), Medicare certification and state license; it is reimbursed as described in paragraph a) above. An agency formed as a result of a merger, acquisition, other change of ownership, business combination, etc. is not a new agency. Each agency of this type will maintain the reimbursement rate it was assigned prior to the transaction. When rates are subsequently adjusted, the appropriate cost report for the base period (as determined by the Department) will be used as a basis for determining the agency's rate.

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

Agencies With Insufficient or Unauditable Cost Data

If an existing agency submits costs data for its fiscal year that corresponds to the base period and the fiscal year is for an insufficient period of time (as determined by the Department but usually a period of less than nine (9) months), that cost data will not be used in establishing the percentile and rate ceilings for the appropriate category and in calculating the statewide supply rate per visit. However, the data will be used to calculate a rate per visit using the methodology previously described. A freestanding agency's actual reimbursement rate in this instance will be the lesser of the calculated rate per visit (including applicable incentive) or the 75th percentile for the appropriate category, calculated exclusive of the agency's insufficient cost data, plus the statewide supply rate per visit, also calculated exclusive of the agency's insufficient cost data. A hospital-based agency's actual reimbursement rate in this instance will be the lesser of the calculated rate per visit (including applicable incentive) or the maximum rate per visit for the appropriate hospital-based subcategory, calculated exclusive of the agency's insufficient cost data, plus the supply rate per visit, also calculated exclusive of the agency's insufficient cost data. There will be no cash settlement for existing agencies with insufficient cost data for the base year.

Existing agencies with cost data which cannot be audited for the fiscal year that corresponds to the base period will be omitted from the rate setting process and assigned the lowest rate in the state for the applicable category until the appropriate records are made available to verify (audit) the cost information.

Amended Medicare and Medicaid Cost Data

An agency may submit an amended Medicare cost report and Medicaid cost Data Form after the initial submission for the most recent fiscal year. An amended report and cost data form must be received by the Department no later than ninety (90) days after the due date of the initial report and form, or ninety (90) days after any due date extension granted by the Department. The amended Medicare report must support the amended Medicaid cost data form. The due date of the initial report and cost data form is contained in the cost report section.

Classification of Agencies

For reimbursement purposes Home Health agencies will be classified as follows:

- (a) Urban - Agency located in a Metropolitan Statistical Area, as evidenced by documentation on file with the Department, including, but not limited to, the address on the Medicare cost report received by the Department or fiscal intermediary.

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SUPERSEDES	NEW

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

- b. Rural - An agency located in a non-Metropolitan Statistical Area, as evidenced by documentation on file with the Department, including, but not limited to, the address on the Medicare cost report received by the Department or fiscal intermediary.
  
- c. Hospital-based - An agency classified as hospital-based for Medicare purposes will be considered hospital-based for Medicaid purposes. Hospital-based agencies will be further categorized as urban or rural using the criteria in (a) and (b) above. Agencies retrospectively classified as hospital-based by Medicare will not be classified retrospectively as hospital-based by the Department. The agency will be notified of the prospective effective date.

Agencies which submit Medicare cost reports with addresses different from the address on the Statement of Participation on file with the Department will have their cost reports returned for verification. If the agency uses the address on the Medicare cost report for Medicare purposes, this same address will be utilized in designation of a location for rate setting purposes for the Department.

**H. EPSDT Private Duty (Continuous) Nursing Services**

The maximum reimbursement for public and private providers of private duty nursing services is limited to the lower of:

- a) The actual charges for the service; or
  
- b) The statewide rate in effect on the dates of services is based on a survey of seven (7) states conducted in 1999. Another state survey will be conducted when legislatively mandated.

POLICY AND METHODS 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.



**Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415****Physician Services – Vaccine Administration**

For calendar years (CY) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

- Medicare Physician Fee Schedule rate
- X  State regional maximum administration fee set by the Vaccines for Children program
- X  Rate using the CY 2009 conversion factor

**Documentation of Vaccine Administration Rates in Effect 7/1/09**

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

The imputed rate effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: \_\_\_\_\_

A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: \_\_\_\_\_

X  Alternative methodology to calculate the vaccine administration rate in effect 7/1/09: Vaccine administration codes 90460, 90465 and 90471 were not in effect on 07/01/2009. Two rates were used for vaccine administration services according to the following current procedural terminology codes and diagnosis codes:

1. Single Antigen Vaccine Rate of \$8.00 for the following combination: 90633/V053, 90634/V053, 90647/V0381, 90648/V0381, 90649/V0489, 90650/V0481, 90655/V0481, 90656/V0481, 90657/V0481, 90658/V0481, 90660/V0481, 90670/V0382, 90680/V0489, 90681/V0489, 90713/V040, 90716/V054, 90732/V0382, 90734/V0389, 90744/V053, 90746/V053, 90747/V053
2. Multiple Antigen Vaccine Rate of \$10.00 for the following combination: 90636/V053, 90698/V068, 90700/V061, 90707/V064, 90714/V065, 90715/V061, 90723/V068, 90748/V068.

The vaccine rate in effect for 07/01/2009 was calculated using the codes and rates specified above times their respective claims volume which encompasses 07/01/2009 and is \$8.60.

Note: This section contains a description of the state's methodology and specifies the affected billing codes. Effective January 1, 2013, Georgia Medicaid EPSDT providers can bill the vaccine administration codes 90460, 90471, 90472, 90473 and 90474 (for members up to age 19 years) and, 90471-90474 (for members aged 19-20 years) for vaccines administered. Each of these codes pays \$10.00. Effective January 1, 2013, for providers under the Patient Protection and Affordable Care Act, the vaccine administration codes will pay the following amounts for providers using VFC vaccines for members 18 years of age and younger: 90460, 90471 and 90473-the VFC Regional rate. The rate for code 90472 and 90474 will be the Medicare fee schedule rate. Effective January 1, 2013, for providers under the Patient Protection and Affordable Care Act the vaccine administration code for providers using their private stock for members 19-20 years of age will reimburse codes 90471-90474 at the Medicare fee schedule rate.

### **Effective Date of Payment**

#### Vaccine Administration

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at:

<https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Fee%20Schedules/tabId/56/Default.aspx>.

**Addendum to SPA: Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415**

**Method of Payment**

The Department's intent is to make a payment at the higher rate for each Evaluation and Management and vaccine administration code using an adjusted fee schedule. However, the Department will make at least quarterly supplemental payments in lieu of the Medicaid Management Information System (MMIS) being configured to reflect the adjusted fee schedule. The state will not adjust the fee schedule to account for any changes in Medicare rates throughout the year.

**Physician Services - Vaccine Administration**

For procedure 90460 the Department used the state regional maximum administration fee set by the Vaccines for Children program.

For procedures 90471, 90472, 90473, and 90474 the Department used the CY 2009 conversion factor (from the CMS Deloitte Primary Care Excel Enhanced payment tool).

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

J. PHYSICIAN SERVICES (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.

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

J. **PHYSICIAN SERVICE** (Includes Physicians, Podiatrists, Optometrists and  
Psychologists)(continued)

\*Descriptions:

- AA Anesthesia services personally performed by an Anesthesiologist
- QK Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individual(s) [i.e., Certified Registered Nurse Anesthetists (CRNAs) or Physician Assistant Anesthesiology Assistants (PAAAs)] by an Anesthesiologist
- QX CRNA and PAAA performing anesthesia services under the direct supervision of an anesthesiologist
- QY Single (one) medically directed anesthesia service performed by an Anesthesiologist
- QZ Non-medically directed CRNAS
- 78 Return trip to the operating room

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

J. PHYSICIAN SERVICES (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 provider'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 lesser 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 fiscal agent's website<sup>1</sup>. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

<sup>1</sup>The fiscal agent's website is assessable via Georgia Medicaid's website at [www.dch.georgia.gov](http://www.dch.georgia.gov); click on the "Georgia Medicaid" link, then click on the fiscal agent, Georgia Health Partnership's link (Hewlett Packard (HP) after July 1, 2010).

Providers subject to this change include but may not be limited to: Physicians, Physician assistants, Nurse Midwives, Advanced Nurse Practitioners, Podiatrists, Oral Maxillofacial Surgeons, and related providers eligible to administer injectable drugs.

J. PHYSICIAN SERVICES cont'd (Includes Physicians, Podiatrists, Optometrists and Psychologists)

Vaccine Administration:

Effective for dates of services on and after October 9, 2009, the maximum allowable reimbursement to providers administering the H1N1 influenza vaccine to adults over 19 years of age, where the vaccine is supplied at no cost to the provider, shall be paid at the lesser of (a) the usual and customary charge or b) the statewide maximum allowable reimbursement amount allowed for the procedure code reflecting the service rendered.

The agency's rates were set as of October 9, 2009, and are effective for services on or after that date. All rates are published on the agency's fiscal agent's website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Anesthesia Services:

Payments to physicians for anesthesia services performed by the physician or the mid level providers supervised by the physician are paid based on the calculated anesthesia formula in effect on the date of service.

The sum of Base Units plus Time Units plus Special Condition Units, if applicable, is multiplied times the conversion factor for anesthesia services.

The conversion factor service dates beginning on or after January 1, 1992, is 16.00 for all geographic areas when filing modifier\* AA or 78.

For modifiers\* QK and QY, the conversion factor is 5.58 and modifiers\* QX and QZ conversion factors are 10.42 and 15.84, respectively.

If a CPT procedure is non-covered, anesthesia for that service is also non-covered.

Descriptions:

AA	Anesthesia services personally rendered by an Anesthesiologist
QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individual(s) [CRNA's] or [PAAA's] by an anesthesiologist.
QX	Medically Directed—salaried employee of Anesthesiology
QY	Medical direction of on anesthesia procedure involving a qualified individual [CRNA's] or [PAAA's] by anesthesiologist
QZ	Non medically Directed-self employed
78	Return to the operating room

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

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

Services Provided From October 1, 2005 through June 30, 2016

For physician services provided in a hospital or hospital-based clinic on and after October 1, 2005, faculty practices affiliated with governmental teaching hospitals will be eligible for a supplemental payment. All physician services provided on and after August 1, 2006, by faculty practices affiliated with governmental teaching hospitals located in Metropolitan Statistical Areas (MSAs) will be eligible for a supplemental payment.

A teaching hospital shall be defined as a hospital associated with an accredited medical school that offers clinical and other facilities to those studying to become physicians.

An accredited medical school shall be defined as a medical school accredited by the Liaison Committee on Medical Education (LCME) or the Commission on Osteopathic College Accreditation.

Eligible physician faculty practices consist of those affiliated with the following:

Medical College of Georgia Hospital  
Floyd Medical Center  
Grady Memorial Hospital  
Medical Center of Central Georgia  
Memorial Health University Medical Center  
Phoebe Putney Memorial Hospital  
Satilla Regional Medical Center  
The Medical Center

Services Provided On and After July 1, 2016

All services provided by physicians and eligible mid-level providers at a physician practice affiliated with a governmental teaching hospital enrolled in Georgia Medicaid on and after July 1, 2016 will be eligible for a supplemental payment.

An eligible mid-level provider shall be defined to include Advanced Registered Nurse Practitioners (ARNPs), Certified Registered Nurse Anesthetists (CRNAs), Physician Assistants, Certified Nurse Midwives (CNMs), Clinical Social Workers (CSWs), Clinical Psychologists, and Optometrists.

Eligible physician faculty practices on and after July 1, 2016 consist of those affiliated with the following:

Augusta University Medical Center	Piedmont Columbus Regional - Northside Campus
Colquitt Regional Medical Center	The Medical Center, Navicent Health
Dekalb Medical Center	Phoebe Putney Memorial Hospital
Floyd Medical Center	Southeast Georgia Health System - Camden Campus
Grady Memorial Hospital	Southeast Georgia Health System - Brunswick Campus
Piedmont Columbus Regional - Midtown Campus	

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

Methodology for Calculating the Supplemental Payments

The methodology for calculating physician supplemental payments will be the difference between the Medicare equivalent of the average commercial rate and the Medicaid payment. For anesthesia services, the supplemental payment will be the difference between the Medicare rate and the Medicaid rate. Only the physician component of a procedure is eligible for a supplemental payment.

Base data will be collected from each eligible practice, but the Medicare equivalent of the average commercial rate will be calculated by hospital affiliation. To benefit the small urban practices affiliated with Grady Memorial Hospital that do not have the strength in contracting of the larger practices, the Medicare equivalent of the average commercial rate of the largest physician practice affiliated with Grady Memorial Hospital will be used for all physician practices affiliated with Grady Memorial Hospital.

The Medicare equivalent of the average commercial rate will be determined as follows based on a per affiliation calculation (except as noted previously):

1. For the first payment, Medicaid paid claim data for physician professional services will be used for a defined base period (April 2005 to March 2006) for each practice eligible for a physician supplemental payment. The paid claim data will be compiled to identify the number of procedures and payment amounts included in the paid claims, sorted by procedure code for services provided in a hospital setting. For subsequent payments, the data will be collected for the same period for each subsequent year.

For payments after July 1, 2016, Medicaid paid claim data for physician professional services and eligible mid-level provider services will be used for a defined base period for each faculty practice eligible for a physician supplemental payment.

2. For the first payment, using the same base period as was used for the Medicaid paid claims data, each faculty practice will identify the average payment (including patient share amounts) per procedure code for the practice's five largest commercial payers or all payers. The top five commercial payers will be determined by total billed charges reported by eligible practices. After the first payment, the average payment per procedure code is updated every two years.
3. The base period average commercial payment will be calculated by multiplying the average commercial rate per procedure by the number of times each procedure code was rendered in the base period and paid to eligible practices on behalf of Medicaid beneficiaries as reported from the MMIS. The sum of the product for all procedure codes shall determine the base period's average commercial payment ceiling.
4. For the same base period as used to identify Medicaid claim data and average payments per procedure code for commercial payers, the Medicare fee schedule for physician services will be used to identify the Medicare equivalent payment rates.

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TN No. 16-0010

Supersedes

TN No. 06-011

Approval Date: 12/20/18

Effective Date: 07/01/16

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

5. The base period Medicare payment ceiling will be calculated for each of the procedure codes used to determine the average commercial payment by multiplying the base period non-facility, Medicare allowed rate by the number of times each procedure code was rendered in the base period and paid to eligible practices on behalf of Medicaid beneficiaries as reported from MMIS. The sum of the product for all procedure codes shall represent the base period Medicare equivalent payment ceiling.
6. The base period Medicare equivalent of the average commercial rate will be calculated by dividing the base period average commercial payment ceiling by the base period Medicare payment ceiling. If an average commercial payment rate or Medicare-equivalent payment rate is not available for a particular procedure code, paid claim data for the procedure code will be excluded from the aggregate values.
7. Periodic update to the base period Medicare equivalent of the average commercial rate-- The State shall update this ratio every two years. Average commercial ratios are subject to revision, if necessary, based on the Department's review of provider-reported data regarding commercial payment rates.

Determination of the Supplemental Payment

8. The supplemental payment will be determined by multiplying the Medicare equivalent of the average commercial rate by the applicable Medicare non facility rate per procedure code. The product is then multiplied by Medicaid volume per code (as reported through the MMIS paid claims data) for the payment period. The products for all codes are summed to determine the maximum payment amount for the payment period.
9. The Medicaid supplemental payment for each practice shall equal the payment period maximum amount at the Medicare equivalent of the average commercial rate less all Medicaid payments, including enhanced payments for procedure codes rendered in the payment period and paid to eligible physician practices on behalf of Medicaid beneficiaries as reported from the MMIS paid claims data.
10. Payment will be made quarterly not prior to the delivery of services and will be based on individual CPT codes associated with physician services reported through the State's MMIS paid claims data.
11. Supplemental payment is not available for non-physician services such as, but not limited to, diagnostic laboratory services and the non-physician, technical component of bundled radiology services.

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TN No. 16-0010

Supersedes

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

12. For anesthesia services paid on the same basis as Medicare, supplemental payments will be the difference between Medicare equivalent payments and Medicaid payments. Calculated as follows:
  - i. For the payment period, multiply the Medicare rate for anesthesia by the number of Medicaid units (base plus time) per procedure code. The Medicare rate should be adjusted depending on the procedure modifier to determine the appropriate Medicare conversion factor.
  - ii. Sum the products of the above step to determine total Medicare equivalent payments. This represents the payment ceiling for anesthesia services paid on the same basis as Medicare.
  - iii. For the same codes and payment period, subtract the total Medicaid payments from the payment ceiling. This amount represents the total amount eligible for a supplemental payment.
  
13. For anesthesia services paid on a fixed fee, supplemental payments will be the difference between Medicare equivalent payments and Medicaid payments. Calculated as follows:
  - i. MMIS data for a sample period (October 2005 to September 2007) will be used to determine the average number of units (base plus time) per procedure code and by modifier for eligible physician faculty practices. For the payment period, multiply the Medicare rate by the average number of units per procedure code and by the number of times that the procedure code was paid by Medicaid. The Medicare rate should be adjusted depending on the procedure modifier to determine the appropriate Medicare conversion factor.

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

- ii. Sum the products of the above step to determine total Medicare equivalent payments. This represents the payment ceiling for anesthesia services paid on the same basis as Medicare.
  - iii. For the same code and payment period, subtract total Medicaid payment from the payment ceiling. This amount represents the total amount eligible for a supplemental payment.
14. All supplemental payments will be determined on a retrospective basis and will not be subject to subsequent adjustment.

## 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 CFR 447.00 remain in effect. The rates will be 100 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 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.

Effective with payments made after 10/1/2021, eligible primary care physicians who receive the Medicare enhanced rate are eligible to receive supplemental reimbursement via the Physician Upper Payment Limit (UPL) Program

The state will also reimburse at the above mentioned CY 2014 rates for services provided by physicians and physician extenders with an obstetrical and/or gynecological specialty designation.

### 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 Evaluation and Management (E&M) billing codes 99202-99205, 99212- 99215, 99217, 99218, 99221, 99222, 99231-99233, 99238, 99239, 99244, 99381, 99460, 99462, 99468, 99469, 99477, and 99391-99395.

Starting July 1, 2017, this payment will also apply to E&M billing codes 99201, 99211, 99219, 99220, 99223 – 99226, 99234 – 99236, 99241, 99242, 99243, 99245, 99251 – 99255, 99281 – 99285, 99291, 99292, 99304 – 99310, 99318, 99324 – 99328, 99334 – 99337, 99341 – 99345, 99347 – 99350, 99354 – 99357, 99382, 99383, 99384, 99385, 99406, 99407, 99412, 99461, 99463 – 99465, 99471, 99472, 99475, 99476, 99478, 99479, and 99480.

Effective with dates of service beginning July 1, 2020 and thereafter, the rate for the following codes will increase by one percent (1%): 90460, 90471-90474, 99201-99205, 99211-99215, 99217-99226, 99231-99236, 99238-99245, 99251-99255, 99281- 99285, 99291-99292, 99304-99310, 99318, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99354-99357, 99381-99385, 99391-99395, 99406-99407, 99412, 99460- 99465, 99469, 99468-99469, 99471-99472, 99475-99480.

Effective with dates of service beginning July 1, 2021 and thereafter, the rates for the following codes will increase to the Medicare 2020 levels: 90472, 99203, 99204, 99212-99215, 99223, 99232, 99233, 99238, 99284, 99285, 99391-99394, 99480.

**Physician Services – Vaccine Administration**

The state reimburses vaccine administration furnished by physicians meeting the requirements of 42 CFR 447.00 (a) at the regional maximum administration fee set by the Vaccines for Children Program in 2014 for code 90460. Codes 90471 and 90472 are reimbursed at the Medicare fee schedule in effect for the CY 2014 under the Patient Protection and Affordable Care Act rate increase for Medicaid primary care and vaccine administration.

Starting July 1, 2017, codes 90473 and 90474 are reimbursed at the Medicare fee schedule in effect for CY 2014.

Starting July 1, 2020 and thereafter, the rate for the following codes will increase by one percent (1%): 90460 and 90471-90474.

**Method of Payment – Vaccine Administration**

The state has adjusted its fee schedule to make payment at the higher rate for each vaccine administration code.

**Primary Care Services Affected by this Payment Methodology**

This payment applies to vaccine administration billing codes 90460, 90471 and 90472.

**Effective Date of Payment**

E&M Services and Vaccine Administration

This reimbursement methodology applies to services delivered on and after July 1, 2016,  
unless otherwise noted herein.

All rates are published at:

[https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/FEE%20SCHEDULES/Schedule%20of%20Maximum%20Allw%20Pvmt%20Physician %20\(006\)%2020210615141107.pdf](https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/FEE%20SCHEDULES/Schedule%20of%20Maximum%20Allw%20Pvmt%20Physician%20(006)%2020210615141107.pdf)

## STATE/TERRITORY: GEORGIA

POLICY AND METHOD FOR ESTABLISHING RATES FOR OTHER TYPES OR  
CARE OR SERVICESN. PERINATAL CASE MANAGEMENT SERVICES

- (a) Except as otherwise noted in the plan, the state-developed fee schedule rates are the same for both governmental and private providers of perinatal case management services. The payment rates for these services can be found in the Perinatal Case Management Provider Manual which can be found at the state's website: <https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx> . These rates were last updated on January 1, 2005, and are effective for services provided on or after that date.
- (b) Reimbursement for perinatal case management services is available for the initial comprehensive contact, follow up contacts, and a postpartum contact.



STATE/TERRITORY: GEORGIA

POLICY AND METHOD FOR ESTABLISHING RATES FOR OTHER TYPES OR  
CARE OR SERVICES

Reserved for later use.

STATE/TERRITORY: GEORGIA

POLICY AND METHOD FOR ESTABLISHING RATES FOR OTHER TYPES OR  
CARE OR SERVICES

Reserved for later use.

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TN No.: 14-003

Supersedes

TN No.: 89-14

Effective Date: January 1, 2014

Approval Date: 06-20-14

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

- N. (c) Early Intervention Case Management services will be reimbursed directly to the providers of case management services on a negotiated rate basis not to exceed actual costs, which meets all requirements of the Office of Management and Budget Circular A-87 dated January 15, 1981.

TRANSMITTAL 91-20  
APPROVED 12-5-91  
EFFECTIVE 5-21-91  
SUPERSEDES NEW

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

N. (d.) Children At-Risk Case Management Services will be billed monthly on the HCFA 1500 form and be reimbursed on a prospective fee-for service basis. Payments to providers are limited to the lesser of the submitted charge or the established rate. The established statewide rates are based on the median cost per visit of providers currently enrolled in the program. Cost will be evaluated periodically and reimbursement rates will be adjusted to reflect cost.

NEW CHILD, COMPREHENSIVE ASSESSMENT: Service to a new child whose care management records must be established. This service will be completed within 30 days of enrollment into case management services. A comprehensive level of service will be provided including an assessment and individualized service plan for the health, educational, social, psychological, and other needs of each youth. A problem list will be developed based upon the comprehensive assessment and service priorities established, initial linkages will be made with providers of the needed identified services for at least the top three priorities. For example:

1. Those children assessed as being in need of health care will be referred to an EPSDT provider for EPSDT services.
2. A referral will be made to the County Department of Family and Children Services to assist children living in abusive family situations.
3. Arrangements will be made for any necessary transportation.

This unit of service will be billed only once for each eligible child served.

CASE MANAGEMENT FOLLOW-UP: Services to an established service recipient. All contacts with the recipient and/or his/her family by Family Connection Case Management personnel must be documented by level of service to receive reimbursement. Reimbursement is

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

limited to a maximum of 12 visits annually. Dates of service must occur after the comprehensive assessment.

The level of service billed will be based on the on the service recipient's individual service plan and the need for case management assistance as defined below.

Brief follow-up: Consist of at least one (1) minimal contact with the recipient, the family or the service provider to ensure that the recipient is complying with the established service delivery plan.

Extended follow-up: Consist of a minimum of one direct contact with the recipient and the family to reevaluate reassess the individual service delivery plans due to changes in recipient's personal or family factors.

TRANSMITTAL 92-01  
APPROVED 5-12-92  
EFFECTIVE 2-1-92  
SUPERSEDES (NEW)

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

- N. (e.) Dropout Recovery Case Management Services will be billed monthly on the HCFA 1500 form and be reimbursed a prospective fee-for-service basis. Payments to public and private providers are limited to the lesser of the submitted charge or the established fees based on the actual cost of public providers as determined by time studies conducted pursuant to methodology approved by HCFA, Region IV. costs will be evaluated annually and fees adjusted to reflect actual cost.

NEW CLIENT, COMPREHENSIVE ASSESSMENT: Service to a newly recovered dropout whose case management records must be established. This service will be completed within 30 days of enrollment into case management services. A comprehensive level of service will be provided including an assessment and individualized service plan for the health, educational, social, psychological, and other needs of each youth. A problem list will be developed based upon the comprehensive assessment and service priorities established. Initial linkages will be made with providers of the needed identified services for at least the top three priorities. For example:

2. Those recovered dropouts assessed as being in need of health care will be referred to an EPSDT provider for EPSDT services.
3. A referral will be made to the County Department of Family and Children Services to assist recovered dropouts living in abusive family situations.
4. A referral will be made to the Public School System or GED providers to assist recovered dropouts to complete a planned secondary educational program.

This unit of service will be billed only once for each eligible child served.

TRANSMITTAL 92-31  
APPROVED 10-27-92  
EFFECTIVE 10-15-92  
SUPERSEDES (NEW)

CASE MANAGEMENT FOLLOW-UP: Services to an established service recipient. All contacts with the recipient and/or his/her family by Dropout Recovery Case Management personnel must be documented by level of service to receive reimbursement. Reimbursement is limited to a maximum of 12 visits annually. Dates of service must occur after the comprehensive assessment.

The level of service billed will be based on the service recipient's individual service plan and the need for case management assistance as defined below.

Brief follow-up: Consist of at least one (1) minimal contact with the recipient, the family or the service provider to ensure that the recipient is complying with the established service delivery plan.

Extended follow-up: consist of a minimum of one direct contact with the recipient and the family to reevaluate or reassess the individual service delivery plans due to changes in recipient's personal or family factors.

TRANSMITTAL	92-31
APPROVED	10-27-92
EFFECTIVE	10-15-92
SUPERSEDES	(NEW)

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR  
OTHER TYPES OF CARE OR SERVICE

M(2) Specialized Transportation for Medicaid eligible Children under age 21, an with Individual Education Programs (IEP)

- 1.Reimbursement for specialized transportation will be based on a flat rate.
2. The statewide rate will be established using the average historic cost of providing specialized transportation services in the school districts.
3. The cost of non-school provided transportation will be excluded form the calculation and will not be paid by Medicaid.
4. The Department will consider periodic inflationary adjustments to the rate.
5. The reimbursement authority to pay for specialized transportation services provided in schools will end effective June 30, 2008.

A trip, for Medicaid billing purposes is defined as a trip for a Medicaid eligible student requiring special transportation services, picked up at home or school, delivered to a location where an approved Medicaid service is provided, or delivered back to home or school from the Medicaid service. This definition is consistent with Section 3.1 a/b of the State Plan.

The school districts will maintain daily transportation logs and provide data related to the number of specialized transportation trips per student. These data will include the number of special transportation students transported and the number of days transported.

Medicaid will be billed only for children who have been determined eligible for Medicaid. In this way the total costs of specialized transportation will be allocated between Medicaid and Non-Medicaid. A specialized transportation claim will only be accepted if the school district can document that the child received specialized transportation service on the same day that a Medicaid covered IEP service was provided.



Policy and Methods for Establishing Payment Rates for other types of Care or Services

- N.(f) Case Management Services for Adults with AIDS will be billed monthly on the DMA-1500C (4/92) form and will be reimbursed on a prospective fee-for-service basis.

Payments to private providers are limited to the lesser of the submitted charge or the established fee (s) based on actual cost as determined by time studies conducted pursuant to methodology approved by the Health care Financing Administration.

Public providers of case management services will be reimbursed directly on a negotiated rate basis not to exceed actual cost.

Costs will be evaluated annually and fees adjusted to reflect actual cost.

New Client comprehensive Assessment:

Service to a new client whose case management records must be established. This service must be initiated within 48 hours of the request for services and must be completed within 30 days of enrollment into case management.

A comprehensive level of service shall be provided including obtaining a medical assessment from the client's primary physician, conducting a psychosocial assessment, developing an individualized service plan for the client's medical, nutritional, social, educational, psychological transportation, housing, legal, financial, and other needs. A problem list shall be generated based on the comprehensive assessment and service priorities shall be established. Initial linkages shall be made with providers of the needed identified services. This unit of service may be billed only once for each client served.

TRANSMITTAL	92-40
APPROVED	1-28-93
EFFECTIVE	10-1-92
SUPERSEDES	(NEW)

Case Management Follow-Up:

Services to an established service recipient. All contacts with the recipient, his or her family members, significant others, and service providers must be documented to receive reimbursement. Reimbursement is limited to a maximum of 12 follow-up services annually. Providers may not bill for an extended and a brief follow-up performed in the same month. Providers may bill for no more than three (3) extended follow-up services annually. Dates of follow-up services must occur after the comprehensive assessment.

The level of service (brief or extended) billed shall be based on the recipient's individual service plan and the descriptions of case management follow-up found below.

Brief Follow-Up:

consists of at least one (1) contact with the recipient AND, if appropriate, his or her significant other, family member, or service provider to ensure that the recipient is complying with the established service delivery plan.

Extended Follow-Up:

Consists of at least one (1) direct contact with the recipient to re-evaluate or reassess the individual service delivery plan due to crisis resulting from changes in recipient's medical condition, loss of social support, employment, or housing, legal problems, or other significant events.

TRANSMITTAL	92-40
APPROVED	1-28-93
EFFECTIVE	10-1-92
SUPERSEDES	(NEW)

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

- N.(g) The results of a time study were applied to projected costs for each of the prospective providers and statewide rates for the first year were established based on an arraying of the costs of the 50th percentile. Cost reports from all providers will be evaluated annually after the first year of implementation to determine subsequent statewide rates. Payments to public and private providers will be limited to the lesser of the submitted charge or established fee based on cost reports from providers. Payment to providers may not exceed actual cost of providing services.

At-Risk of Incarceration Case management Services will be reimbursed on a fee-for-service basis billed monthly on the HCFA 1500 form.

The Department will reimburse one unit of case management service per month per beneficiary. The specific service component (billing unit) covered under the At-Risk of Incarceration program is Basic Case Management.

Basic Case Management

*"Basic Case Management" must be provided by a qualified provider to a child in the care of the Department of Juvenile justice. It must include at least one (1) contact with the recipient, family or service provider to ensure that services are being delivered in accordance with the established service delivery plan. It includes one or more of the following activities:*

- A. *Establishing the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the child.*
- B. *Assisting the child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan.*
- C. *Monitoring the child and service providers to determine that the services received are adequate in meeting the child's needs.*
- D. *Reassessment of the child to determine services needed to resolve any crisis situation resulting from divorce, death, separation, changes in family structure or living conditions, or other events.*

Extended follow-up

The extended follow-up consists of at least one (1) direct contact with the beneficiary and a family member or provider to re-evaluate the individual service plan due to changes in the beneficiary's personal or family factors.

The extended follow-up will require additional documentation if billed more than three (3) times during a calendar year. If subsequent visits are billed, documentation of necessity of the service must be attached to each claim. The Department will either approve or deny the claim.

Only one (1) brief or one (1) extended follow-up may be billed each month with a maximum of twelve (12) follow-up services per year. Dates of service for case management follow-up must occur after the initial assessment.

In the event of multiple types of targeted case management, only one type will be reimbursed during the calendar month for each beneficiary.

TRANSMITTAL	93-04
APPROVED	1-11-95
EFFECTIVE	3-01-93
SUPERSEDES	NEW

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

- N. (h) Perinatal Case Management Services/Area C will be billed monthly on the HCFA 1500 form and be reimbursed on a prospective fee-for-service basis. Payments to public and private providers are limited to the lesser of the submitted charge or the established fees based on the actual cost of public providers as determined by time studies conducted pursuant to methodology approved by HCFA, Region IV, Costs will be evaluated annually and fees adjusted to reflect actual cost.

PREGNANT WOMAN, COMPREHENSIVE ASSESSMENT: Service to a newly pregnant woman whose case management records must be established. This service will be completed within 30 days of enrollment into case management services. A comprehensive level of service will be provided including an assessment and individualized service plan for the health, educational, social, psychological, and other needs of each pregnant woman. A problem list will be developed based upon the comprehensive assessment and service priorities established. Initial linkages will be made with providers of the needed identified services for at least the top three priorities. For example:

1. Pregnant women will be referred to a prenatal care provider.
2. Pregnant women will be referred to the County Department of Health for nutritional assessment and for WIC benefits.
3. Arrangements will be made for any necessary transportation to prenatal care appointments.

This unit of service will be billed once for each eligible pregnant woman.

NEWBORN, COMPREHENSIVE ASSESSMENT: Service to a newborn whose case management records must be established. This service will be completed within 30 days of birth. A comprehensive level of service will be provided including an assessment and individualized service plan for the health, social, psychological, and other needs of each newborn. A problem list will be developed based upon the comprehensive assessment and service priorities established. Initial linkages will be made with providers of the needed identified services for at least the top three priorities. For example:

1. Newborns will be referred to an EPSDT provider for EPSDT services.
2. Newborns will be referred to the county Department of Health for nutritional assessment and for WIC benefits.
3. A referral will be made to the County Department of Family and children Services to assist newborns living in abusive family situations.

This unit of service will be billed one for each eligible newborn.

TRANSMITTAL	93-020
APPROVED	5-4-94
EFFECTIVE	4-1-93
SUPERSEDES	NEW

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

CASE MANAGEMENT FOLLOW-UP: Services to an established service recipient. All contacts with the recipient and/or recipient's family by Case Management personnel must be documented by level of services to receive reimbursement. Reimbursement is limited to a maximum of 12 visits annually. Dates of service must occur after the comprehensive assessment.

The level of service billed will be based on the service recipient's Individual service plan and the need for case management assistance as defined below.

Brief Follow-up: consist of at least one (1) minimal contact with the recipient, the family or the service provider to ensure that the recipient is complying the established service delivery plan.

Extended Follow-up: Consist of a minimum of one direct contact with the recipient and the family to reevaluate or reassess the individual service delivery plans due to changes in recipient's personal or family factors.

TRANSMITTAL	93-020
APPROVED	5-4-94
EFFECTIVE	4-1-93
SUPERSEDES	NEW

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

N.(i) Reimbursement rates will be established based on cost a determined by the quarterly Social Services Random Moment Sample Study. Rates will be adjusted annually based on the results of the previous four quarters. The Random Moment Sample Study must provide an audit trail that identifies each client whose case is included in the data used for rate formulation.

A maximum of one unit of case management services will be reimbursed per month for each eligible recipient. However, if a family has more than one child in the home with the parent and no children have been placed outside of the home, the Department will only reimburse for one child within the family unit. Services will be reimbursed only for eligible recipients.

A unit of case management service is defined as at least one telephone or face-to-face contact with the recipient, a family member, significant other, or agency from which the client receives or may receive services. All contacts must be for the coordination or linkage of services.

TRANSMITTAL 93-40  
APPROVED 5/27/94  
EFFECTIVE 7/1/93  
SUPERSEDES NEW

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

N.(j) Reimbursement rates will be established based on cost as determined by the quarterly Social Services Random Moment Sample Study. Rates will be adjusted annually based on the results of the previous four quarters. The Random Moment Sample Study must provide an audit trail that identifies each client whose case is included in the data used for rate formulation.

A maximum of one unit of case management services will be reimbursed per month for each eligible recipient. A unit of case management service is defined as at least one telephone or face-to-face contact with the recipient, a family member, significant other, or agency from which the client receives or may receive services. All contacts must be for the coordination or linkage of services for a specific recipient.

TRANSMITTAL 93-041  
APPROVED 8/24/94  
EFFECTIVE 7/01/93  
SUPERSEDES NEW



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

2c. Federally Qualified Health Center (FOHC) Services

In accordance with Section 702 of the Medicare, Medicaid and CHIP 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 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, 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 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. 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 center'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 and projections of the cost and volume impact of the change.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE  
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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 payment 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.

Effective for dates of services on or after May 15, 2015, FQHCs may elect to receive reimbursement for Long Acting Reversible Contraceptives (LARCs) (specifically intrauterine devices and single rod implantable devices) for contraceptive purposes.

Reimbursement for the LARCs shall be made in accordance with the following:

- i. To the extent that the LARCs were purchased under the 340B Drug Pricing Program, the FQHC must bill the actual acquisition cost for the device.
- ii. Reimbursement shall be made at the FQHC's actual 340B acquisition cost for LARCs purchased through the 340B program. For LARCs not purchased through the 340B program, reimbursement shall be made at the lower of the provider's charges or the rate on the Department's practitioner fee schedule, whichever is applicable.
- iii. Reimbursement is separate from any encounter payment the FQHC may receive for LARCs.

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

Non-Emergency Transportation Services

Non-Emergency Transportation is reimbursed according to the following methods, depending on type of vehicle and number of passengers for exceptional travel or the number of Medicaid eligibles in a region. Upper reimbursement limits shall not exceed charge determined to be reasonable by the State.

- (a) The Broker is reimbursed a monthly capitated rate for each Medicaid member residing in the region.
- (b) For exceptional travel, the Department of Family and Children Services is reimbursed a mileage rate per passenger for automobile services; commercial and public transportation are reimbursed at the usual and customary rate; escorts, meals and lodging are also reimbursed at the usual and customary rate.

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

N (k) Services Coordination for Children with Individualized Education Programs (IEPs)

- Reimbursement for service coordination will be on a fee-for-service basis billable monthly on a HCFA 1500.
- The initial statewide maximum allowable rates will be established using comparable service coordination activities and rates paid in other existing targeted case management programs (i.e. Children at Risk).
- The Division will collect and evaluate cost data after the first year of service and periodically thereafter from participating local education agencies (LEA) to determine the actual cost of providing this service and establish a statewide fee structure,
- If the initial statewide maximum allowable rates exceed the actual cost of providing this service, the cost data will be utilized to set the maximum allowable rates. If the statewide maximum allowable rates are lower than the actual cost, the Division will periodically consider an increase subject to the availability of funds.

Service Categories

Ongoing monthly special education service coordination activities will be billed based on the child's IEP and the need for service coordination case management services as defined below:

1) Initial IEP

The initial IEP requires that the service coordinator integrate all evaluation data into a description of status that highlights the overall pattern of strengths and weaknesses of the student. Goals and objectives must be developed to address specific weaknesses. Supplementary aids and services to address those goals, in the least restrictive environment, must be considered. Input from the IEP Multidisciplinary Team, a schedule of required services, along with goals and objectives for each, must be determined and documented.

- This service can be billed as one (1) per lifetime for each Medicaid eligible child with an IEP.

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

N (k) Services Coordination for Children with Individualized Education Programs (IEPs)  
(continued)

2) IEP Review

The compilation of progress reports and updated testing information by the service coordinator supports the required annual review of the IEP goals, objectives and services. The service coordinator must integrate this data so that a service schedule can be developed. This review must be done more often if the parent or a professional serving the student request a consideration of a change in services by the IEP Multi-disciplinary Team.

- This service can be billed as one (1) minimal contact or a maximum of three (3) per year.

3) Triennial IEP

Every three years the service coordinator must undertake a comprehensive analysis of available and relevant assessment information on the student. Necessary evaluations must be scheduled and a new IEP per child developed and adopted by the IEP Multi-disciplinary Team.

- This service can be billed as one (1) review every 3 years.

4) On-going Service Coordination

The ongoing contact (billable intervals) of the service coordinator in coordinating and monitoring follow-up with the child, the family, or the service providers (private and public agencies), to ensure access and compliance, as developed and adopted by the IEP Multi-disciplinary Team.

- This service can be billed at intervals of one (1) unit, which equals 15 minutes.

**Policy And Methods For Establishing Payment Rates For Other Types Of Care and Service**

P. Hospice Services

Georgia will pay the Medicaid Hospice rates developed annually by the Centers for Medicare and Medicaid Services and also apply the "appropriate local hospice wage index" for the following categories or levels of care provided. The "appropriate local hospice wage index" is published annually in the Federal Register and is effective October 1 through September 30 of each year.

Medicaid reimbursement for hospice care will be made at predetermined rates for each day the individual receives care under one of the following five categories or levels of hospice care. Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers. The hospice service payment methodology for each category of care is below:

A) Routine Home Care Rate (RHC)

Hospice providers are paid at one of two tiers (levels) of RHC. Effective for dates of service on or after July 1, 2017 the two tiers are based on number of days in care:

Tier 1 RHC: Days 1-60 of hospice care (Higher rate)	\$ (1 unit = 1 day)
Tier 2 RHC: Days 61+Beyond (Decreased rate)	\$ (1 unit = 1 day)

There is a 60 days minimum gap in Hospice Services that must elapse to reset the Hospice day count and be eligible for the higher level of RHC reimbursement.

- |   |   |
|---|---|
| B) Continuous Home Care Rate (CHC)            | \$Full Rate/24 hours or (1 unit=1 hour) |
| C) Inpatient Respite Care Rate                | \$ (1 unit = 1 day)                     |
| D) General Inpatient Care Rate                | \$ (1 unit = 1 day)                     |
| E) Service Intensity Add-On, 7 days Pre-Death | \$ (1 unit = 1 day)                     |

Reimbursement may be made to the hospice provider to cover nursing facility room and board costs (R&B) of hospice members at the following rate.

Hospice NF R&B Per Diem Rate 95% of the NF Per Diem (1 unit = 1 day)

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

Freestanding Birth Center Services

1. The Agency's rates were set as of July 1, 2003, and are effective for services on or after that date. Except as otherwise noted in the plan, the statewide maximum allowable reimbursement rate is 84.645% of the 2000 Resource Based Relative Value Scale as specified by Medicare for Georgia Area 1 (referred to as, "RBRVS") and is the same for both governmental and private providers.
2. Medicaid covers and reimburses for services rendered by providers administering prenatal labor and delivery or postpartum care in freestanding birth care centers such as physicians, nurse midwives and other providers of such services as recognized under Title 43 of the Official Code of Georgia Annotated. Practitioners furnish other covered mandatory services in accordance with Attachment 3.1-A, Page 4a-3.
3. Pregnant women, recipients under twenty-one (21) years of age, nursing home residents, and hospice care recipients, are not required to pay-the co-payment. Emergency services and family planning services are exempt from co-payments.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE: GEORGIA

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

Item: Q. Payment of Title XVIII Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment, if applicable, the Medicaid agency may use the following method:

	Medicare-Medicaid Individual	Medicare-Medicaid QMB Individual	Medicare-QMB Individual
Part A Deductible	<input checked="" type="checkbox"/> Limited to State Plan Rate*	<input checked="" type="checkbox"/> Limited to State Plan Rate*	<input checked="" type="checkbox"/> Limited to State Plan Rate*
	<input type="checkbox"/> Full Amount	<input type="checkbox"/> Full Amount	<input type="checkbox"/> Full Amount
Part A Coinsurance	<input checked="" type="checkbox"/> Limited to State Plan Rate*	<input checked="" type="checkbox"/> Limited to State Plan Rate*	<input checked="" type="checkbox"/> Limited to State Plan Rate*
	<input type="checkbox"/> Full Amount	<input type="checkbox"/> Full Amount	<input type="checkbox"/> Full Amount
Part B Deductible	<input checked="" type="checkbox"/> Limited to State Plan Rate*	<input checked="" type="checkbox"/> Limited to State Plan Rate*	<input checked="" type="checkbox"/> Limited to State Plan Rate*
	<input type="checkbox"/> Full Amount	<input type="checkbox"/> Full Amount	<input type="checkbox"/> Full Amount
Part B Coinsurance	<input checked="" type="checkbox"/> Limited to State Plan Rate*	<input checked="" type="checkbox"/> Limited to State Plan Rate*	<input checked="" type="checkbox"/> Limited to State Plan Rate*
	<input type="checkbox"/> Full Amount	<input type="checkbox"/> Full Amount	<input type="checkbox"/> Full Amount

\* For those Title XVIII services not otherwise covered by the Title XIX State Plan, the Medicaid agency has established reimbursement methodologies as described in Items 2 and 3, specified on page 1 of Attachment 4.19-B,

TN No. 00-018

Supersedes

TN No. 90-42

Approval Date JAN 30 2001

Effective Date OCT 01 2000



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

R. OUTPATIENT HOSPITAL SERVICES

1. Outpatient services by Georgia hospitals are reimbursed on a determination of allowable costs. The determination of allowable costs is made retrospectively and is based on an appropriate CMS Form 2552 cost report submitted by the hospital and audited by the Department or its agents. Only costs incurred in providing patient care are eligible for reimbursement. Fees paid to the Department of Community Health pursuant to the Hospital Medicaid Financing Program Act of 2013 shall be considered allowable cost but will not be included in the retrospective cash settlement and reconciliation of the providers cost report.

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 modified in the Department's "Policies and Procedures for Hospital Services" as published on January 1, 2013.

The amount of interim payment is calculated as a percentage of covered charges. This payment rate is defined by covered as allowable outpatient costs divided by outpatient charges. An interim payment rate cannot exceed one hundred percent of covered charges and is subject to cash settlement determination after an audited cost report is received, reviewed and accepted.

Clinical diagnostic laboratory services performed for outpatients and non-hospital patients are reimbursed at the lesser of the submitted charges or at the Department's fee schedule rates used for the laboratory services program.

Clinical diagnostic laboratory services are subject to an upper payment limit (UPL) at section 1903(i) (7) of the Act, which is the amount Medicare would pay on a per test basis (or per billing code basis for a bundled/panel of tests) from Medicare's clinical laboratory fee schedule. Federal matching funds are available to the extent a state pays at or below the per test rate paid by Medicare for these services.

2. The Department will provide for appropriate audit to assure that payments made to providers for outpatient hospital services meet the requirements of reasonable cost.
3. Outpatient services provided by non-participating non-Georgia hospitals are reimbursed at 45% of covered charges.
4. The maximum allowable payment for outpatient services will be 85.6% of the hospital specific inpatient per case rate, which includes the base rate amount plus

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POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER  
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Capital add-on, Graduate Medical Education add-on, Newborn add-on and the Hospital Provider Fee rate add-on, for enrolled Georgia hospitals. This case rate for enrolled non-Georgia hospitals does not include the Hospital Provider Fee add-on amount.

5. Emergency room visits for minor and non-acute illnesses which are not considered as true or potential medical emergencies will be reimbursed at an all-inclusive rate of \$50.00.
6. The maximum allowable payment to enrolled Georgia and non-Georgia hospitals for Medicare outpatient coinsurance (crossover claims) will be 85.6% of the hospital-specific Medicaid per case rate. The maximum allowable payment to non-Georgia hospitals not enrolled the Georgia Medicaid program for Medicare outpatient crossover claims will be 85.6% of the average hospital-specific inpatient per case rate for enrolled non-Georgia hospitals.
7. For the determination of reasonable and reimbursable costs, the costs listed below are non-allowable (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 or 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 expense in excess 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

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POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER  
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patient transport, the portion of cost that is unrelated to patient care staff or patient transport is non-allowable;

- 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 issuance reviews, 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
  - 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.
8. When the outpatient cost-based settlements are made, claims for outpatient services which were paid at the per case rate will be excluded from the settlement calculations.
9. Hospital-based physicians services will not be reimbursed if billed to the Hospital program. These services must be billed to the Physician program in order to be reimbursed by the Department.
10. The Department will limit payment on outpatient Medicare crossover claims as using the following steps:
- (a) multiply the allowable deductible and coinsurance amount by the hospital-specific percent of charges rate in effect on the date of payment;
  - (b) compare the dollar amount from (a) to the hospital's inpatient per case rate in effect on the date of payment and,
  - (c) reimburse the lower of these two amounts.

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POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER  
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11. A \$3.00 recipient co-payment is required on all non-emergency outpatient hospital visits. Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospital care recipients are not subject to the co-payment. Emergency services and family planning services are exempt from co-payment. When the outpatient cost-based settlements are made for hospital services, the co-payments plus Medicaid and certain third party payments will be compared to the allowable cost to determine the amount of final settlement.
12. The Department shall exclude from paid claims data used to calculate settlement claims for which a third party paid at or in excess of the amount Medicaid would pay. Third party payments which were below the Medicaid payment amount will be included in the interim payment amounts that are compared to reimbursable costs. The paid claims data used in the initial determination of outpatient settlements will be used when such settlements are adjusted.
13. Effective July 1, 2013, an adjustment will be added to the hospital outpatient payment rate. Critical Access Hospitals (CAH) Psychiatric Hospitals and State-Owned / State-Operated Hospitals are exempt from the provider fee and the rate increase. 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 adjustment for different classes of hospitals.

<b>Provider Type</b>	<b>Provider Fee Percent</b>	<b>Rate Increase Percent</b>
Participating Acute Care Hospitals and Specialty Hospitals	1.45%	11.88%
Trauma Hospitals	1.40%	11.88%
Critical Access Hospitals, State- Owned and State- Operated Hospitals, Out-of- State Hospitals	N/A	N/A

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POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER  
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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 factor. 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.

When calculating the Final Allowed Charge, the addition of this new Base Rate Change Add-on will be the final step before any cutbacks are considered. The dollar amount will be calculated as a percentage of the Allowed Charge at that point in adjudication.

**Outpatient Cost-to-Charge Ratio Base Payment is Calculated as:**

CCR Base Payment = Total Calculated Allowed Charge\*\* x Cost-To-Charge Ratio (CCR)\* percent

CCR Base Payment + Cap/GME Add-on + Newborn Add-on = Allowed Charge

Allowed Charge x .1188 Base Rate Change Factor) = Base Rate Change Add-on

Allowed Charge + Base Rate Change Add-on - deductions (Copay, COB, Patient Liability) = Reimbursement Amount

The payment is the lower of the reimbursement amount or the inpatient per case rate plus Base Rate Change add on.

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\* The system finds the provider's Cost-To-Charge Ratio (CCR) percent on the reference institutional rate table using the provider number and the claim's admission date.

\*\* Calculation of the Allowed Charge occurs for each claim line. The total of the claim line Allowed Charges is used to calculate the cost-to-charge ratio (CCR) base payment.

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POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER  
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Effective for dates of service on and after July 1, 2013, through June 30, 2025, the payment method is modified as follows:

- a. For enrolled hospitals other than those identified in items band c below, the reimbursement rate is 95.77% of costs.
- b. For out-of-state enrolled hospitals, payments are made at the statewide average percentage of charges paid to Georgia hospitals that are reimbursed at 85.6% of costs and are not subject to cost settlement. The payment rate for out-of-state enrolled hospitals will not exceed 65% of covered charges.
- c. For hospitals that are designated as a Critical Access Hospital, a historically minority-owned hospital, or as a state-owned hospital, the reimbursement rate continues at 100% of costs.

Example settlement calculation for critical access, historically minority owned hospital, or state-owned hospitals:

Percentage of charges paid on interim basis	60%
Charges for services provided during cost report period	\$1,000,000
Interim payments	\$600,000
Retrospective determination of allowable costs*	\$585,000
% of allowable costs reimbursed	100%
Retrospective determination of reimbursable costs	\$585,000
Settlement amount due from hospital	\$15,000

Example settlement calculation for all other enrolled Georgia hospitals:

Percentage of charges paid on interim basis	52%
Charges for services provided during cost report period	\$1,000,000
Interim payments	\$520,000
Retrospective determination of allowable costs*	\$585,000
% of allowable costs reimbursed	95.77%
Retrospective determination of reimbursable costs	\$560,250
Settlement amount due from hospital	\$24,750

\* amount would not exceed charges for services

14. Governmental facilities and Critical Access eligible hospitals which meet departmental requirements will be eligible for rate payment adjustments. The rate adjustment payments are intended to provide supplemental funding for Medicaid services to these facilities that based on their governmental status,

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POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER  
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need sufficient funds for their commitments to meet the healthcare needs of all members of their communities.

The rate payment adjustments will be subject to federal upper payment limits. For the appropriate groupings of State governmental facilities, non-State governmental facilities and non-governmental facilities, aggregate rate adjustment payments available without exceeding upper payment limits will be determined by measuring the difference between:

- All amounts paid for services provided to Medicaid patients including interim Medicaid claim payments and estimated Medicaid cost report settlement amounts, based on data from cost report worksheet E-3 Part III, and
- Estimated payment amounts for such services if payments were based on Medicare payment principles. Cost based and rate payment measures (for clinical diagnostic lab services) will be used to determine Medicare payment amounts.

Comparisons of amounts paid for services provided to Medicaid patients and estimated payment amounts for such services if payments were based on Medicare payment principles will also be made for each facility to determine facility-specific rate adjustment payments. If an individual facility cannot be paid a portion of its full rate adjustment payment due to a facility-specific charge limit, this rate adjustment amount can be allocated to other facilities that are eligible to receive additional rate adjustment payments without exceeding facility-specific charge limits. These rate payment adjustments will be made on quarterly or, at least, annual basis and will be determined in a manner that will not duplicate compensation provided from payments for individual patient claims. A sample of how a rate adjustment payment is calculated is presented below.

line	Facility Name	comments	
1	base period report period beginning date		XYZ Hospital 9/1/xxxx
2	base period report period ending date		8/31/xxxx+1
3	HS&R processing date for Medicaid data		9/6/xxxx+2
4	adjustment factor (if period not equal to 1 year)		1

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POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER  
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5	CAH status (1 = yes)		0
	<u>subject to cost settlement</u>		
6	cost of Medicaid covered services		755,769
7	covered charges		2,511,680
8	annual cost of Medicaid covered services	Line 6 x line 4	755,769
9	cost settlement rate		95.77%
10	annual Medicaid payments after cost settlement	Line 8 x line 9	721,382
	fee schedule lab only		
11	payments		102,275
12	annual interim payments	Line 11 x line 4	102,275
13	estimated payments for fee schedule lab services if paid on Medicare Lab fee schedule		244,687
	<u>subject to fixed fee payment</u>		
14	<u>covered charges</u>		223,627
15	<u>payments</u>		26,427
16	<u>annual covered charges</u>	Line 14 x line 4	223,627
17	annual interim payments	Line 16 x line 4	26,427



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POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER  
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18	annual cost of services	Line 16 x line 6/ line 7	67,290
	<u>subject to limit of inpatient rate</u>		
19	covered charges		137,463
20	payments		48,481
21	annual covered charges	Line 20 x line 4	137,463
22	annual interim payments	Line 21 x line 4	48,481
23	annual cost of services	Line 21 x line 6/ line 7	41,363
24	adjustment factors cost inflation	from cost report to UPL period	1.040

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

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25	adjusted Medicaid annual payments	(Line 10 x line 24)	
26	adjusted annual cost of services	(Line 8 + line 13 + line 18+ line 23) x line 24	750,237
27	UPL amount	Line 26 - line 25	1,153,473
			403,236

**Footnotes for UPL Adjustment Factors:**

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

Line 26: Cost Inflation:

DCH uses Global Insight Hospital Market Basket (Table 6.3), as adopted by CMS, for all inflation-related hospital cost estimates. This quarter-by-quarter index provides a breakout of all relevant categories of hospital cost.

This is primarily eligibility growth. DCH currently predicts Medicaid fee-for-service eligibility in the Aged, Blind and Disabled (ABD) population to grow annually at 1.4%.

15. Effective for dates of service April 1, 1991, and after, the Department will provide payment to enrolled hospitals which offer, either directly or through contract, birthing and parenting classes to Medicaid-eligible pregnant women. Reimbursement will be the lesser of the amount billed for revenue code 942 or the maximum allowable payment amount established by the Department. When the outpatient cost-based settlements are made, claims for outpatient services for birthing and parenting classes will be excluded from the settlement calculations as reimbursement is at a fixed payment rate.

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

Supplemental Access to Care Payments for Private Hospitals:

- A As of July 1, 2013, privately owned Georgia hospitals, excluding children's, geriatric, osteopathic, critical access, rehabilitative and psychiatric hospitals, ("private hospital subclass") shall be paid supplemental amounts for the provision of hospital outpatient services set forth in this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services.
- B Payments are not to exceed the outpatient upper payment limit (UPL) gap calculated in Section 14 on page 8.6 of Attachment 4.19-B less Section 14 rate payment adjustments, supplemental payments shall be made to hospitals with 50 beds or less in the private hospital subclass which provide presenting access to telemedicine, tele-trauma or tele-stroke services for Georgia's Medicaid and general population as determined by the Georgia Partnership for Telehealth and updated annually with the most recent information available as of July 1 of each fiscal year. These additional payments shall be an amount of \$75.00 per outpatient Medicaid fee-for-service encounter derived from the most recent Medicaid MMIS outpatient fee-for-service date of service claims data.
- C Payments are equal to the outpatient UPL gap calculated in Section 14 on page 8.6 of Attachment 4.19-B, less Section 14 rate adjustment payments and paragraph (B) Access to Care Payments, hospitals in the private subclass shall receive a payment equal to a percentage increase applied to annual outpatient hospital Medicaid fee-for-service payments derived from the most recent Medicaid MMIS Outpatient fee-for-service date of service claims data and updated annually with the most recent information available as of July 1 of each fiscal year. The percentage increase will be equal to the remaining pool amount divided by the annual outpatient hospital Medicaid fee-for-service payments for the private hospital subclass.
- D Supplemental payments shall be paid in four installments within the state fiscal year.
- E Hospital payments made under this section, when combined with other payments made under the state plan shall not exceed the limit specified in 42 CFR 447.321.
- F The total funds that will be paid to each hospital will be included in the calculation of disproportionate share limits as described in Section III B.3 of Attachment 4.19 - A.

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

S. Nurse Practitioner Services

Payments are limited to the lower of:

- (a) The submitted charge, or
- (b) Ninety percent (90%) of the statewide rate for physician services in effect on the date of service.
- (c) Effective with date of service July 1, 1994, a \$2.00 recipient co-payment is required on all non-emergency office visit services for nurse practitioner providers. Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care recipients are not required to pay the co-payment. Emergency services and family planning services are also exempt from the co-payment.

EPSDT Nursing Services

Nursing services which includes medication administration and nursing treatment will be reimbursed based on a statewide rates established by the Division. Statewide rates will be based on reasonable cost for the services provided.

TRANSMITTAL 94019  
APPROVED 2-3-95  
EFFECTIVE 7-1-94  
SUPERSEDES 90-33

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES  
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T. Extended Services to Pregnant Women

Postpartum Services

Extended Pregnancy Related and Postpartum Services have been removed from the State Plan.

Childbirth Education Program

Reimbursement for childbirth education classes is based on an average of the fee charged for childbirth education classes provided by local area hospitals.

Instructors will be reimbursed the instructor's usual and customary charge or the maximum allowable, whichever is lower.

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

U. DIAGNOSTIC, SCREENING, AND PREVENTIVE SERVICES

Payments are limited to the lower of:

- a) The submitted charge for the procedure; or
- b) the statewide rate based on a percentage of Medicare's RBRVS (Resource Based Relative Value Scale) not to exceed the current applicable year.

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

u. 1. Rehabilitative Services

Payments are made to all providers 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 service based on the Resource Based Relative Value Scale (RBRVS) for Region I (Atlanta) except for nursing, and counseling services. The rates for Nursing Services and Counseling Services are based on established statewide rates.



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

- V. Therapy Services: (Includes Physical, Occupational, and Speech Pathology Therapists)

Payments are made for specific authorized procedures 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 on the date of service based on the Resource Based Relative Value Scale (RBRVS) for Region 1 (Atlanta).

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SUPERSEDES 93-044

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER  
TYPES OF CARE OR SERVICE

- V. Therapy Services (includes Physical, Occupational and Speech Pathology Therapists), Nursing Services, Counseling Services, Nutrition Services and Audiology Services).
1. Reimbursement to Therapy Service providers under the Children's Intervention Services program is based on the lower of submitted charges or the state's maximum allowable rate as listed in the Part II, Policies and Procedures for Children's Intervention Services. Effective for dates of service on or after July 1, 2020, the state's maximum allowable rate is 84.645% of Medicare's Resource Based Relative Value Scale (RBRVS) for 2020 for Region IV (Atlanta). The CIS rates utilized for each state fiscal year are those rates that are in effect on July 1st, the start of the state fiscal year. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of therapy services and the fee schedule is published in the Georgia Department of Community Health's Policies and Procedures Manual for Children's Intervention Services.
  2. Effective for dates of service on or after July 1, 2020, the state's maximum allowable rate for codes 97110, 97112, 97116, 97140, 97530 and 97535 will be based on 80% of Medicare's Resource Based Relative Value Scale (RBRVS) for 2020 for Region IV (Atlanta). The CIS rates utilized for each state fiscal year are those rates that are in effect on July 1st, the start of the state fiscal year.
  3. Children's Intervention School Services – School-Based Reimbursement Program  
  
Reimbursement to Local Education Agencies (LEAs) under the Children's Intervention School Services (CISS) program is based on a cost-based methodology. Medicaid Services provided under the Children's Intervention School Services program are services that are medically necessary and provided to Medicaid recipients by LEAs in accordance with an Individualized Education Program (IEP) under the Individuals with Disabilities Education Act (IDEA). For Nursing Services, medical necessity can be documented in an Individual Education Program (IEP), Individual Family Service Plan (IFSP), other medical plans of care, or where medical necessity has otherwise been established) and defined in Attachment 3.1-A pages 1k-1o:

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER  
TYPES OF CARE OR SERVICE

- a. Audiology Services Performed by Licensed Audiologists
- b. Counseling Services Performed by Licensed Clinical Social Workers
- c. Nursing Services Performed by Licensed Registered Professional Nurses or Licensed Practical Nurses/Licensed Vocational Nurses
- d. Nutrition Services Performed by Licensed Dietitians
- e. Occupational Therapy Services Performed by Licensed Occupational Therapists and/or Occupational Therapists Assistants
- f. Physical Therapy Services Performed by Licensed Physical Therapists and/or Physical Therapists Assistants
- g. Speech-Language Pathology Services Performed by Licensed Speech Language Pathologists and/or Masters Level Speech Language Pathologists (with professional certificate from GA Department of Education or Certificate of Clinical Competence in Speech Language Pathology by ASHA).

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF  
CARE OR SERVICE

A. Direct Medical Services Payment Methodology

Providers will be reimbursed on interim basis for School-Based direct Medicaid covered services provided according to a fixed fee schedule.

The Department of Community Health (DCH) will use a cost-based methodology for all LEAs. This methodology will consist of a Cost Report, a CMS reviewed Random Moment Time Study (RMTS) methodology, Cost Reconciliation, and Cost Settlement. If payments exceed Medicaid allowable costs, the excess will be recouped. If payments are less than Medicaid allowable costs, DCH will pay the federal share of the difference to the LEA and submit claims to CMS for reimbursement of that payment.

Data Capture for the Cost of Providing Rehabilitative-Related Services

Data capture for the cost of providing health-related services will be accomplished utilizing the following data sources:

Total direct and indirect costs, less any federal non-Medicaid payments or other revenue offsets for these costs, will be captured utilizing the following data:

- a. School-Based direct Medicaid Services cost reports received from school districts as described below
- b. Georgia Department of Education (GA DOE) Unrestricted Indirect Cost Rate (UICR);
- c. Random Moment Time Study (RMTS) Activity Code 4b (Direct Medical Services pursuant to IEP or IFSP), Activity Code 4c (Direct Medical Services pursuant to other medical plan of care), and Activity Code 10 (General Administration):
  - i. Direct medical RMTS percentage (IEP/IFSP Services);
  - ii. Direct medical RMTS percentage (Direct Medical Services pursuant to other medical plan of care) – To be applied to Nursing Services ONLY
- d. District specific Medicaid These are defined in detail in Section #4 below
  - i. Medicaid IEP/IFSP Ratio
  - ii. Medicaid Ratio for Other Medical Plan of Care

The ratios are defined in detail in Item #4 on the following pages. To determine the Medicaid-allowable direct and indirect costs of providing direct medical services to Medicaid-enrolled clients in the LEA, the following steps are performed:

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1. Allowable Costs: Direct costs for direct medical services include payroll and general ledger cost data that can be directly charged to direct medical services cost pools using the random moment time study results. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the descriptions of the covered Medicaid services delivered by school districts. Costs for administrative staff are not included in the annual cost report. These direct costs will be calculated on a district-specific level and will be reduced by any federal payments for these costs, resulting in adjusted direct costs.

Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as medically-related purchased services, supplies and materials. Additional direct costs include payments made for out of district health related services, including Medicaid covered health related services provided through approved private schools and special school districts including contracted staff costs. These direct costs are accumulated on the annual School-Based Health Services Cost Report and are reduced by any federal payments for these costs, resulting in adjusted direct costs. The cost report contains the scope of cost and methods of cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

The source of this financial data will be audited payroll and general ledger records kept at the school district level.

- a. Direct Medical Services

Non-federal cost pool for allowable providers consists of:

- i. Salaries;
- ii. Benefits;
- iii. Medically-related purchased services; and
- iv. Medically-related supplies and materials

2. Indirect Costs: Indirect costs are determined by applying the school district's specific unrestricted indirect cost rate to its adjusted direct costs. The Georgia Department of Education (GA DOE) has, in cooperation with the United States Department of Education (ED), developed an indirect cost plan to be used by public school districts in Georgia. Pursuant to the authorization in 34 CFR §75.561(b), GA DOE, as the cognizant agency, approves unrestricted indirect cost rates for school districts for the ED. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

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### Indirect Cost Rate

- a. Apply the Georgia Department of Education (GA DOE) Cognizant Agency Unrestricted Indirect Cost Rate applicable for the dates of service in the rate year.
  - b. The GA DOE UICR is the unrestricted indirect cost rate calculated by the Georgia Department of Education.
3. Time Study Percentages: A CMS-reviewed time study is used to determine the percentage of time that medical service personnel spend on IEP, IFSP, or other medical plan of care direct medical services, general and administrative time, and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. The RMTS methodology will utilize two distinct cost pools; one cost pool for Direct Medical Services which includes all eligible staff except Licensed Registered Nurses (RN) and Licensed Practical Nurses (LPN) and one also for Direct Medical Services staff but only to include Licensed Registered Nurses (RN) and Licensed Practical Nurses (LPN). The RMTS will generate two Direct Medical Services time study percentages; one for Direct Medical Services pursuant to an IEP or IFSP and one for Direct Medical Services pursuant to other medical plan of care. The Direct Medical Service time study percentages will be applied to only those costs associated with Direct Medical Services to generate a Direct Medical Service Costs amount for services provided pursuant to an IEP or IFSP for both cost pools. The Direct Medical Services Cost amount for services provided pursuant to other medical plan of care will only be applied to the cost pool containing Licensed Registered Nurses (RN) and Licensed Practical Nurses (LPN). The direct medical services costs and time study results must be aligned to ensure proper cost allocation. The CMS approval letter for the time study will be maintained by the DCH and CMS.
4. Medicaid Ratio Determinations: Two distinct Medicaid Ratios will be established for each participating school district. When applied, these ratios will discount the associated Direct Medical Service cost pools by the percentage of Medicaid enrolled students.
- a. Medicaid IEP Ratio: The numerator will be the number of Medicaid enrolled IEP students in the LEA who have an IEP and received direct medical services as outlined in their IEP and the denominator will be the total number of students in the LEA with an IEP who received direct medical services as outlined in their IEP. Direct medical services are those services billable under the FFS program as defined in pages 1k through 1o of Attachment 3.1-A. This ratio is calculated

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annually based on census data on March 1st of each year and will be applied to the entire Fiscal Year.

- a. Medicaid Eligibility Ratio for Other Medical Plan of Care: The numerator will be the number of Medicaid enrolled students in the LEA and the denominator will be the total number of students in the LEA. This ratio will only be utilized for the Nursing Services Cost Pool calculation of direct medical services pursuant to other medical plans of care. This ratio is calculated annually based on census data on March 1st of each year and will be applied to the entire Fiscal Year.

5. Total Medicaid Reimbursable Cost: The result of the previous steps will be a total Medicaid reimbursable cost for each LEA for Direct Medical Services.

B. Certification of Funds Process

Each LEA will submit a Certification of Public Expenditure of Forms to DCH on an annual basis. On an annual basis, each LEA will certify through its cost report its total actual, incurred Medicaid allowable costs/expenditures, including the federal share and the nonfederal share. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

C. Annual Cost Report Process

For Medicaid services provided in schools during the state fiscal year (July 1 through June 30), each provider must complete an annual cost report. The cost report is due on or before September 15 following the reporting period each year. At the discretion of DCH, providers may be granted extensions up to three months.

Providers that fail to fully and accurately complete Medicaid cost reports within the time period specified by DCH or that fail to furnish required documentation and disclosures for Medicaid cost reports required under this Plan within the time period specified by the Department, may be subject to penalties for non-compliance.

The primary purposes of the LEA provider's cost report are to:

- 1) Document the LEA provider's total CMS reviewed Medicaid allowable costs of delivering Medicaid coverable services using a CMS reviewed cost allocation methodology.
- 2) Reconcile the annual interim payments to the LEA provider's total CMS reviewed, Medicaid-allowable costs using a CMS reviewed cost allocation methodology

#### D. Annual Cost Reconciliation Process

The annual Children's Intervention School Services (CISS) Cost Report includes a certification of funds statement to be completed, including certifying the provider's actual, incurred costs/expenditures. All filed annual CISS Cost Reports are subject to desk review by DCH or its designee.

The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual CISS Cost Report. The total CMS-reviewed, Medicaid allowable scope of costs based on CMS-reviewed cost allocation methodology procedures are compared to the LEA provider's Medicaid interim payments delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

For the purposes of cost reconciliation, the state may not modify the CMS-reviewed scope of costs, the CMS reviewed cost allocation methodology procedures, or its CMS-reviewed RMTS for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or RMTS for cost-reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

#### E. The Cost Settlement Process

Services delivered during the period covering July 1 through June 30, the annual CISS Cost Report is due on or before September 15 of that same year (i.e. services delivered July 1, 2011 through June 30, 2012 would be included in the annual cost report due September 15, 2012), with the cost reconciliation and settlement processes completed within twenty-four months of the cost report due date.

If the LEA provider's interim payments exceed the actual, certified costs for the delivery of school-based health services to Medicaid clients, the LEA provider will return an amount equal to the overpayment. DCH will submit the federal share of the overpayment to CMS in the federal fiscal quarter following receipt of payment from the provider.

If the LEA provider's actual, certified costs exceed the interim payments, DCH will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.



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

W. Psychological Services:

Payments are limited to the lower of:

- (a) The submitted charge, or;
- (b) The statewide maximum allowable reimbursement which is 84.65% of the 2000 Resource Based Relative Value Scale (RBRVS) as specified by Medicare for Georgia locality 01 (Atlanta).

X. Counseling Services:

CPT code 99406 is reimbursed at 86.1% of the 2014 Medicare fee schedule for non- facilities using Georgia locality 01(Atlanta). CPT code 99407 is reimbursed at 80.2% of the 2014 Medicare fee schedule for non-facilities using Georgia locality 01 (Atlanta).

Except as noted in this State Plan, all other counseling services are reimbursed at 84.645% of the January 1, 2000 Medicare fee schedule.

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**Autism Spectrum Disorder Services Reimbursement.** Services to treat Autism Spectrum Disorders (ASD), as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, include assessment and treatment services provide to Medicaid beneficiaries in accordance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards and according to medical necessity. Pursuant to 42 CFR 440.130(c), services must be recommended by a licensed physician or other licensed practitioner of the healing arts acting within their scope of practice under state law to prevent the progression of ASD, prolong life, and promote the physical and mental health and efficiency of the individual.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Autism Spectrum Disorder Services. The agency's fee schedule rate was set as of January 1, 2018 and is effective for services provided on or after that date, and is located at:

<https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Fee%20Schedules/tabId/56/Default.aspx>.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory:                     GEORGIA                    

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES  
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

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Except for a nominal recipient copayment (as specified in Attachment 4.18 of this state plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to state plan-rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".  
For specific Medicare services which are not otherwise covered by this state plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in Item \_\_\_\_\_ of this attachment (see 3. below).
2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."
3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item 1-5 of this attachment, for those groups and payments listed below and designated with the letters "NR".
4. Any exceptions to the general methods used for a particular group of payment are specified on Page 3 in Item of this attachment (see 3. above).

MR Chiropractor	SP Mental Health Clinics
MR Licensed Clinical Social Worker	SP Dialysis Services
<hr/>	
NR Nursing Facilities	SP Dental Services
NR Swing-Beds	SP Prescribed Drugs
NR Outpatient Hospital	SP Prosthetic Devices
NR Inpatient Hospital	SP Nurse Midwife Services
NR Ambulance	SP Hospice Services
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SP Rural Health Clinics	SP Extended Services to Pregnant Women
SP Federally Qualified Health Centers	SP Other Diagnostic, Preventive, Screening and Rehabilitative Services
SP Laboratory and X-Ray	SP Physical Therapy
SP Physician Services	SP Occupational Therapy
SP Podiatrist Services	SP Speech Therapy
SP Optometrist Services	
SP Nurse Practitioners	
SP Home Health	
SP Durable Medical Equipment	



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory:                     GEORGIA                    

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES  
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

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1. Nursing Facilities

Effective with dates of payment of February 1, 1991, and after, the maximum allowable payment for Medicare nursing facility coinsurance (crossover) claims will be the nursing facility's Medicaid specific per diem rate in effect for the dates of service of the crossover claims. The crossover claims will not be subsequently adjusted due to subsequent per diem rate adjustments.

Daily cost-sharing charges for beneficiaries except for QMBs will commence on the 21<sup>st</sup> day of service through the 100th day of service. These patients must be eligible for Part A Medicare and be admitted to an approved Medicare facility under conditions payable by Medicare.

2. Swing-Bed Services

When a Medicaid recipient also has Medicare Part A coverage, payment for swing-bed services for up to one hundred days may be allowed by Medicare. In this instance, the swing-bed services must be billed to Medicare prior to billing the Department. The Medicare intermediary reimburses for the first through the twentieth day of coverage at 100% of the Medicare per diem rate. For the twenty-first through the one-hundredth day, the Medicare intermediary pays a reduced amount and Medicaid pays the applicable coinsurance amount. When Medicare Part A swing-bed benefits, i.e., skilled nursing facility care, are exhausted for these recipients, charges for days in excess of Medicare covered days may be submitted to the Department for reimbursement at the Medicaid per diem rate.

3. Outpatient Hospital Services

Effective with dates of payment on and after November 1, 1991, the Department will limit payment on outpatient Medicare crossover claims as follows: (a) multiply the allowable deductible and coinsurance amount by the hospital-specific percent of charges rate in effect on the date of payment; (b) compare the product from (a) to the hospital's inpatient per case rate in effect on the date of payment; and (c) reimburse the lower of the two amounts in (b).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE: GEORGIA

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

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Payment of Medicare Part A and Part B Deductible/Coinsurance

4. Inpatient Hospital Services

Effective with dates of payment of October 16, 2000 and after, 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 DRG rate. The maximum allowable payment to non-Georgia hospitals not enrolled in the Georgia Medicaid program for Medicare inpatient crossover claims will be the weighted average hospital-specific inpatient per case rate for enrolled non-Georgia hospitals.

5. Ambulance Services

For Medicare crossover claims, no payment will be made by Medicaid unless the Medicaid maximum allowable for the service exceeds the payment made by Medicare.

STATE: Georgia

METHODS FOR ESTABLISHING PAYMENT RATES FOR MEDICALLY NECESSARY SERVICES  
FOR EPSDT RECIPIENTS WHEN SUCH SERVICES ARE NOT NORMALLY COVERED  
UNDER THE PLAN

	<u>Service</u>	<u>Place</u>	<u>Provider</u>	<u>Methodology</u>
1.	Private Duty Nursing	Home	RN or LPN	The rate established for nursing services under the Waivered Services Program.
2.	Physical Therapy, Speech Therapy	Hospital, Home	Licensed Physical Therapist, Licensed Speech Therapist	According to the methodology used and rates established in the Home Health Services Program (Attachment 4.19-A, Item G), Outpatient Hospital Services (Attachment 4.19-B, Item R) and Physician Services (Attachment 4.19-B, Item J) wherein these services are Reimbursed
3.	Occupational Therapy	Home Hospital	Licensed Occupational Therapist	According to the methodology used and rates established in the Community Care Services Program and Outpatient Hospital Services (Attachment 4.19-B, Item R).
4.	Respiratory Care Services	Home	Licensed Respiratory Therapist	The rate established for respiratory care under the Model Waiver Services Program
5.	Chiropractor	Office, Hospital	D.C.	50 <sup>th</sup> percentile of sample charges.
6.	Child and Adolescent Mental Health Services	Home, School, Therapeutic Foster Care, Child Caring Institutions (IMDs excluded)	Community Mental Health Centers and other providers who meet the standards of participation	<p>Reimbursement for Community Mental Health Centers will be based on pre-established flat rates in a fee schedule by procedure code.</p> <p>Reimbursement for other providers will be based on reasonable costs from cost reports submitted annually by participating providers. The base period will be a state fiscal year. Rates will be set not to exceed actual costs adjusted for inflation. The inflation rate will be based on the DRI McGraw Hill Health costs: Regional Forecasts Tables.</p>

STATE: Georgia

METHODS FOR ESTABLISHING PAYMENT RATES FOR MEDICALLY NECESSARY SERVICES  
FOR EPSDT RECIPIENTS WHEN SUCH SERVICES ARE NOT NORMALLY COVERED  
UNDER THE PLAN

	<u>Service</u>	<u>Place</u>	<u>Provider</u>	<u>Methodology</u>
1.	Private Duty Nursing	Home	RN or LPN	The rate established for nursing services under the Waivered Services Program.
2.	Physical Therapy, Speech Therapy	Hospital, Home	Licensed Physical Therapist, Licensed Speech Therapist	According to the methodology used and rates established in the Home Health Services Program (Attachment 4.19-A, Item G), Outpatient Hospital Services (Attachment 4.19-B, Item R) and Physician Services (Attachment 4.19-B, Item J) wherein these services are Reimbursed
3.	Occupational Therapy	Home Hospital	Licensed Occupational Therapist	According to the methodology used and rates established in the Community Care Services Program and Outpatient Hospital Services (Attachment 4.19-B, Item R).
4.	Respiratory Care Services	Home	Licensed Respiratory Therapist	The rate established for respiratory care under the Model Waiver Services Program
5.	Chiropractor	Office, Hospital	D.C.	50th percentile of sample charges.
6.	Child and Adolescent Mental Health Services	Home, School, Therapeutic Foster Care, Child Caring Institutions (IMDs excluded)	Community Mental Health Centers and other providers who meet the standards of participation	<p>Reimbursement for Community Mental Health Centers will be based on pre-established flat rates in a fee schedule by procedure code.</p> <p>Reimbursement for other providers will be based on reasonable costs from cost reports submitted annually by participating providers. The base period will be a state fiscal year. Rates will be set not to exceed actual costs adjusted for inflation. The inflation rate will be based on the DRI McGraw Hill Health costs: Regional Forecasts Tables.</p>

TN No. 99-011

Supersedes

TN No. 93-038Approval Date MAY 12 2000Effective Date 7/1/99



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
**State/Territory: Georgia**

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

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**1905(a)(29) Medication-Assisted Treatment (MAT)**

**§29 Medication-Assisted Treatment (MAT) Pursuant to section 1905(a)(29) of the Social Security Act**

The state will cover all formulations of MAT drugs and biologicals for OUD that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

The reimbursement for unbundled MAT prescribed drugs and biologicals used to treat opioid use disorder will be reimbursed using the same methodology as described for covered outpatient drugs in Attachment 4.19-B, pages 2 and 2.1a, for prescribed drugs that are dispensed or administered.

The Reimbursement for counseling services and behavioral health therapies as part of MAT will be reimbursed using the same methodology as described counseling and behavioral therapies in Attachment 4.19B pages 1a.7 through 1a.20.

#### PAYMENT FOR RESERVED BEDS

Regular state payment is permitted for reserving beds during a recipient's absence from an inpatient facility with the following limitations:

1. The patient's plan of care provides for absences, other than hospitalization.
2. Seven (7) days per hospitalization for Medicaid patients who are hospitalized during a stay in the nursing home.
3. Planned therapeutic home visits.
  - For nursing facility residents up to eight (8) days in any calendar year with no limit on the number of days per visit
  - For ICF-MR residents up to thirty (30) days per calendar year with no limit on the number of days per visit

Payments for reserved beds are made at 75% of the rate paid for days when a patient is onsite at a facility. Because payments for reserved beds are not subject to the nursing home provider fee, the payment rate for reserved beds excludes any compensation for the provider fee.

TN No. 04-010

Supersedes

TN No. 03-003

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES  
NURSING FACILITY SERVICES**

The following sections summarize the methods and procedures for determining nursing facility reimbursement rates in the format prescribed by the Department of Health and Human Services (DHHS).

**Explanation of Commonly Used Terms**

**Dodge Index Factor:** An index of activity in the construction industry in the United States, produced by McGraw Hill, an information services company.

**Growth Allowance Factor:** Inflation factor applied to the allowed per diem for each of the four non-property cost centers.

**Net Per Diem:** Net amount determined by dividing total audited cost by total audited patient days. This net per diem amount is calculated for each of the four non-property cost centers.

**Quality Incentive Adjustment:** A one or two percent increase to a provider's allowed Routine Services per diem amount as a result of achieving certain clinical and non-clinical criteria established by the Department.

**Quarterly Medicaid Case Mix Score:** The quarterly relative weight assigned to a Medicaid patient based on the patient's Resource Utilization Group (RUG) category.

**Resource Utilization Group (RUG):** Mutually exclusive categories that reflect levels of resource need in long-term care settings, primarily to facilitate Medicare and Medicaid payment.

**Standard Per Diem:** The maximum allowed per diem amount for each of the four non-property cost centers.

**A. Cost Finding and Cost Reporting**

1. All nursing facilities are required to report costs for the twelve months ending June 30th of each year. Cost report instructions are published by July 31st of each year for use during that State fiscal year. Release of the instructions may be delayed on occasion in order to implement significant policy changes.
2. All nursing facilities are required to detail their entire costs for the reporting year, or for the period of participation in the plan (if less than the full cost reporting year) for allowable costs under the Georgia Plan. These costs are reported by the facility using a Uniform Chart of Accounts prescribed by the State Agency and on the basis of generally accepted accounting principles and accrual methods of accounting.

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES  
NURSING FACILITY SERVICES**

- a. All nursing facilities are required to report costs on a uniform cost report form provided by the State Agency. Hospital-Based facilities using Medicare fiscal year ending dates between May 31 and June 30 must submit cost reports on or before November 30. Those using Medicare fiscal year ending dates between July 31 and September must submit cost reports on or before December 31 using the most recent complete fiscal year cost data. All other facilities are required to submit cost reports on or before September 30 of the year in which the reporting period ends.
  - b. All nursing facilities are required to submit to the Department any changes in the amount of or classification of reported costs made on the original cost report within thirty days after the implementation of the original cost report used to set reimbursement rates. Adjustments to amounts or changes in classification of reported costs in prior years will not be considered.
1. All nursing facilities are required to maintain financial and statistical detail to substantiate the cost data reported for a period of at least three years following the date of submission of the cost report form to the State Agency. These records must be made available upon demand to representatives of the State Agency or the DHHS.
  2. The State Agency shall retain all uniform cost reports submitted in accordance with paragraph 2a above for a period of three years following the date of submission of such reports, and will properly maintain those reports.
- A. Field Examinations and Desk Reviews
1. The State Agency has, as needed, updated and revised resource materials developed in prior years through the accomplishment of the following tasks:
    - a. The development of standards of reasonableness for each major cost center of a nursing facility;
    - b. The development of a computerized desk review process for the submitted uniform cost reports; and
    - c. The development of a detailed field examination plan, using American Institute of Certified Public Accountants (AICPA) generally accepted auditing standards.

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES  
NURSING FACILITY SERVICES**

The standards, desk review, and on-site examinations ensure that only expense items allowable under the Georgia Plan, as detailed under Section C of this attachment, are included in the facility's uniform cost report and that the expense items included are accurately determined and are reasonable.

2. The State Agency will conduct analyses of the uniform cost reports for the reporting year ending the previous June 30th to verify that the facility has complied with paragraphs 2 and 3 above in Section A.
3. Where the analyses conducted, as specified in paragraph B 2 above, reveal that a facility has not complied with requirements, further examination of the facility's financial and statistical records and other documents will be conducted as needed.
4. On-site examinations of the financial and statistical records will be performed annually in at least 15 percent of participating facilities, with desk reviews completed for the remaining facilities. The independent accountant reports will be submitted for the Department's approval by September 30 of the year following the reporting year of the cost reports. Such on-site examinations of financial and statistical records will be sufficiently comprehensive in scope to ascertain whether, in all material respects, the uniform cost report complies with Section B, Paragraph 1 above.
5. The on-site examinations conducted in accordance with Section B, paragraph 4 above shall produce an independent accountant report which shall meet AICPA generally accepted auditing standards. The report shall declare the accountant's opinion as to whether, in all material respects, the uniform cost report includes only expense items allowable under the Georgia Plan, as detailed under Section C of this attachment, and that the expense items included are accurately determined, and are reasonable. These independent accountant reports shall be kept by the State Agency for at least three years following the date of submission of such reports, and will be properly maintained.
6. Any overpayments found in the field examinations and desk reviews under this paragraph will be accounted for on Form HCFA-64 no later than 60 days from the date that the final rate notification is sent to the nursing facility.

B. Allowability of Costs

The Department uses the Centers for Medicare and Medicaid Services Manual (CMS 15-1) Medicare principles, as a guide to determine allowable and non-allowable costs. However, in situations where warranted, the Department has developed policy regarding cost allowability outside of CMS 15-1. In addition to the use of the CMS 15-1 as a guide, the Department describes specific cost allowability in Supplement 2 of Attachment 4.19-D. The following paragraphs address the allowability of costs:

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES  
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1. Allowable Costs Include the Following:
  - a. The cost of meeting certification standards. These costs include all items of expense which providers must incur to meet the definition of nursing facilities under Title XIX statutory and regulatory requirements and as otherwise prescribed by the Secretary of HHS for nursing facilities; in order to comply with requirements of the State Agency responsible for establishing and maintaining health standards; and in order to comply with any other requirements for nursing facility licensing under the State law;
  - b. All items of expense which providers incur in the provision of routine services. Routine services include the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities. Additional allowable costs include depreciation, interest, and rent expense as defined in the principles of reimbursement in CMS-15-1, except that actual malpractice insurance costs are reimbursed as reported in the facility's cost report, subject to audit verification; and
  - c. Costs applicable to services, facilities, and supplies furnished to a provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. Providers are required to identify such related organization and costs on the State's uniform cost report.

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES  
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2. Non-Allowable Costs Include the Following:
- a. Bad debts of non-Title XIX program patients and charity and courtesy allowances shall not be included in allowable costs. The only bad debts allowable are those defined in 42 CFR 413.80. The value of operating rights and licenses and/or goodwill is not an allowable cost and is not included in the computation of the return on equity;
  - b. Effective for the determination of reasonable costs used in the establishment of reimbursement rates on and after April 1, 1991, the costs listed below are nonallowable.
    - i. 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;
    - ii. Memberships in civic organizations;
    - iii. Out-of-state travel paid by the provider for persons other than board members or those employed or contracted by the provider. Out-of-state travel for provider personnel must be related to patient care;
    - iv. Vehicle depreciation or vehicle lease expense in excess of the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles; provided, however, such limits shall not apply to specialized patient transport vehicles (e.g. ambulances);
    - v. 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;
    - vi. Fifty percent (50%) of membership dues for national, state and local associations;
    - vii. 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 issuance reviews, 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;



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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES  
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- i. 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; and
- ii. The cost of home office vehicle expense.

C. Methods and Standards for Determining Reasonable Cost-Related Payments

The 2010 cost report, using the reporting format and underlying instructions established by the Department, will be used to determine a facility's allowable cost that will be the basis for computing a rate.

1. Prospective Rates

Payment rates to nursing facilities and ICF/MRs are determined prospectively using costs from a base period. For dates of service beginning February 1, 2012, the 2009 Cost Report is the basis for reimbursement.

2. Determination of Payment Classes

Classes are determined in accordance with Section 1002 of Supplement 2 to Attachment 4.19-D of the State Plan.

D. Payment Assurances

The State will pay each provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the provider under the Plan according to the methods and standards set forth in Section D, above.

In no case shall the payment rate for services provided under the plan exceed the facility's customary charges to the general public for such services.

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES  
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F. Provider Participation

Payments made in accordance with methods and standards described in this attachment are designed to enlist participation of a sufficient number of providers of services in the program; so that eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public.

G. Payment in Full

Participation in the program shall be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the State Plan.

H. Payment Limitation Applicable to patients in Nursing Facilities with Medicare Part A Entitlement

Effective with dates of payment of February 1, 1991, and after, the maximum allowable payment for Medicare nursing facility coinsurance (crossover) claims will be the nursing facility's Medicaid specific per diem rate in effect for the dates of services of the crossover claims. The crossover claims will not be subsequently adjusted due to subsequent per diem rate adjustments.

Daily cost-sharing charges for beneficiaries will commence on the 21st day of service through the 100th day of service. These patients must be eligible for Part A Medicare and be admitted to an approved Medicare facility under conditions payable by Medicare.

I. Nurse Aide Training

The Department adjusts per diem payment rates to reimburse the costs associated with replacement wages and overtime for nurse aide training and testing. This adjustment does not apply to ICF/MR facilities. Beginning with dates of service July 1, 1992, and after, the Department will not adjust reimbursement rates for the cost of replacement wages and overtime for nurse aide training and testing because these costs are included in the 1991 cost reports.

J. Public Process

The State has in place a public process which complies with the requirement of Section 1902(a)(13)(A) of the Social Security Act.

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES  
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K. Other Adjustments to Rates

1. Effective July 1, 2003, in order to recognize the Medicaid share to a facility's cost of paying fees for Georgia's Nursing Home Provider Fee Act, an adjustment equal to the fee payable for each Medicaid patient day will be added to the facility's rate. During the quarter beginning July 1, 2003, the adjustment amount will be estimated by the Division; any difference between the estimated and actual fee will be corrected by changes to rates for a subsequent quarter. For periods beginning October 1, 2003, the adjustment amount will be based on the fee applicable for the prior quarter.
2. For payments made for services provided on or after July 1, 2005, State governmental facilities and non-State governmental facilities will be eligible for rate payment adjustments. The rate adjustment payments are intended to provide supplemental funding for Medicaid services to facilities that based on their governmental status, need sufficient funds for their commitments to meet the healthcare needs of all members of their communities. The rate payment adjustments will be subject to federal upper payment limits. For the appropriate groupings of State governmental facilities, non-State governmental facilities and non-governmental facilities, aggregate rate adjustment payments available without exceeding upper payment limits will be determined by measuring the difference between:
  - a. All amounts paid for services provided to Medicaid patients; and,
  - b. Estimated payment amounts for such services if payments were based on Medicare payment principles.
3. Comparison of all amounts paid for services provided to Medicaid patients and estimated payment amounts for such services if payments were based on Medicare payment principles will also be made for each facility to determined facility specific rate adjustment payments. These rate payment adjustments will be made at the end of the quarter and will be determined in a manner which will not duplicate compensation provided from payments for individual patient claims.

An example of how a rate adjustment payment is calculated is presented on the following pages. This table is for illustrative purposes only and the values are meaningless.

Provider Name: XYZ Nursing Home  
 Provider Number: xxxxxxxxA

	Quarter Ending 09/30/11	Quarter Ending 12/31/11	Quarter Ending 03/31/12	Quarter Ending 06/30/12
<b>Medicare UPL Rate</b>				
PPS rate based on Medicaid patients for each				
<b>Line 1</b>	189.00	213.09	213.09	213.09
<b>Line 2</b>	1.0158	1.0093	1.0093	1.0096
<b>Line 3</b>	191.99	215.07	215.07	215.14
<b>Medicaid UPL Rate</b>				
<b>Line 4</b>	161.02	161.02	161.02	161.02
<b>Line 5</b>	13.39	13.39	13.39	13.39
<b>Line 6</b>	14.11	14.11	14.11	14.11
<b>Line 7</b>	188.52	188.52	188.52	188.52
<b>Medicare UPL rate minus Medicaid UPL rate</b>				
<b>Line 8</b>	3.47	26.55	26.55	26.62
<b>Medicaid Patient Days</b>				
<b>Line 9</b>	26,500	28,317	28,317	28,317
<b>Line 10</b>	(0.0109)	(0.0101)	(0.0101)	(0.0067)
<b>Line 11</b>	25%	25%	25%	25%
<b>Line 12</b>	6,553	7,008	7,008	7,032
<b>Facility-Specific UPL calculation</b>				
<b>Line 13</b>	22,763	186,088	186,088	187,218
<b>Facility-Specific UPL calculation for 07-01-11 to 06-30-12</b>				
<b>Allocation of UPL aggregate limit</b>		(1) 0	0	0
<b>UPL calculation subject to aggregate limit</b>	22,762	186,088	186,088	187,218
<b>UPL calculation for 07-01-11 to 06-30-12</b>				582,156

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
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**Administrative and General Maximum Cost at 105% of Median**

Nursing Home Net Per Diems for 11 nursing homes from lowest to highest:

\$90, \$95, \$95, \$100, \$115, \$120, \$120, \$130, \$135, \$140, \$150

**Maximum Cost Standard Determination at 105% of Median**

Median Net Per Diem is the per diem amount that falls in the middle of the group or \$120

$\$120 \times 105\% = \$126$

**Administrative and General Maximum Cost at 105% of Median (Interpolation)**

Nursing Home Net Per Diems for 10 nursing homes from lowest to highest:

\$90, \$95, \$95, \$100, \$115, \$120, \$120, \$130, \$135, \$140

**Maximum Cost Standard Determination at 105% of Median**

Median Net Per Diem is the average of the two middle net per diem amounts that fall in the middle of the group ( $\$115 + \$120 / 2 = \$118$ )

$\$118 \times 105\% = \$124$

There are several instances where a facility could fall in more than one group. Intermediate care facilities for the mentally retarded which also are nursing facilities are classified as intermediate care facilities for the mentally retarded and not grouped with other nursing facilities.

For the purpose of determining the Standard Per Diem and the Allowed Per Diem for each cost center, a facility is grouped according to the type facility (e.g., nursing facility, hospital-based nursing facility, or

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intermediate care facility for the mentally retarded.)it is as of the date the Standard Per Diem is calculated.

If a facility changes classification to hospital-based or grouping on January 1 through June 30 of any calendar year, it will be grouped into its new category for reimbursement purposes, as indicated above, for dates of services July 1 of that year and thereafter. If a facility changes classification as described above on July 1 through December 31 of any calendar year, regrouping will occur from January 1 of the following year.

Allowed Per Diem =

Summation of the Net Per Diem or Standard Per Diem, whichever amount is less. This applies to the allowed per diem for the Dietary, Laundry and Housekeeping, Plant Operations and Maintenance and Administrative and General cost centers. For the Property and Related cost centers, the methodology described in the Section N (Property and Related Reimbursement) shall apply. The Allowed Per Diem for Taxes and Insurance shall be equal to the Net Per Diem for this cost center. The resulting per diem amount for Routine and Special Services is multiplied by a facility's quarterly case mix score as determined by the Division for Medicaid patients during the most recent calendar quarter for which information is available.

Efficiency Per Diem =

The Efficiency Per Diem is calculated by summing the Standard Per Diem minus 75% of the Net Per Diem , to arrive at the Maximum Efficiency Per Diem for each of the four Non-Property Cost Centers.

Growth Allowance =

Summation of 1.19% of the Allowed Per Diem for each of the four Non-Property and Related cost centers (Routine and Special Services; Dietary; Laundry and Housekeeping and Operation and Maintenance of Plant; and Administrative and General).

Further explanation of these terms is included below:

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- a. In general, the Net Per Diem is determined from the costs of operation of the individual facility in which eligible patients reside. These reports (as defined in Section 1002 in the Manual under "cost center") are determined by utilizing the information submitted by the facility on its Cost Report.

All amounts and supporting data submitted on the Cost Report are subject to verification and adjustment by the Division. These modifications concern: mathematical calculation errors; limitations placed on allowable costs by the Manual, and the documents, principles, and criteria referenced therein; reasonableness limitations placed on salaries paid employees of the facility; reasonableness limitations using the principles contained in CMS-15-1; as defined in the Manual. These modifications define what expenses are attributable to the care received and the allowable expenses that are attributable to care. See Appendix 1 of the Manual for appellate procedures to resolve disputes of specific contested adjustments. Specifically, the Net Per Diem for each of the five cost centers is determined as follows (all Schedule references are to the Cost Report):

See Section 1002.5 of the Manual for additional description of such limitations.

Allowable Home Office salary costs are limited to an appropriate maximum. Fringe benefits are also limited to an appropriate maximum. A per bed salary ceiling also is imposed, based on the 70th percentile of costs per the 1988 home office cost reports, plus an allowance for inflation. Home Office salaries and related fringe benefits are subjected to a \$100,000 maximum salary for CEO, COO, CFO and other Home Office personnel. Therefore, in addition to the per bed salary ceiling, we have incorporated a position maximum of \$100,000 to be applied only to owners of nursing facilities and related parties. Reimbursement for the cost of home office vehicles is eliminated, except to the extent that home office vehicle costs can be included with related home office salaries as a fringe benefit, and in total, fall below any designated maximums.

Routine and Special Services Net Per Diem

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Historical Routine and Special Services (Schedule B, Lines 5 plus 7, Column 4) divided by (Total Patient Days, Schedule A, Line 13, Column 6); for Nursing Facilities, the resulting per diem amount is divided by a case mix index score as determined by the Division for all residents in the facility during the base period, the cost reporting period identified in section 1002.2 of the manual. The method by which a case mix index score is calculated is described in Appendix D (Uniform Chart Of Accounts, Cost Reporting, Reimbursement Principles And Other Reporting Requirements) of the manual.

ICF-MR Routine Services and Special Services Net Per Diem =

Historical ICF-MR Routine and Special Services (Schedule B, Lines 6 plus 7, Column 4) divided by (Total ICF-MR Patient Days, Schedule A, Line 13, Column 7).

When costs for State Distinct Part Nursing Facilities can be identified, be they routine services or special services, the costs will be allocated as identified. Where costs have not been identified, the patient days method will be used to allocate costs. The example below shows the treatment of these costs:

Total Routine Services Cost, (Medicaid Cost Report Schedule B, Line 6, Column 4): \$5,000,000

Patient Days

Total Medicaid ICF-MR Patient Days (Medicaid Cost Report Schedule A, Line 13, Sum of Columns 4, 5, and 6):	40,000 80%
Total Medicaid NF Patient Days (Medicaid Cost Report Schedule A, Line 13, Sum of Columns 4, 5, and 6):	10,000 20%
Total Patient Days:	50,000 100%

Allocation

Routine Services Cost allocated to ICF-MR (Schedule B, Line 6, Column 4 is \$5,000,000 x 80% = \$ 4,000,000)  
Routine Services Cost allocated to NF (Schedule B, Line 6, Column 4 is \$5,000,000 x 20%= \$1,000,000)



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Dietary Net Per Diem =

Historical Dietary, Schedule B (Medicaid Cost Report), Line 8,  
Column 4, Divided By Total Patient Days

Laundry and Housekeeping and Operation and Maintenance of  
Plant Net Per Diem =

Historical Laundry, Housekeeping, Operation and Maintenance of  
Plant, Schedule B (Medicaid Cost Report), Lines 9 plus 10,  
Column 4, Divided By Total Patient Days

Administrative and General Net Per Diem =

Historical Administrative and General, Schedule B (Medicaid Cost  
Report),, Line 11, Column 4, Divided By Total Patient Days

Property and Related Net Per Diem =

Historical Property and Related costs (Schedule B (Medicaid Cost  
Report), Line 12, Column 4) are divided By Total Patient Days.  
The resulting net per diem will be adjusted to the greater of the  
facility's Dodge Rate, or the approved property reimbursement per  
diem in effect as of July 1, 2009, or the Fair Rental Value System  
per diem rate. Property reimbursement under FRVS will replace  
use of the Dodge index over a three year period beginning July 1,  
2009. FRV reimbursement beginning July 1, 2009, shall not  
increase by more than 150% of the amount that would have been  
paid using the Dodge index alone but will also be no less than the  
property per diem based on the Dodge index or the approved  
property reimbursement per diem in effect on June 30, 2009. After  
three years FRV will replace the property component determined  
by the Dodge index and any otherwise previously approved  
property reimbursement per diem.

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Costs for property taxes and property insurance, as defined in the Uniform Chart of Accounts, are calculated separately and are not subject to property-related cost center Standard Per Diem.

Routine and Special Services Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

Nursing Facility

Intermediate Care Facility for the Mentally Retarded

Dietary Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

Free Standing Nursing Facility

Hospital-Based Nursing Facility

Intermediate Care Facility for the Mentally Retarded

Laundry and Housekeeping and Operation and Maintenance of Plant Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

Nursing Facility

Intermediate Care Facility for the Mentally Retarded

Administrative and General Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

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Nursing Facility

Intermediate Care Facility for the Mentally Retarded

Property and Related Standard Per Diem

There is no standard per diem for this cost center,

c. The Efficiency Per Diem represents the summation of the Efficiency Per Diem for each of the four Non-Property cost centers. If the Net Per Diem is equal to or exceeds the Standard Per Diem in any cost center, or if the Net Per Diem is equal to or less than 15% of the Standard Per Diem, the Efficiency Per Diem for the cost center is zero (\$0.00). If the Net Per Diem is less than the Standard Per Diem in any cost center, and if the Net Per Diem is more than 15% of the Standard Per Diem, the Efficiency Per Diem for the cost center is calculated by subtracting the Net Per Diem from the Standard Per Diem for that cost center and then multiplying the difference by 0.75. The product represents the Efficiency Per Diem for that cost center subject to the following maximums which have been established through legislative authority:

Routine and Special Services Maximum Efficiency Payment	\$0.53
Dietary Maximum Efficiency Payment	\$0.22
Laundry and Housekeeping and Operation and Maintenance of Plant Maximum Efficiency Payment	\$0.41
Administrative and General Maximum Efficiency Payment	\$0.37

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M. Total Allowed Per Diem Billing Rate For Facilities For Which A Cost Report or Case Mix Score Cannot Be Used To Set A Billing Rate

1. If the Department determines that a cost report cannot be used to set a billing rate the per diem rate will be established, as follows:
  - a) When changes in ownership occur, new owners will receive the prior owner's per diem until a cost report basis can be used to establish a new per diem rate. (See Appendix D2(h) of the manual.)
  - b) Newly enrolled facilities will be reimbursed the lower of: projected costs; or 90% of the appropriate cost center ceilings, plus a growth allowance and the appropriate Property and Related Net Per Diem until a cost report is submitted which can be used to establish a rate.
  - c) In all other instances (except as noted below for newly constructed facilities) where the Division determines that a cost report cannot be used to set a reimbursement rate, the Total Allowed Per Diem Billing Rate will be resolved as described in the provisions discussed below for unauditable cost reports.

The Total Allowed Per Diem Billing Rate for homes with more than 50 beds determined by the Division to be newly constructed facilities is equal to 95% of the four Non-Property and Related Standard Per Diem amounts plus the appropriate growth allowance and Property and Related Net Per Diem.

The Property and Related Net Per Diem referred to in subsections (a) through (c) above is equal to the Fair Rental Value Rate as determined under Section N.

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- d) In all other instances where the Department determines that a cost report cannot be used to set a reimbursement rate, the Total Allowed Per Diem Billing Rate will be resolved as described in the provisions discussed below for unauditible cost reports. If the Department determines that a cost report which was to be used to set a reimbursement rate is unauditible (i.e., the Department's auditors cannot render an opinion using commonly accepted auditing practices on the filed cost report, either on the desk audit or on-site audit), or unreliable (See Appendix D2(h) of the manual), the Department may reimburse the facility the lower of the following:
- The last Total Allowed Per Diem Billing Rate issued prior to the reimbursement period to be covered by the unauditible cost report;
  - The Total Allowed Per Diem Billing Rate calculated from the unauditible cost report; or
  - The Total Allowed Per Diem Billing Rate calculated according to 90% of the four Non-Property and Related Standard Per Diem amounts plus the appropriate growth allowance and Property and Related Net Per Diem.

Once a cost report becomes auditable and appropriate, the Total Allowed Per Diem Billing Rate will then be calculated using the audited cost report as a basis. The resulting reimbursement rate will then be applied to the appropriate period.

- e) If a case mix score cannot be determined for a facility, the average score for all facilities may be used in a rate calculation. If a facility's number of MDS assessments for Medicaid patients in a quarter is limited so as to make the resulting average case mix score unreliable for rate calculations, the Department will use the average score for all facilities.

N. Property and Related Reimbursement

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1. Effective for dates of service on and after July 1, 2009, the Property and Related Net Per Diem shall be the higher of: (i) such Per Diem being paid as of June 30, 2009 (based on the Dodge index); or (ii) the amount computed using the fair rental value (FRV) reimbursement system described below. Property reimbursement under FRV will replace use of the Dodge index over a three year period beginning July 1, 2009. FRV reimbursement beginning July 1, 2009, shall not increase by more than 150% of the amount that would have been paid using the Dodge index alone but will also be no less than the amount based on the Dodge index or the approved property reimbursement per diem in effect on June 30, 2009. After three years FRV will replace the property component determined by the Dodge index and previously approved property reimbursement per diems. Under a FRV system, a facility is reimbursed on the basis of the estimated current value of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest, and rent / lease expenses. The FRV system shall establish a nursing facility's bed value based on the age of the facility, its location, and its total square footage.
2. The Property and Related Net Per Diem initially established under the FRV system shall be calculated as follows:
  - (a) Effective for dates of service on and after July 1, 2009, the value per square foot shall be based on the \$141.10 construction cost for nursing facilities, as derived from the 2009 RSMeans Building Construction cost data for Nursing Homes (national index for open shop construction). The Value per Square Foot shall be adjusted by using the RSMeans Location factors based on the facility's zip code as well as by a Construction Cost Index which is initially set at 1.000. The resulting product is the Adjusted Cost per Square Foot.
  - (b) A Facility Replacement Value is calculated by multiplying the Adjusted Cost per Square Foot by the Allowed Total Square Footage. The latter figure is the lesser of a nursing facility's actual square footage (computed using the gross footage method)

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compared to the number of licensed beds times 700 square feet (the maximum allowable figure per bed).

- (c) An Equipment Value is calculated by multiplying the number of licensed beds by \$6,000 (the amount allowed per bed) and by an initial Equipment Cost Index of 1.000.
- (d) A Depreciated Replacement Value is calculated by depreciating the sum of the Facility Replacement Value and the Equipment Value. The amount depreciated is determined by multiplying the Adjusted Facility Age, discussed in all of (N)(5), by a 2% Facility Depreciation Rate. The initial Adjusted Facility Age will be the lesser of the calculated facility age or 25 years.
- (e) The Land Value of a facility is calculated by multiplying the Facility Replacement Value by 15% to approximate the cost of land.
- (f) A Rental Amount is calculated by summing the facility's Depreciated Replacement Value and the Land Value and multiplying this figure by a Rental Rate which is 9.0% effective July 1, 2009.
- (g) The Annual Rental Amount is divided by the greater of the facility's actual cumulative resident days during the 2006 cost reporting period or 85% of the licensed bed capacity of the facility multiplied by 365. The resulting figure constitutes the Property and Related Net Per Diem established under the FRV system.

An example of how the Property and Related Net Per Diem is calculated is presented in the following table.

**Example Calculation of Initial Fair Rental Value Per Diem**

<u>Ref</u>	<u>Data Element</u>	<u>Example Data</u>	<u>Source of Data</u>
A	Facility Name	XYZ Nursing Home	Department Data
B	Medicaid Provider ID	12345678A	Department Data
C	Rate Setting Year	2009	Department Criteria

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D	Adjusted Base Year	1989	Based on Initial Age adjusted by Bed Additions and Facility Renovations
E	Licensed Nursing Facility Beds	138	Department Data
F	Nursing Facility Square Footage	68,857	Department Data
G	Nursing Facility Zip Code	30312	Department Data
H	Total Patient Days	48,552	Department Data
I	Per Bed Square Footage Limit	700	Department Criteria
J	Maximum Allowable Square Footage	96,600	E x I
K	Allowed Total Square Footage	68,857	lesser of F or J
L	Rate Year RS Means Cost per Square Foot	\$141.10	RS Means lookup based on Rate Year
M	RS Means Location Factor	0.9	RS Means lookup based on Zip Code (G)
N	Construction Cost Index	1	Department Criteria
O	Adjusted Cost per Square Foot	\$126.99	L x M x N
P	Facility Replacement Value	\$8,744,150	K x O
Q	Equipment Allowance	\$6,000	Department Criteria
R	Equipment Cost Index	1	Department Criteria
S	Equipment Value	\$828,000	E x Q x R
T	Facility Value Excluding Land	\$9,572,150	P+S
U	Bed Additions and Facility Renovations	-	Separate calculations affecting the Nursing Facility Age (see D and V)
V	Nursing Facility Age	20	C-D (D is based on initial age adjusted by additions & renovations per U)
W	Maximum Years for FRV Age	25	Department Criteria
X	FRV Adjusted Facility Age	20	lesser of V or W
Y	Facility Depreciation Rate	2.00%	Department Criteria
Z	Depreciation Using FRV Adjusted Age	\$3,828,860	T x X x Y
AA	Depreciated Replacement Value	\$5,743,290	T-Z
AB	Land Percentage	15.00%	Department Criteria
AC	Land Value	\$1,311,623	P x AB
AD	Depreciated Replacement Value & Land	\$7,054,913	AA + AC
AE	Rental Rate	9.00%	Department Criteria
AF	Rental Amount	\$634,942	AD x AE



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AG	Minimum Occupancy Percentage Bed Days at Minimum	85.00% 42,815	Department Criteria
AH	Occupancy		E x 365 x AG
AI	Total Allowed Patient Days	48,552	higher of H or AH
AJ	Fair Rental Value Per Diem	\$13.08	AF / AI
AK	06/30/09 Property and Related Net Per Diem	\$5.43	Department Data (Dodge Index)
AL	Property and Related Net Per Diem	\$13.08	Greater of AJ or AK, but not more than a 150% increase of AK

3. The Property and Related Net Per Diem initially established under (N)(2) shall be updated annually on July 1, effective for dates of service on and after July 1, 2010 as follows:
- (a) The value per square foot shall be based on the construction cost for nursing facilities, as derived from the most recent RSMeans Building Construction cost data available on June 1st of each year. The Value per Square Foot shall be adjusted by using the RSMeans Location factors based on the facility's zip code and by using a cost index to correspond to annual state appropriations.
  - (b) A complete facility replacement, which includes either relocating to a newly constructed facility or gutting a complete facility and rebuilding it, will result in a new base year correlating to the date in which the facility went into operation. All partial replacements will be treated as renovations and will have their base year age adjusted based on the methodology proscribed for a renovation.
4. A Renovation Construction Project shall mean a capital expenditure (as defined in Section (N)(4)(a)) that exceeds \$500 per existing

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licensed bed and has been filed with the Office of Health Planning as a New Construction Project under the authority of O.G.C.A. § 290-5-8

(a) Allowable capital expenditures include the costs of buildings, machinery, fixtures, and fixed equipment (see Table 5 in Estimated Useful Lives of Depreciable Hospital Assets (Revised 2008 Edition), published by Health Forum, Inc, for a complete listing of allowable items) constituting any New Construction Project as referenced in paragraph 4, above. The exception to this requirement is for telemedicine terminals, solar panels, tankless water heaters and low flow toilets. Capital expenditures are asset acquisitions that meet the criteria of §108.1 of the Provider Reimbursement Manual (CMS-15-1) or are betterments or improvements which meet the criteria of §108.2 of the Provider Reimbursement Manual (CMS-15-1) or which materially (a) expand the capacity, (b) reduce the operating and maintenance costs, (c) significantly improve safety or (d) promote energy conservation.

5. For purposes of the FRV calculation, the age of each facility shall be determined as follows:
- (a) The initial age of each facility shall be determined as of July 1, 2009, comparing 2009 to the later of the facility's year of construction or the year the building was first licensed as a nursing facility; provided, however, that such age will be reduced for Construction Projects, or bed additions that occurred subsequent to the initial construction or conversion of the facility but prior to July 1, 2009.
- (b) For periods subsequent to July 1, 2009, the FRV adjusted age determined in (N)(5)(a) of a facility will be reduced on a quarterly basis to reflect new Renovation Construction Projects or bed additions that were completed after July 1, 2009, and placed into service during the preceding quarter. The rate adjustment for Renovation Projects or bed additions will be effective the first day of the calendar quarter subsequent to such project being completed and placed into service.

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- (c) Once initial rates are established under the FRV reimbursement system, subsequent calculations of the FRV adjusted age will be determined by subtracting the adjusted base year (derived by calculating the impact of bed additions and facility renovations) from the rate setting year. The FRV adjusted age will be recalculated each July 1 to make the facility one year older, up to the maximum age of 32.5 years and will be done in concert with the calculations of the Value per Square Foot as determined in section (N)(3)(a). Age adjustments and Rate adjustments are not synonymous.
- (d) If a facility has added beds, the age of these additional beds will be averaged in with the age of the remaining beds, and the weighted average age for all beds will be used as the facility's age. An example of how an addition would reduce the age of the facility is presented in the following table:

**Example Calculation of the Impact of an Addition on a Nursing Facility's Base Year**

<b><u>Ref</u></b>	<b><u>Data Element</u></b>	<b><u>Example</u></b>	<b><u>Source of Data</u></b>
		<b><u>Data</u></b>	
A	Facility Name	XYZ Nursing Home	Department Data
B	Medicaid Provider ID	123456789A	Department Data
C	Year Bed Additions were Completed	1981	Department Criteria
D	Base Year Prior to Additions	1970	Based on Initial Age adjusted by Prior Bed Additions and Facility Renovations
E	Existing Beds prior to Bed Additions	130	Department Data
F	Number of Beds Added	8	Department Data
G	Age of Existing Beds when Additions were Completed	11	C-D

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H	Weighted Average of Existing Beds	1430	E x G
I	Total Beds After Bed Additions were Completed	138	E+F
J	Base Year Age Adjustment	10.36	H/I
K	New Base Year	1,971.00	C - J (rounded)

- (e) If a facility performed a Renovation Construction Project as defined in section (N)(4), the cost of the Project will be converted to an equivalent number of replacement beds by dividing the value of the renovation by the depreciated bed replacement value.
- i. The renovation completion date will be used to determine the year of renovation.
  - ii. An Age Index factor will be used to calculate a bed replacement cost for any renovation occurring prior to July 1, 2009. The Age Index factor is derived by using the 2009 Edition of the RSMeans and dividing the Historical Cost Index for the year of the renovation by the Historical Cost Index for 2009.
  - iii. To determine the accumulated depreciation per bed, 2 percent per year will be used for a maximum number of 25 depreciable years.

In no case will the consideration of a Renovation Construction Project reduce the age of the facility to a number less than zero. An example of how the cost of a renovation Construction Project would be converted to an equivalent number of replacement beds and a new base year is presented in the following table:

**Example Calculation of the Impact of a Renovation on a Nursing Facility's Base Year**

<u>Ref</u>	<u>Data Element</u>	<u>Example Data</u>	<u>Source of Data</u>
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A	Facility Name	XYZ Nursing Home	Department Data
B	Medicaid Provider ID	12345678A	Department Data
C	Rate Setting Year	2009	Department Data
D	Year Renovation was Completed	2003	Department Data
E	Base Year Prior to Renovation	1981	Based on Initial Age Adjusted by Prior Bed Additions and Facility Renovations
F	Licensed Nursing Facility Beds	138	Department Data
G	Facility Square Footage	40,060	Department Data
H	Nursing Facility Zip Code	30442	Department Data
I	Renovation Amount	\$372,662	Department Data
J	Renovation Year RS Means Cost Index	132.00	RS Means lookup based on Year Renovation Completed
K	Rate Year RS Means Cost Index	185.90	RS Means lookup based on Rate Year
L	Facility Age Index Factor	0.7101	J/K
M	Rate Year RS Means Cost per Square Foot	\$141.10	RS Means lookup based on Rate Year
N	Maximum Square Feet per Bed	700	Department Criteria
O	Allowed Facility Square Footage	40,060	Lesser of G or (F x N)
P	Facility Cost Prior to Adjustments	\$5,652,466	M x O
Q	RS Means Location Factor	0.77	RS Means lookup based on Zip Code (H)
R	Adjusted facility Cost	\$3,090,461	P x L x Q
S	Age of Beds at Time of Renovation	22	D-E
T	Maximum Bed Replacement Years	25	Department Criteria
U	Allowed Age of Beds	22	Lesser of S or T
V	Initial Aging Depreciation Rate	2.00%	Department Criteria
W	Allowed Facility Depreciation	\$1,359,803	R x U x V
X	Adjusted Bed Replacement Cost	\$12,541	(R-W)/F
Y	New Bed Equivalents	29.72	I / X (but limit is F)
Z	Total Beds to be Weighed	108.28	F-Y
AA	Weighed Average of Beds	2,382.26	Z x S
AB	Base Year Age Adjustment	17.26	AA/F
AC	New Base Year	1986	D-AB (rounded)

O. Overall Limitations on Total Allowed Per Diem Billing Rate

In no case shall the Total Allowed Per Diem Billing Rate, whether determined under either Section 1002.2 or Section 1002.3 of the Nursing Facility Manual, exceed the facility's customary charges to the general public for those services reimbursed by the Division.

P. Payment in Full for Covered Services

The facility must accept as payment in full for covered services the amount determined in accordance with Section 1002 of the Nursing Facility Manual.

Q. Other Rate Adjustments1. Quality Improvement Initiative Program

Facilities must enroll in the Quality Improvement Program to receive the following incentives:

- a. A staffing adjustment equal to 1% of the Allowed Per Diem for Routine and Special Services may be added to a facility's rate. To qualify for such a rate adjustment, a facility's Nursing Hours and Patient Days Report must demonstrate that the facility meets the minimum staffing requirements presented in section 1003.1 of the manual.
- b. For the most recent calendar quarter for which MDS information is available, Brief Interview for Mental Status (BIMS) scores for Medicaid patients will be measured, as determined by the Division. An adjustment factor may be applied to a facility's Routine and Special Services Allowed Per Diem based on the percentage of Medicaid patients whose BIMS scores are less than or equal to 5. The adjustment factors are as follows:

% of Medicaid Patients	Adjustment Factor
<20%	0%
20% - <30%	1%
30% - <45%	2.5%
45% - 100%	5.5%

- c. A quality incentive adjustment may be added to a facility's rate utilizing the following set of indicators.

I. Clinical Measures:T.N. No: 20-0011

Supersedes

T.N. No: 09-007Approval Date: 6/15/21Effective Date: August 14, 2020

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The source of data is the Center for Medicare and Medicaid Services (CMS) website. Each measure is worth 1 point if the facility-specific value is in excess of the statewide average.

- (a) Percent of High Risk Long-Stay Residents Who Have Pressure Sores.
- (b) Percent of Long-Stay Residents Who Were Physically Restrained.
- (c) Percent of Long-Stay Residents Who Have Moderate to Severe Pain.
- (d) Percent of Short-Stay Residents who had Moderate to Severe Pain.
- (e) Percent of Residents Who Received Influenza Vaccine.
- (f) Percent of Low Risk Long-Stay Residents Who Have Pressure Sores.

2. Alternative Clinical Measures:

Facilities that do not generate enough data to report on the CMS website (due to not meeting the minimum number of assessments for a reporting in a quarter) will use the following measures from the My InnerView (MIV) Quality Profile. The values used from MIV Quality Profile will be compared to the MIV Georgia average values for those measures. Each measure is worth 1 point if the facility-specific value is in excess of the MIV Georgia average.

- (a) Chronic Care Pain - Residents without unplanned weight loss/gain.
- (b) PAC Pain - Residents without antipsychotic medication use.
- (c) High Risk Pressure Ulcer- Residents without acquired pressure ulcers.
- (d) Physical Restraints - Residents without acquired restraints.
- (e) Vaccination: Flu - Residents without falls.
- (f) Low Risk Pressure Ulcer - Residents without acquired catheters.

3. Non-Clinical Measures:

Each measure is worth 1 point as described.

- (a) Participation in the Employee Satisfaction Survey.

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- (b) Most Current Family Satisfaction Survey Score for "Would you recommend this facility?" Percentage of combined responses either "excellent" or "good" to meet or exceed the state average of 85% combined.
  - (c) Quarterly average for RNs/LVNs/LPNs Stability (retention). to meet or exceed the state average.
  - (d) Quarterly average for CNAs/NA Stability (retention) to meet or exceed the state average.
  - (e) AHCA Active Bronze Quality Award Winner per the AHCA Active Bronze Quality Award Winner list.

4. Additional Quality Points Available:

The following measures are worth the specified number of points as described in the two criteria below in addition to the 1% or 2% available incentive.

- (a) AHCA Active Silver Quality Award winner per the AHCA Active Silver Quality Award Winner List will earn an additional incentive equal to 1%.
- (b) AHCA Active Gold Quality Award winner per the AHCA Active Gold Quality Award Winner List will earn an additional incentive equal to 2%.
- (c) Nursing Center who has earned and is currently accredited as a Joint Commission Accredited Nursing Care Centers will earn an additional incentive equal to 2%.

To qualify for a quality incentive adjustment equal to 1% of the Allowed Per Diem for Routine and Special Services for the most recent calendar quarter, the facility must obtain a minimum of three (3) points in the following combination: One (1) point must come from clinical measures, one (1) point from the non-clinical measure, and a third point from either the clinical or non-clinical measures.

To qualify for a quality incentive adjustment equal to 2% of the Allowed Per Diem for Routine and Special Services, for the most recent calendar quarter, the facility must obtain a minimum of six (6) points in the following combination: Three (3) points must come from the clinical measures, one (1) point from the



non-clinical measures, and two (2) points from either the clinical or non-clinical measures.

An additional 1% incentive can be earned by a facility that is an active AHCA Silver Award Winning Center.

An additional 2% incentive can be earned by a facility that is an active AHCA Gold Award Winning Center or Joint Commission Accredited.

NOTE: Facilities placed on the Special Focus List generated by CMS will not earn the DCB 1% Quality Incentive until the following conditions have been met:

- The facilities next standard survey and/or compliant survey, after being placed on the list, does not have a deficiency cited over Level E scope and severity; and
- The facilities second standard survey and /or compliant survey, after being placed on the list, does not have a deficiency cited over Level E scope and severity; or
- If the facility is removed from the special focus list by CMS for any other reason.

T.N. No: 20-0011

Supersedes

T.N. No: 09-007

Approval Date: 6/15/21

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2. Other Adjustments to Rates

- (a) Payment rates for state-owned nursing facilities will be adjusted to 100% of service costs. This provision will apply in addition to all others in this chapter and will supersede those that are in direct conflict only to the extent that they are not capable of simultaneous application.
- (a) Effective July 1, 2003, in order to recognize the Medicaid share of a facility's cost of paying fees for Georgia's the Nursing Home Provider Fee Act, an adjustment equal to the fee payable for each Medicaid patient day will be added to a facility's rate. During the quarter beginning July 1, 2003, the adjustment amount will be estimated by the Division; any difference between the estimated and actual fee will be corrected by changes to rates for a subsequent quarter. For periods beginning October 1, 2003, the adjustment amount will be based on the fee applicable for the prior quarter.
- (b) For payments made for services provided on or after July 1, 2005, State governmental facilities and non-State governmental facilities will be eligible for rate payment adjustments. The rate adjustment payments are intended to provide supplemental funding for Medicaid services to these facilities that, based on their governmental status, need sufficient funds for their commitments to meet the healthcare needs of all members of their communities. The rate payment adjustments will be subject to federal upper payment limits. For the appropriate groupings of State governmental facilities, non-State governmental facilities and non-governmental facilities, aggregate rate adjustment payments available without exceeding upper payment limits will be determined by measuring the difference between:
- All amounts paid for services provided to Medicaid patients and
  - Estimated payment amounts for such services if payments were based on Medicare payment principles. Either cost based or rate payment measures may be used as Medicare payment principles.

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A request for a fair rental value rate increase that is the result of a Renovation Construction Project, bed addition, or replacement subsequent to July 1, 2009, must be submitted to the Department by the end of the quarter following the completion of the project. The request must be completed on a standard form for rate requests and contain documented approval of the project from the Department's General Counsel Division.

Comparisons of all amounts paid for services provided to Medicaid patients and estimated payment amounts for such services if payments were based on Medicare payment principles will also be made for each facility to determine facility-specific rate adjustment payments. These rate payment adjustments will be made on a monthly, quarterly or annual basis and will be determined in a manner that will not duplicate compensation provided from payments for individual patient claims.

An example of how a rate adjustment payment is calculated is presented on the following pages.

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Provider Name:		XYZ Nursing Home			
		Quarter Ending 09/30/05	Quarter Ending 12/31/05	Quarter Ending 03/31/06	Quarter Ending 06/30/06
<b>Medicare UPL Rate</b>					
<b>Line 1</b>	PPS rate based on Medicaid patients for each quarter <sup>1</sup>	157.92	149.92	149.92	149.92
<b>Line 2</b>	Adjustment for change in case mix	1.0150	1.0150	1.0150	1.0150
<b>Line 3</b>	Adjusted Medicare rate for UPL	160.29	152.17	152.17	152.17
<b>Medicaid UPL Rate</b>					
<b>Line 4</b>	Medicaid rate without provider fee <sup>1</sup>	89.63	86.90	85.63	90.69
<b>Line 5</b>	Provider Fee adjustment	9.15	9.15	9.15	9.15
<b>Line 6</b>	Statewide average payment for other services <sup>1</sup>	14.11	14.11	14.11	14.11
<b>Line 7</b>	Adjusted Medicaid rate for UPL	112.89	110.16	108.89	113.95
<b>Medicare UPL rate minus Medicaid UPL rate</b>					
<b>Line 8</b>		47.40	42.01	43.28	38.22
<b>Medicaid Patient Days</b>					
<b>Line 9</b>	Medicaid days reported in SFY 2005 cost report	22,026	22,026	22,026	22,026
<b>Line 10</b>	Portion of year for each quarter	25%	25%	25%	25%
<b>Line 11</b>	Adjusted Medicaid patient days for UPL	5,507	5,507	5,507	5,507
<b>Facility-Specific UPL calculation</b>					
<b>Line 12</b>		261,032	231,349	238,343	210,478
<b>Facility-Specific UPL calculation for 7-1-05 to 06-30-06</b>					941,202

<sup>1</sup> Data for the UPL rate period will be used if available. If such data is not available, amounts for payment periods may be determined by use of data from prior periods with adjustments for expected changes that are reasonable and appropriately documented. If applicable, projected changes in Medicaid payment rates would be based on budgeted changes.

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facility name	XYZ ICF-MR Nursing Home	
<u>line description</u>	<u>comments</u>	<u>amount</u>
1 total cost per day for SFY2004	after audit adjustments	267.70
2 capital cost per day for SFY2004	after audit adjustments	9.44
3 routine services cost per day for SFY2004	col 1 - col 2	258.26
4 projected routine service cost per day for SFY2006 12% of projected routine service cost per day for SFY2006	col 3 x 1.06181	274.22
5 SFY2006	col 4 x 0.12	32.91
6 Medicaid ICF-MR patient days from SFY 6-30-2004	after audit adjustments	29,415
7 available UPL calculation for SFY2006	col 5 x col 6	968,048

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2. Nursing Facility Rate Determination for Ventilator Dependent Residents

- (1) Effective for dates of service on and after July 1, 2019, the nursing facility per diem for a ventilator dependent resident will be \$540.55.

Effective for dates of service on and after July 1, 2020, the nursing facility per diem for a ventilator dependent resident will be \$556.77.

Effective for dates of service on and after July 1, 2021, the nursing facility per diem for a ventilator dependent resident will be \$589.62.

- (2) The per diem costs of providing services to the ventilator dependent residents shall be maintained separately (as a distinct part) of each facility's annual cost report beginning November 13, 2009.
- (3) Ventilator dependent per diem rates will cover all skilled nursing care services and will be all-inclusive.
- (4) No additional amount above the current nursing facility daily rate shall be allowed until the service is prior authorized by the Department's Medical Management Contractor.
- (5) The resident's clinical condition shall be reviewed every 90 days to determine if the resident's medical condition continues to warrant services at the ventilator dependent nursing facility rate. Prior authorization through the Department's Medical Management Contractor spans a 90-day maximum time period. The nursing facility is required to resubmit requests for continued stay prior to expiration of the current PA. If a resident no longer requires the use of a ventilator, the provider shall not receive additional reimbursement beyond the Georgia Medicaid nursing home per diem rate determined for the facility.

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- the additional reimbursement is determined by a replacement cost appraisal (however, at the Division's discretion, for capital items not affecting the entire facility, multiple, competitive arm's length bids by contractors can be used instead of replacement cost appraisals).
- the provider could not with reasonable diligence ascertain that the renovation would be required by the Georgia Department of Human Resources Standards and Licensure Unit. Reasonable diligence will include but is not limited to obtaining an inspection and its resulting report by the Architect of the Standards and Licensure Section specifically for the purpose of determining what repairs, renovations or other actions will be required of the facility to meet all applicable physical plant requirements, as well as all other inspections and deficiency reports on file at the Georgia Department of Human Resources Standards and Licensure Unit for that facility.

- (ii) If the facility was being reimbursed under the provisions of paragraphs (a) through (g), reimbursement for additions and expansions will be subject to limitations described in paragraphs (b) through (f). If the addition or expansion does not add beds, there will be no additional reimbursement. If beds are added, the addition will be treated in a manner similar to a new facility to determine a separate property rate sub-component for the addition.

1002.6

Overall Limitations on Total Allowed Per Diem Billing Rate

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In no case shall the Total Allowed Per Diem Billing Rate, whether determined under either Section 1002.2 or Section 1002.3, Nursing Facility Manual, exceed the facility's customary charges to the general public for those services reimbursed by the Division.

1002.7 Payment in Full for Covered Services

The facility must accept as payment in full for covered services the amount determined in accordance with Section 1002, Nursing Facility Manual.

1002.8 Adjustments to Rates

Payment rates for state-owned nursing facilities will be adjusted to 100% of service costs. This provision will apply in addition to all others in this chapter and will supersede those that are in direct conflict only to the extent that they are not capable of simultaneous application.

1003. Additional Care Services

1003.1 Required Nursing Hours

The minimum required number of nursing hours per patient day for all nursing facilities is 2.50 actual working hours.

1003.2 Failure to Comply

- (a) The minimum standard for nursing hours is 2.50.
- (b) Facilities found not in compliance with the 2.50 nursing hours will be cited for being out of compliance with a condition of participation. This will lead to imposition of a civil monetary penalty, denial of reimbursement for newly admitted patients, or suspension or termination whichever is appropriate as determined by the Division.

1004. Medicare Crossover Claims

The maximum allowable payment for Medicare nursing facility coinsurance (crossover) claims will be the nursing facility's Medicaid specific per diem rate in effect for the dates of service of the crossover claims. The crossover claims will



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not be subsequently adjusted due to subsequent per diem rate adjustments. This section is also included in Chapter 1100 of the Manual.

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**APPENDIX D**

**UNIFORM CHART OF ACCOUNTS, COST REPORTING,  
REIMBURSEMENT PRINCIPLES AND OTHER REPORTING  
REQUIREMENTS**

General

This appendix discusses the use of a uniform chart of accounts, the annual submission of a cost report, the principles of reimbursement which comprise the basis for the financial reporting requirements of facilities participating in the Georgia Medicaid Program and other reporting requirements. The Georgia Division of Medical Assistance Uniform Chart of Accounts as comprised on the date of service is incorporated by reference herein. A copy is available from the Division upon request. Cost reports and instructions are made available to each facility near the end of the reporting period. The reimbursement principles discussed in this appendix are selected from the Centers for Medicare and Medicaid Services Provider Reimbursement Manual (CMS-15-1). Copies of the Manual, which provide a detailed description of allowable costs, are available from the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

1. Uniform Chart of Accounts

The Georgia Division of Medical Assistance requires that all nursing facilities participating in the Medicaid Program utilize the classification of accounts shown in the Uniform Chart of Accounts in reporting its financial operations in the cost reporting system. While it is not mandatory that books of original entry or ledgers be maintained in accordance with the Uniform Chart of Accounts, facilities are strongly encouraged to do so. The Uniform Chart of Accounts has been designed to meet management needs for budgeting information, information flow, internal control, responsibility accounting and financial reporting. Also, it has been designed in such a manner that accounts may be added or deleted to tailor the financial information to the facility's needs.

Should a facility elect to maintain its books of original entry or ledgers in a manner other than that specified in the Uniform Chart of Accounts, the facility is required to have available a detailed description of how its

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accounting system differs. This description of differences must be used by the facility for converting the output of its reporting system into the format specified in the Uniform Chart of Accounts. This description of differences and conversion of reporting information into the proper format are considered to be essential components of a facility's accounting records. When such information is needed but not maintained, a facility's cost report will be determined to be unacceptable for fulfilling reporting requirements and penalties described in Section 2.b and 2.g of this appendix will be imposed.

2. Cost Reporting

Reimbursement of expenses incurred by nursing facilities in the provision of care to Medicaid recipients is accomplished through the mechanism of the cost report. This document reports historical costs and details recipient occupancy data experienced during the fiscal year. The following cost reporting requirements apply to providers of nursing facility services and all home offices who allocate costs to nursing facilities:

- a. Each nursing facility must annually file a cost report with the Division of Medical Assistance which covers a twelve-month period ending June 30th. Cost reports must be e-mailed to the Division on or before September 30th. (See Hospital-based facility exception in 2(d) below.)
- b. If such cost reports are not filed by September 30th, the Division shall have the option of either terminating the provider agreement upon thirty days written notice or imposing a penalty of \$50.00 per day for the first thirty days and a penalty of \$100.00 per day for each day thereafter until an acceptable cost report is received by the Division. The only condition in which a penalty will not be imposed is if written approval for an extension is obtained from the Division Director of Nursing Home Reimbursement Services prior to September 30.
- c. If a cost report is received by the Division prior to September 30th but is unacceptable, it will be returned to the facility for proper completion. No penalty will be imposed if the properly completed report is filed by the September 30th deadline. However, the

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above described penalties may be imposed after the September 30th deadline until an acceptable cost report is received by the Division

- d. Hospital-based facilities using Medicare fiscal year ending dates between July and April must submit cost reports to the Division on or before September 30. Facilities using fiscal year ending dates between May and June must submit cost reports on or before November 30. The financial information to be included on the Medicaid cost report must be taken in total from the provider's most recent Medicare cost report that precedes June 30. The rules regarding unacceptability and timeliness described above in sections b. and c. also apply to hospital-based facilities' cost reports.

Approval for extensions beyond the September 30 or November 30 deadline, where applicable, will be granted only if the provider's operations are "significantly adversely affected" because of circumstances beyond the provider's control (i.e., a flood or fire that causes the provider to halt operations). Each provider must submit a written request specifying the hospital-based facility and the reason for the extension.

- e. To be acceptable, a cost report must be complete and accurate, include all applicable schedules, and be correctly internally cross-referenced. Further, the amount per book column for Schedules B and C must agree with the amounts recorded in the facility's general ledger; however, there may have to be certain groupings of the general ledger amounts to agree with the cost report line items. Estimated amounts used for a conversion to a June 30th year-end are not acceptable. Reported costs of interest paid to non-related parties must be reduced by non-related parties must be reduced by an amount equal to the lesser of: (1) interest paid to non-related parties; or (2) investment income other than the exceptions identified in CMS-15, Section 202.2. Reported costs of special services must be reduced, as indicated on Schedule B-1A, by an amount resulting from revenue received from sources other than the Division for these services. Adjustments will be based on

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auditable records of charges to all patients as required by cost report instructions.

- f. All nursing facilities are required to submit to the Division any changes in the amount of or classification of reported costs made on the original cost report within thirty days after the implementation of the original cost report used to set reimbursement rates. Adjustments to amounts or changes in classification of reported costs in prior years will not be considered.
- g. Late cost report penalties will be invoiced through the Accounting Section of the Division for the total amount of the assessed penalty. The provider must submit payment to the Division. Penalties not properly paid will be deducted from the monthly reimbursement check. The assessments will not be refunded.
- h. New facilities, which have less than twelve but not less than six months of actual operating cost experience, will only submit cost data for their actual months of operation as of June 30. New facilities that have less than six months of actual operating cost experience are not required to submit a cost report. Facilities in which there has been a change of ownership must submit a separate report for each owner. The subsequent owner will be reimbursed based on the previous owner's cost report (with an adjustment in the property cost center only) until a new cost report is received from the new owner and determined reliable and appropriate. The Division will determine whether each submitted cost report is appropriate and reliable as a basis for computing the Allowed Per Diem billing rate and may calculate a facility's Allowed Per Diem billing rate in accordance with Section 1002.3.

For ownership changes effective with at least six months of patient day data on the applicable June 30 fiscal year cost report, the initially submitted cost report will be used to establish the new owner's rate when the comparable cost reports are used to set rates. For the periods prior to the use of the new owner's cost report, the new owner will receive rates based on the previous owner's approved cost report data, with the appropriate Dodge Index property rate. If the new

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
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owner's initial cost report contains less than six months of patient day data, when the initial cost report period reports are used to set rates, the new owner will receive a rate based on the previous owner's last approved cost report inflated to current costs, as determined by the Division, or the costs from the new owner's initial cost report, whichever is lower. If the ownership change is between related parties, when the initial cost report period reports are used to set rates, the old owner's cost report and new owner's cost report for the year of the ownership change may be combined and considered in determining the minimum rate for the new owner.

- i. Reported costs must conform to Divisional instructions, or in the absence of specific instructions, to the allowable costs discussed in the CMS-15-1. Reported costs are subject to audit verification by the Division, State or Federal auditors or their agents. Providers using computerized information systems for accounting or other purposes must make this information available in a suitable electronic format if requested by the Division or its agents. Where such audit verifications determine that the cost report was prepared based upon inadequate accounting records, the facility will be required to correct its records and submit a corrected cost report. A penalty will be imposed on the facility for the costs incurred by the Division for any additional audit work performed with the corrected cost report.
- j. For audit examinations described in (i) above, it is expected that a facility's accounting records will be available within the State. Should such records be maintained at a location outside the State, the facility will be required to pay for travel costs incurred for any examination conducted at the out-of-state location.
- k. Should a cost report submitted to the Nursing Home Unit for review need explanation or clarification, appropriate workpapers or letters of explanation should be attached.
- l. All cost reports and correspondence concerning these cost reports are to be mailed to the following address:

Division of Medical Assistance  
Nursing Home Services Unit

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
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2 Peachtree Street, N.W.  
Atlanta, Georgia 30303-3159

3. Reimbursement Principles

The objective of a system of reimbursement based on reasonable costs is to reimburse the institution for its necessary and proper expenses incurred related to patient care. As a matter of general reimbursement principle, costs with respect to individuals covered by the Medicaid Program will not be borne by those not covered and costs with respect to individuals not covered by the Medicaid Program will not be borne by the Program. The principles of cost reimbursement require that institutions maintain sufficient financial records and statistical data for proper determination of costs payable under the Program. Such records and data must be maintained for a period of at least three years following the date of submission of the cost report

4. Case Mix Index Reports

- a. MDS Data for Quarterly Patient Listing - Using Minimum Data Set (MDS) information submitted by a facility, the Division will prepare a Case Mix Index Report, listing information for patients in a facility on the last day of a calendar quarter. A preliminary version of the report will be distributed to a nursing facility about the middle of the following quarter after each calendar quarter end. The preliminary version of the report will be distributed with instructions regarding corrections to patient payer source information that a nursing facility may submit for consideration before the final version of the report is prepared and distributed.
- b. RUG Classification - For each patient included in the quarterly Case Mix Index Report, the most recent MDS assessment will be used to determine a Resource Utilization Group (RUG) classification. Version 5.12, with 34 grouper and index maximizer, the RUG classification system will be used to determine a patient's RUG category

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
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- c. Payer Source - For each patient included in the quarterly Case Mix Index Report, a payer source will be identified. As described in section D.4.a, a facility will have the opportunity to submit updated payer source information for changes that may occur by the last day of the calendar quarter.
- d. Relative Weights and Case Mix Index Scores for All Patients - For each patient included in the quarterly Case Mix Index Report, a relative weight will be assigned by the Division. Exhibit D-1 identifies the relative weights for each RUG category. This data will be used to determine a case mix score for all patients in a facility.
- e. Relative Weights and Case Mix Index Scores for Medicaid Patients - For each Medicaid patient included in the quarterly Case Mix Index Report, a Medicaid relative weight will be assigned by the Division. Exhibit D-1 identifies the relative weights for each RUG category. This data will be used to determine a case mix score for Medicaid patients in a facility.
- f. CPS Scores - For each patient included in the quarterly Case Mix Index Report, the most recent MDS assessment will be used to determine a Cognitive Performance Scale (CPS) score.
- g. Corrections to MDS and Payer Source Information Corrections to MDS and payer source information used in payment rate calculations applicable to prior dates of service that result from appeals or audit adjustments will be processed as adjustments to rate calculations in a subsequent period. If a prospective correction would otherwise result in excess or advance payments of material amounts, with materiality determined by the amount or percentage of payment, the Division will process the correction by a retrospective adjustment to prior payments.

A detailed description of all data elements in the Case Mix Index Report is presented in Exhibit D-2.

5. Nursing Hours and Patient Day Report



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Except for ICF-MR and state owned facilities, each facility must submit a Nursing Hours and Patient Day Report for each calendar quarter, within one month after the end of the quarter. The required information will be submitted in accordance with a format and instructions as distributed by the Division. A facility's request to correct or amend a nursing home provider fee report will be limited to a 30 day period following the report's due date. Corrections to nursing hours and patient day data used in payment rate calculations applicable to prior dates of service that result from appeals or audit adjustments may be processed as adjustments to rate calculations in a subsequent period. If the impact of the correction is significant, the Division may elect to process the correction by a retrospective adjustment to prior payments.

If a facility does not submit a report or does not submit a report when due, a late fee of \$10 per day may be assessed.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
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**EXHIBIT D-1**

	Category	Classification	Code	Case Mix Index for All Patients	Case Mix Index for Medicaid Patients
1	Extensive	Extensive Special Care 3 / ADL > 6	SE3	2.839	2.896
2	Extensive	Extensive Special Care 2 / ADL > 6	SE2	2.316	2.362
3	Rehabilitation	Rehabilitation All Levels / ADL 17-18	RAD	2.284	2.330
4	Extensive	Extensive Special Care 1 / ADL > 6	SE1	1.943	1.982
5	Rehabilitation	Rehabilitation All Levels / ADL 14-16	RAC	1.936	1.975
6	Special Care	Special Care / ADL 17-18	SSC	1.877	1.915
7	Rehabilitation	Rehabilitation All Levels / ADL 9-13	RAB	1.772	1.807
8	Special Care	Special Care / ADL 15-16	SSB	1.736	1.771
9	Special Care	Special Care / ADL 4-14	SSA	1.709	1,743
10	Rehabilitation	Rehabilitation All Levels / ADL 4-8	RAA	1.472	1.501
11	Clinically Complex	Clinically Complex with Depression / ADL 17-18	CC2	1.425	1.454
12	Clinically Complex	Clinically Complex / ADL 17-18	CC1	1.311	1.337
13	Clinically Complex	Clinically Complex with Depression / ADL 12-16	CB2	1.247	1.272
14	Physical	Physical Function with Nursing Rehab / ADL 16-18	PE2	1.188	1.212
15	Clinically Complex	Clinically Complex / ADL 12-16	CB1	1.154	1.177
16	Physical	Physical Function with Nursing Rehab / ADL 11-15	PD2	1.095	1.117
17	Impaired Cognition	Cognitive Impairment with Nursing Rehab / ADL 6-10	IB2	1.061	1.082
18	Clinically Complex	Clinically Complex with Depression / ADL 4-11	CA2	1.043	1.064
19	Physical	Reduced Physical Function / ADL 16-18	PE1	1.077	1.077
20	Behavioral Problems	Behavior Problem with Nursing Rehab 1/ ADL 6-10	BB2	1.021	1.041

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
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	Category	Classification	Code	Case Mix Index for All Patients	Case Mix Index for Medicaid Patients
21	Physical	Reduced Physical Function / ADL 11-15	PD1	0.990	0.990
22	Impaired Cognition	Cognitive Impairment / ADL 6-10	IB1	0.938	0.957
23	Physical	Physical Function with Nursing Rehab / ADL 9-10	PC2	0.937	0.956
24	Clinically Complex	Clinically Complex / ADL 4-11	CAL	0.934	0.953
25	Behavioral Problems	Behavior Problem / ADL 6-10	BB1	0.866	0.883
26	Physical	Physical Function with Nursing Rehab / ADL 6-8	PB2	0.824	0.841
27	Physical	Reduced Physical Function / ADL 9-10	PC1	0.865	0.865
28	Impaired Cognition	Cognitive Impairment with Nursing Rehab / ADL 4-5	IA2	0.777	0.777
29	Behavioral Problems	Behavior Problem with Nursing Rehab / ADL 4-5	BA2	0.750	0.750
30	Physical	Reduced Physical Function / ADL 6-8	PB1	0.749	0.749
31	Impaired Cognition	Cognitive Impairment / ADL 4-5	IAI	0.703	0.703
32	Physical	Physical Function with Nursing Rehab / ADL 4-5	PA2	0.637	0.637
33	Behavioral Problems	Behavior Problem / ADL 4-5	BA1	0.612	0.612
34	Physical	Reduced Physical Function / ADL 4-5	PA1	0.575	0.575

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
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**Exhibit D-2**  
**Detailed Description of Data Presented in Case Mix Index Reports**

Selection criteria for quarterly "Listing of Residents" reports – Residents are determined by identifying individuals for whom an MDS assessment has been received and for whom no subsequent discharge tracking document has been received. It is assumed that residents for whom a periodic assessment is more than 3 months past due have been discharged, and these individuals are not included in this report. The following data elements are selected from the most recent assessment data for patients residing in the nursing home on the last day of a calendar quarter:

AA8a, b – Reasons for assessment as reported in section AA8 of the MDS

Section a, primary reason for assessment

- 1 = admission assessment
- 2 = annual assessment
- 3 = significant change in status assessment
- 4 = significant correction of prior full assessment
- 5 = quarterly review assessment
- 6 = discharged - return not anticipated
- 7 = discharged – return anticipated
- 8 = discharged prior to completing initial assessment
- 9 = reentry
- 10 = significant correction of prior quarterly assessment
- 0 = none of the above

Section b, codes for assessments required for Medicare PPS or the State

- 1 = Medicare 5 day assessment
- 2 = Medicare 30 day assessment
- 3 = Medicare 60 day assessment
- 4 = Medicare 90 day assessment
- 5 = Medicare readmission/return assessment
- 6 = other state required assessment
- 7 = Medicare 14 day assessment
- 8 = other Medicare required assessment

Resident Name - Self explanatory

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
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SSN- Resident's social security number

Effective Date (R2b) – For assessments, this is the date completed as reported in section R2b of the MDS. For discharge tracking, this is the date of discharge. For re-entry tracking, this is the date of re-entry.

Classification Code -- RUG classification code (see “Case Mix Index for All Patients” in Exhibit D-1) from application of 34 grouper with index maximizing

Classification Category – Description of RUG classification (see Exhibit D-1)

Resident ID - Identification number assigned to resident by MDS reporting system

CPS Score - 5 MDS measures (related to coma, decision-making, impairment count, severe impairment count and total dependent eating) are used to classify a resident's condition into one of the following Cognitive Performance Scale categories: intact, borderline impairment, mild impairment, moderate impairment, moderately severe impairment, severe impairment or very severe impairment.

Payment Source – Primary source of payment for services to resident based on information included in MDS assessment data. If the MDS data includes a Medicaid identification number or Medicaid pending designation, Medicaid is assumed to be the resident's payment source. If a Medicaid identification number is not present and a Medicare identification number is present, Medicare is assumed to be the payment source. If neither a Medicaid nor Medicare identification number is present, the payment source is identified as “other.” A facility may submit a correction entry to the Division to note any changes to a patient's payment source that may not be reflected in MDS data. Such correction entries for payment status will be assumed to be permanent unless a subsequent correction entry is submitted for a resident.

Number of Residents, Overall CMI Averages and Medicaid CMI Average – The number of residents and average case mix index score, based on relative weights for “Case Mix Index for All Patients” in Exhibit D-1, are listed for 3 categories of residents by payment source – Medicaid, Medicare and Other. For Medicaid patients, an average case mix index score, based on relative weights for “Case Mix Index for Medicaid Patients,” is also listed.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
NURSING FACILITY SERVICES

Number and % of Residents Included in CPS Add-On - The number and percentage of Medicaid residents with CPS classifications of moderately severe impairment, severe impairment or very severe impairment

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
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For payments made for services provided on or after July 1, 2005, State governmental facilities and non-State governmental facilities will be eligible for rate payment adjustments. The rate adjustment payments are intended to provide supplemental funding for Medicaid services to these facilities that, based on their governmental status, need sufficient funds for their commitments to meet the healthcare needs of all members of their communities.

The rate payment adjustments will be subject to federal upper payment limits. For the appropriate groupings of State governmental facilities, non-State governmental facilities and non-governmental facilities, aggregate rate adjustment payments available without exceeding upper payment limits will be determined by measuring the difference between:

- All amounts paid for services provided to Medicaid patients and
- Estimated payment amounts for such services if payments were based on

Medicare payment principles. Either cost based or rate payment measures may be used as Medicare payment principles.

Comparisons of all amounts paid for services provided to Medicaid patients and estimated payment amounts for such services if payments were based on Medicare payment principles will also be made for each facility to determine facility-specific rate adjustment payments. These rate payment adjustments will be made on a monthly, quarterly or annual basis and will be determined in a manner that will not duplicate compensation provided from payments for individual patient claims.

A sample of how a rate adjustment payment is calculated is presented on the following pages.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
NURSING FACILITY SERVICES

Provider Name:		XYZ Nursing Home			
		Quarter Ending 09/30/05	Quarter Ending 12/31/05	Quarter Ending 03/31/06	Quarter Ending 06/30/06
<b>Medicare UPL Rate</b>					
<b>Line 1</b>	PPS rate based on Medicaid patients for each quarter <sup>1</sup>	157.92	149.92	149.92	149.92
<b>Line 2</b>	Adjustment for change in case mix	1.0150	1.0150	1.0150	1.0150
<b>Line 3</b>	Adjusted Medicare rate for UPL	160.29	152.17	152.17	152.17
<b>Medicaid UPL Rate</b>					
<b>Line 4</b>	Medicaid rate without provider fee <sup>1</sup>	89.63	86.90	85.63	90.69
<b>Line 5</b>	Provider Fee adjustment	9.15	9.15	9.15	9.15
<b>Line 6</b>	Statewide average payment for other services <sup>1</sup>	14.11	14.11	14.11	14.11
<b>Line 7</b>	Adjusted Medicaid rate for UPL	112.89	110.16	108.89	113.95
<b>Medicare UPL rate minus Medicaid UPL rate</b>					
<b>Line 8</b>		47.40	42.01	43.28	38.22
<b>Medicaid Patient Days</b>					
<b>Line 9</b>	Medicaid days reported in SFY 2005 cost report	22,026	22,026	22,026	22,026
<b>Line 10</b>	Portion of year for each quarter	25%	25%	25%	25%
<b>Line 11</b>	Adjusted Medicaid patient days for UPL	5,507	5,507	5,507	5,507
<b>Facility-Specific UPL calculation</b>					
<b>Line 12</b>		261,032	231,349	238,343	210,478
<b>Facility-Specific UPL calculation for 7-1-05 to 06-30-06</b>					941,202

<sup>1</sup> Data for the UPL rate period will be used if available. If such data is not available, amounts for payment periods may be determined by use of data from prior periods with adjustments for expected changes that are reasonable and appropriately documented. If applicable, projected changes in Medicaid payment rates would be based on budgeted changes.



METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
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facility name	XYZ ICF-MR Nursing Home		
<u>line description</u>	<u>comments</u>	<u>amount</u>	
1 total cost per day for SFY2004	after audit adjustments	267.70	
2 capital cost per day for SFY2004	after audit adjustments	9.44	
3 routine services cost per day for SFY2004	col 1 - col 2	258.26	
4 projected routine service cost per day for SFY2006 12% of projected routine service cost per day for	col 3 x 1.06181	274.22	
5 SFY2006	col 4 x 0.12	32.91	
6 Medicaid ICF-MR patient days from SFY 6-30-2004	after audit adjustments	29,415	
7 available UPL calculation for SFY2006	col 5 x col 6	968,048	

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-  
NURSING FACILITY SERVICES

NURSING FACILITY RATE DETERMINATIONS FOR VENTILATOR DEPENDENT  
RESIDENTS

- (1) Effective for dates of service on and after July 1, 2019, the nursing facility per diem for a ventilator dependent resident will be \$540.55.

Effective for dates of service on and after July 1, 2020, the nursing facility per diem for a ventilator dependent resident will be \$556.77.

Effective for dates of service on and after July 1, 2021, the nursing facility per diem for a ventilator dependent resident will be \$589.62.

- (2) The per diem costs of providing services to the ventilator dependent residents shall be maintained separately (as a distinct part) of each facility's annual cost report beginning November 13, 2009.
- (3) Ventilator dependent per diem rates will cover all skilled nursing care services and will be all-inclusive.
- (4) No additional amount above the current nursing facility daily rate shall be allowed until the service is prior authorized by the Department's Medical Management Contractor.
- (5) The resident's clinical condition shall be reviewed every 90 days to determine if the resident's medical condition continues to warrant services at the ventilator dependent nursing facility rate. Prior authorization through the Department's Medical Management Contractor spans a 90-day maximum time period. The nursing facility is required to resubmit requests for continued stay prior to expiration of the current PA. If a resident no longer requires the use of a ventilator, the provider shall not receive additional reimbursement beyond the Georgia Medicaid nursing home per diem rate determined for the facility.

## **REIMBURSEMENT FOR NURSING FACILITY SERVICES**

A facility's Actual Reimbursement Rate is the amount the Division will reimburse to a facility for nursing services rendered to a particular eligible patient for one patient day and is calculated by subtracting Patient Income from Total Allowed Per Diem Billing Rate. In addition, it is subject to retroactive adjustment according to the relevant provisions of Supplement 4 to Attachment 4.19-D.

- a. Patient Income is that dollar amount shown on the Summary Notification letter issued by the Division of Family and Children Services (DFCS). The patient's income is deducted in full from the Medicaid reimbursement rate until the income has been exhausted.
- b. Total Allowed Per Diem Billing Rate is the amount derived from the rate setting process, as defined on pages 7 through 17 of this Supplement in the sections titled "*Total Allowed Per Diem Billing Rate for Facilities for Which a Cost Report is Used To Set a Billing Rate*" and "*Total Allowed Per Diem Billing Rate for Facilities for Which a Cost Report or Case Mix Score Cannot Be Used to Set a Billing Rate.*"
- c. A Nursing Facility is an institution licensed and regulated to provide nursing care services or intermediate care services for individuals with intellectual disabilities in accordance with the provisions of this Supplement. For reimbursement purposes, nursing facilities including hospital-based facilities are divided into two types based upon the mix of Medicaid patients residing in the facilities. The type of classification of a nursing facility may change as described in this Supplement. The types are described below:

**REIMBURSEMENT FOR NURSING FACILITY SERVICES**

1. **Nursing Facilities:** These facilities provide skilled and intermediate nursing care continuously, but do not provide constant medical and support services available in an acute care facility or hospital.
  
2. **Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)-**These facilities provide care to patients that have intellectual disabilities.
  
- d. **Cost Center** refers to one of the five groupings of expenses reported on Schedule B-2 of the “Nursing Home Cost Report Under Title XIX,” hereinafter referred to as the Cost Report. Specifically, expenses for the five cost centers are reported in Column 3 of the Schedule as Routine and Special Services (Line 17 and 77), Dietary (Line 89), Laundry and Housekeeping and Operation and Maintenance of Plan (Line 109 and 123), Administrative and General (Line 169), and Property and Related (Line 186). See hospital-based and state institutions cost reports for appropriate cost center expense groupings.
  
- e. **Distinct Part Nursing Facilities** are facilities in which a portion operates as a nursing facility and another portion operates separately as an intermediate care facility for persons with intellectual disabilities.
  
- f. **Total Patient Days** are the number of days reported by the facility on Schedule A, Line 13, Column 8 of the Cost Report subject to correction or adjustment by the Division for incorrectly reported data.
  
- g. **Hospital-Based Nursing Facilities**-A nursing facility is hospital-based when the following conditions are met:

**REIMBURSEMENT FOR NURSING FACILITY SERVICES**

1. The facility is affiliated with an acute care hospital that is enrolled with the Division in the Hospital Services Program.
2. The facility is subordinate to the hospital and operated as a separate and distinct hospital division that has financial and managerial responsibilities equivalent to those of other revenue producing divisions of the hospital.
3. The facility is operated with the hospital under common ownership and governance. The long-term care facility, as a division of the hospital, must be responsible to the hospital's governing board.
4. The facility is financially integrated with the hospital as evidenced by the utilization of the hospital's general and support services.
5. A minimum of four services from Section A and two services from Section B below must be shared with the hospital.

Section A

- a. Employee benefits
- b. Central services and supply
- c. Dietary
- d. Housekeeping
- e. Laundry and linen
- f. Maintenance and repairs

Section B

- a. Accounting
- b. Admissions
- c. Collections
- d. Data Processing
- e. Maintenance of Personnel

**REIMBURSEMENT FOR NURSING FACILITY SERVICES**

Facilities must provide organizational evidence demonstrating that the above requirements of (4) have been met. This evidence will be used to determine which facilities will be hospital-based.

Evidence that the required number of services in Section A and B are shared with the hospital must be included in the hospital's Medicare cost report.

Appropriate costs should be allocated to the nursing facility and the Medicare cost report must be approved by the Medicare intermediary.

In making the determination that a long-term care facility is hospital-based, co-location is not an essential factor; however, the distance between the facilities must be reasonable as determined by the Division or its agents.

The Division will recover the monetary difference reimbursed to the facility between hospital-based and freestanding status for any time period the facility does not qualify for hospital-based status.

To change classification to hospital-based from another class, or to enroll in the program as a hospital-based provider, the following restrictions apply in addition to the requirements described above:

1. Only one hospital-based nursing facility per hospital is allowed.
2. Any cost increases for the change to the hospital-based classification will be reimbursed when the first filed Medicare

## **REIMBURSEMENT FOR NURSING FACILITY SERVICES**

cost report is used to file the Medicaid cost report to set a per diem rate.

Nursing facilities classified as hospital-based prior to July 1, 1994 will be exempt from the above additional requirements. Hospitals which currently have more than one hospital-based nursing facility will not be allowed to include any additional hospital-based facilities.

h. Property Transaction is the sale of a facility or of a provider; the lease of a facility; the expiration of a lease of a facility; the construction of a new facility; an addition to the physical plant of a facility; or any transaction, other than change of ownership of a provider due solely to acquisition of capital stock, or the merger of a provider with another legal entity (statutory merger). For purposes of reimbursement, a sale shall not include any transaction in which acquisition is less than 51% of a partnership or proprietorship, or accomplished solely by acquisition of the capital stock of the corporation without acquisition of the assets of that corporation. The effective date of any Property Transaction shall be the latest of all of the following events that are applicable to the transaction:

1. The effective date of the sale or the lease.
2. The first day a patient resides in the facility.
3. The date of the written approval by the Office of Health Planning of the relevant proposal.
4. The effective date of licensing by the Division of Healthcare Facility Regulation.
5. The effective date of the Statement of Participation in the Georgia Medical Assistance Program.

**REIMBURSEMENT FOR NURSING FACILITY SERVICES**

6. The date on which physical construction is certified complete by whichever agency(ies) is/are responsible for this determination.
  7. The date of the approval of a Certificate of Need by the Office of Health Planning.
- 
- i. Gross Square Footage is the outside measurement of everything under a roof, which is heated and enclosed. When the Division issues the provider a rate under the Fair Rental Value System, it is a tentative rate based upon the data previously submitted to the Division for verification. The data received on gross square footage and age of a facility is subject to audit review (along with other parameters which affect the billing rate calculation). Documentation should include but not be limited to blueprints, architect plans, certified appraisals, etc.
  - j. Age is defined on page 21 of this Supplement in the section titled “*Property and Related Reimbursement.*”
  - k. Cost is the expense incurred for goods and services used to operate a nursing facility. In the establishment of a per diem billing rate, most costs are allowable while certain other costs are not. A definition of cost and a discussion of allowable and non-allowable costs are contained in the Centers for Medicare and Medicaid Services Provider Reimbursement Manual (CMS-15-1). In addition to those non-allowable costs discussed in the CMS-15-1, the costs listed below are non-allowable:
    1. Costs related to lobbying and governmental relations, including costs for employees with duties related to lobbying



**REIMBURSEMENT FOR NURSING FACILITY SERVICES**

- and government relations, honorariums and reimbursement of travel or other expenses of elected officials;
2. Memberships in civic organizations;
  3. Out-of-state travel paid by the provider for persons other than board members or those employed or contracted by the provider. Out-of-state travel for provider personnel must be related to patient care;
  4. Vehicle depreciation or vehicle lease expense in excess of the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles provided, however, such limits shall not apply to specialized patient transport vehicles (e.g., ambulance);
  5. 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 non-allowable. For purposes of this provision, patient care staff includes only those who are transported in order to provide direct medical care to an individual patient.
  6. Fifty percent (50%) of membership dues for national, state and local associations;
  7. Legal services for an administrative appeal or hearing, or court proceedings involving the provider and the Division or any other state agency when a judgment of relief is not granted to

**REIMBURSEMENT FOR NURSING FACILITY SERVICES**

the provider. Legal services associated with certificate of need issuance reviews, 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;

8. Advertising costs that are (a) for fundraising 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.
9. Funds expended for personal purchases.

**Total Allowed Per Diem Billing Rate for Facilities for Which a Cost Report is Used to Set a Billing Rate**

For dates of service beginning July 1, 2018 through June 30, 2021, the June 30, 2012 Medicaid Cost Report is the basis for reimbursement for all nursing facilities except those nursing facilities reimbursed in accordance with the rules applicable to nursing facilities purchased from an unrelated party between January 1, 2012 and June 30, 2014. For those facilities, the June 30, 2013, June 30, 2014 or December 31, 2014 cost report is the basis for reimbursement. Effective July 1, 2018 through June 30, 2021, the basis for reimbursement for the Supplemental Administrative and General-General and Professional Liability Insurance cost

**REIMBURSEMENT FOR NURSING FACILITY SERVICES**

center will be the June 30, 2018 GL-PL Insurance Supplemental Report. Effective July 1, 2019 through June 30, 2021, the minimum nursing facility per diem billing rate shall be \$147.00.

For dates of service beginning July 1, 2021 and thereafter, the June 30, 2019 Medicaid Cost Report is the basis for the nursing facility reimbursement rate. The Department will update the Medicaid Cost Report year used for the nursing facility reimbursement rate at least every two years.

A hold-harmless provision for the first year of the transition period will apply. Nursing facilities whose calculated rate using the June 30, 2019 Medicaid Cost Report is less than their rate on June 30, 2021 will continue to be reimbursed at their June 30, 2021 Medicaid reimbursement rate.

This hold-harmless provision will apply to the following quarterly rate setting periods: July 1, 2021, October 1, 2021, January 1, 2022, and April 1, 2022.

Effective July 1, 2021, the basis for reimbursement for the Supplemental Administrative and General -General and Professional Liability Insurance, and Property and Related cost center will be the June 30, 2019 GL-PL Insurance Supplemental Report.

For these facilities the following formulas apply:

Total Allowed Per Diem Billing Rate =

Allowed Per Diem + Efficiency Per Diem + Growth Allowance + Other Rate Adjustments.

Summation of the (Net Per Diem or Standard Per Diem, whichever amount is less as to the facility; for Nursing Facilities, the resulting per diem amount for Routine and Special Services is multiplied by a facility's quarterly case mix score as determined by the Division for Medicaid patients during the most recent calendar

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quarter for which information is available) for each of the four Non-Property Cost Centers (including the Supplemental Administrative and General-General and Professional Liability Insurance cost center) plus the Net Per Diem for the Property and Related Cost Center. The Property and Related Cost Center reimbursement is the facility's computed Fair Rental Value per diem.

Efficiency Per Diem = Summation of (Standard Per Diem minus Net Per Diem) x 75% up to the Maximum Efficiency Per Diem for each of the five cost centers.

Growth Allowance

Effective July 1, 2021, the growth allowance is the summation of 5% of the Allowed Per Diem for each of the following cost centers: Routine, Dietary, Laundry & Housekeeping, Plan Operations & Maintenance and Admin & General.

Effective July 1, 2019, through June 30, 2021, summation of 13.37% of the Allowed Per Diem for each of the four Non-Property and Related cost centers

(Routine and Special Services; Dietary; Laundry and Housekeeping and Operations and Maintenance of Plant; and Administrative General).

Further explanation of these terms is included below:

- a. In general, the Net Per Diem is determined from the costs of operation of the individual facility in which eligible patients reside. These reports are determined by utilizing the information submitted by the facility on its Cost Report.

All amounts and supporting data submitted on the Cost Report are subject to verification and adjustment by the Division. These modifications concern: mathematical calculation errors; limitations placed on allowable costs, and the documents, principles, and criteria referenced therein; reasonableness limitations placed on salaries paid employees of the facility; reasonableness limitations using the principles contained in CMS-15-1; or other parameters

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placed on reasonable cost by the Division. These modifications basically concern what expenses are attributable to the care received and the reasonableness of the amounts of expenses that are attributable to care.

See Supplement 4 to Attachment 4.19-D for appellate procedures to resolve disputes of specific contested adjustments. Specifically, the Net Per Diem for each of the five cost centers is determined as follows (all Schedule reference are to the Cost Report):

See page 20 of this Supplement in the section titled “Property and Related Reimbursement” for additional descriptions of such limitations.

Allowable Home Office salary costs are limited to an appropriate maximum.

Fringe benefits are also limited to an appropriate maximum. (A per bed salary ceiling also is imposed, based on the 70<sup>th</sup> percentile of costs per the 1988 home office cost reports, plus an allowance for inflation. Home Office salaries and related fringe benefits are subjected to a \$100,000 maximum salary for CEO, COO, CFO and other Home Officed personnel. Therefore, in addition to the per bed salary ceiling, we have incorporated a position maximum of \$100,000 to be applied only to owners of nursing facilities and related parties.) Reimbursement for the cost of home office vehicles is eliminated, except to the extent that home office vehicle costs can be included with related home office salaries as a fringe benefit, and in total, fall below any designed maximums.

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Routine and Special Services Net Per Diem=

Nursing Facilities Net Per Diem=

(Historical Routine and Special Services (Schedule B, Lines 5 plus 7, Column 4) divided by (Total Patient Days, Schedule A, Line 13, Column 8); for Nursing Facilities, the resulting per diem amount is divided by a case mix index score as determined by the Division for all residents in the facility during the base period, the cost reporting period identified on page 7 of this Supplement titled “*Total Allowed Per Diem Billing Rate for Facilities for Which a Cost Report is Used To Set a Billing Rate.*” The method by which a case mix index score is calculated is described in Supplement 3 to Attachment 4.19-D (Uniform Chart of Accounts, Cost Reporting, Reimbursement Principles and other Reporting Requirements) of this Attachment.

ICF-IDD Net Per Diem=

(Historical ICF-IDD Routine and Special Services (Schedule B, Lines 6 plus 7, Column 4) divided by (Total IFC/IDD Patient Days, Schedule A, Line 13, Column 8).

When costs for State Distinct Part Nursing Facilities can be identified, be they routine services or special services, the costs will be allocated as identified. Where costs have not been identified, the patient days method will be used to allocate costs. The example below shows the treatment of these costs:

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Total Routine Services Costs, (Medicaid Cost Report)  
 Schedule B, Line 6 Column 4 \$5,000,000

Patient Days

Total Medicaid ICF-IDD Patient Days (Medicaid Cost Report)

Schedule A, Line 13 (Sum of Columns 4, 5, and 6): \$40,000 80%  
 Total Medicaid NF Patient Days (Medicaid Cost Report)

Schedule A, Line 13 (Sum of Columns 4, 5, and 6) \$10,000 20%  
 Total Patient Days: \$50,000 100%

Allocation

Routine Services Cost allocated to ICF-IDD (Schedule B, Line 6, Column 4 is  
 \$5,000,000 x 80% = \$4,000,000)

Routine Services Cost allocated to NF (Schedule B, Line 6, Column 4 is  
 \$5,000,000 x 20% = \$1,000,000)

Dietary Net Per Diem=

Historical Dietary, Schedule B, Line 8, Column 4, Divided by Total Patient  
 Days.

Laundry and Housekeeping and Operation and Maintenance of Plant Net Per  
 Diem=

Historical Laundry, Housekeeping, Operation and Maintenance of Plant,  
 Schedule B, Lines 9 plus 10, Column 4, Divided By Total Patient Days.

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Administrative and General Net Per Diem=

Historical Administrative and General, Schedule B, Line 11, Column 4,  
Divided by Total Patient Days.

Supplemental Administrative and General-General and Professional  
Liability Insurance Net Per Diem

Historical Administrative and General-General and Professional Liability  
Insurance, Freestanding GL-PL Insurance Supplemental Report, Section C4,  
Divided by Total Patient Days, Section C5 Hospital-Based GL-PL Insurance  
Supplemental Report, Section C10, Divided by Total Patient Days, Section  
C9.

Property and Related Net Per Diem=

Property and Related net per diem calculated under the Fair Rental Value  
System.

The Return on Equity Percent is 0% for all facilities.

- b. Standard Per Diem for each of the five cost centers (Routine and Special Services; Dietary; Laundry and Housekeeping and Operation and Maintenance of Plan; and Administrative and General) is determined after facilities with like characteristics concerning a particular cost center are separated into distinct groups. Once a group has been defined for a particular cost center, facilities in a group shall be ordered by position number from one to the number of facilities in the group, arranged by Net Per Diem from the lowest (Number “1”) to the highest dollar value Net Per Diem. The number of facilities in the applicable group shall be multiplied by the



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Maximum Percentile, or a median net per diem may be chosen, with the Maximum Cost per day being determined as a percentage of the median.

The Maximum Cost per day for the Administrative and General costs of all nursing facilities eligible for an efficiency incentive payment is 105% of the median cost per day within each peer group. The Maximum Percentile is the eighty-fifth for Laundry and Housekeeping and Operation and Maintenance of Plant cost centers. The Maximum Percentile is the ninetieth percentile for the Routine Services and Special Services, and the Property and Related cost centers. For the Dietary cost center, the Maximum Percentile is the sixtieth percentile for the Hospital-Based Nursing Facility group and the ninetieth percentile for the Free-Standing Nursing Facility group and the Intermediate Care Facility for the Intellectual Disabilities group. If the Maximum Percentile does not correspond to a specific value in the array of net per diem amounts, the maximum percentile is determined by interpolation (i.e., finding the mid-point between whole integers).

The grouping will be done using Net Per Diem for each cost center that has been reported by the facility, and calculated by the Division in each facility's rate sheet. Effective July 1, 2018, the Administrative and General cost center standard per diem will be recalculated in the rate sheet by removing general and professional liability insurance cost and determining a new Net Per Diem amount. General and professional liability insurance costs will be recorded in the rate sheet in the Supplemental Administrative and General- General and Professional Liability Insurance cost center which will not have a per diem calculated. Subsequent to the recalculation of the Administrative and General cost center standard, there will not be any recalculation of standards based upon the changes in rates due to subsequent determination of additional allowable cost, disallowance of previously allowable cost or any

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change in the Net Per Diem in any cost enter. The following examples show groupings by Net Per Diem:

Routine and Special Services Maximum Percentile at 90%

Nursing Home Net Per Diem for 10 nursing homes from lowest to highest:  
\$90, \$95, \$95, \$100, \$115, \$120, \$120, \$130, \$135, \$140

Maximum Percentile Standard Determination

(10 net per diems) X (90<sup>th</sup> percentile) = 9<sup>th</sup> position or \$135

Administrative and General Maximum Cost at 105% of Median

Nursing Home Net Per Diems for 11 nursing homes from lowest to highest:

\$90, \$95, \$95, \$100, \$115, \$120, \$120, \$130, \$135, \$140, \$150

Maximum Cost Standard Determination at 105% of Median

Median Net Per Diem is the per diem amount that falls in the middle of the group or \$120

\$120 x 105%= \$126

Administrative and General Maximum Cost at 105% of Median

(Interpolation)

Nursing Home Net Per Diems for 10 nursing homes from lowest to highest:

\$90, \$95, \$95, \$100, \$115, \$120, \$120, \$130, \$135, \$140

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Maximum Cost Standard Determination at 105% of Median

Median Net Per Diem is the average of the two middle net per diem amounts that fall in the middle of the group ( $\$115 + \$120/2 = \$118$ )

$$\$118 \times 105\% = \$124$$

There are several instances where a facility could fall in more than one group. Intermediate care facilities for Individuals with Intellectual Disabilities which are also nursing facilities are classified as intermediate care facilities for the Intellectually Disabled and not grouped with other nursing facilities.

For the purpose of determining the Standard Per Diem and the Allowed Per Diem for each cost center, a facility is grouped according to the type facility (e.g., nursing facility, hospital-based nursing facility, or intermediate care facility for the Intellectually Disabled) it is as of the date the Standard Per Diem is calculated.

If a facility changes classification to hospital-based or grouping on January 1 through June 30 of any calendar year, it will be grouped into its new category for reimbursement purposes for dates of services July 1 of that year and thereafter. If a facility changes classification as described above on July 1 through December 31 of any calendar year, regrouping will occur from January 1 of the following year.

Routine and Special Services Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

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Nursing Facility

Intermediate Care Facility for the Intellectually Disabled

Dietary Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

Free Standing Nursing Facility

Hospital-Based Nursing Facility

Intermediate Care Facility for the Intellectually Disabled

Laundry and Housekeeping and Operation and Maintenance of Plant  
Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

Nursing Facility

Intermediate Care Facility for the Intellectually Disabled

Administrative and General Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

Nursing Facility

Intermediate Facility for the Intellectually Disabled

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Property and Related Standard Per Diem

Costs for property taxes and property insurance as defined in the Uniform Chart of Accounts, are calculated separately and are not subject to property-related cost center Standard Per Diem.

Supplemental Administrative and General-General and Professional Liability Insurance Standard Per Diem

Costs for property taxes and property insurance as defined in the Uniform Chart of Accounts, are calculated separately and are not subject to property-related cost center Standard Per Diem.

- c. The Efficiency Per Diem represents the summation of the Efficiency Per Diem for each of the five cost centers. If the Net Per Diem is equal to or exceeds the Standard Per Diem in any cost center, or if the Net Per Diem is equal to or less than 15% of the Standard Per Diem, the Efficiency Per Diem for the cost center is zero (\$0.00). If the Net Per Diem is less than the Standard Per Diem in any cost center, and if the Net Per Diem is more than 15% of the Standard Per Diem, the Efficiency Per Diem for the cost center is calculated by subtracting the Net Per Diem from the Standard Per Diem for that cost center and then multiplying the difference by .75. The product represents the Efficiency Per Diem for that cost center subject to the following maximums which have been established through legislative authority:

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Routine and Special Services	
Maximum Efficiency Payment	\$0.53
Dietary Maximum Efficiency Payment	\$0.22
Laundry and Housekeeping and Operation and Maintenance of Plant	
Maximum	
Efficiency Payment	\$0.41
Administrative and General Maximum	
Efficiency Payment	\$0.37
Property and Related Maximum	
Efficiency Payment	\$0.40

**Total Allowed Per Diem For Facilities Purchased From An Unrelated Party  
Between January 1, 2012 and June 30, 2014**

Facilities purchased from a party not related to the new owner between  
January 1, 2012 and June 30, 2014 will have their per diem rates effective

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July 1, 2015 determined based on the cost of the new owner. Related parties shall be defined to include the following:

(1) Immediate family members including the previous owner's spouse, child, sibling, parent, grandparent, or grandchild. Related parties shall also include stepparents, stepchildren, stepsiblings, and adoptive relationships; and

(2) A business corporation, general partnership, limited partnership, limited liability company, joint venture, nonprofit corporation, or any other for profit or not for profit entity that owns or controls, is owned or controlled by, or operates under common ownership or control of the previous owner.

The new owner's rate effective July 1, 2015 will be determined as follows:

a. The first cost report ending June 30th that contains at least six months of cost under the new owner will be used to establish the provider's rate effective July 1, 2015.

b. If there is not a cost report ending June 30<sup>th</sup> that contains at least six months of cost under the new owner available when establishing the July 1, 2015 rate, cost report information covering from the date of change in ownership through December 31, 2014 will be used.

c. Rates determined based on cost report information subsequent to June 30, 2014 will be reconciled and retroactively adjusted upon review of the information.

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d. The cost ceilings used when establishing the rate effective July 1, 2015 will be determined using the same June 30th year end used for determining cost. The June 30, 2014 cost reports will establish ceilings for cost data submitted for the period ending December 31, 2014.

e. Providers will continue to receive rates based on the new owner's cost report until a later cost report is approved for rebasing.

f. Effective April 1, 2017 through June 30, 2017, the growth allowance is 12% for nursing facilities reimbursed in accordance with the rules applicable to nursing facilities purchased from an unrelated party between January 1, 2012 and June 30, 2014.

**Total Allowed Per Diem Billing Rate For Facilities For Which A Cost Report or Case Mix Score Cannot Be Used To Set A Billing Rate**

If the Division determines that a cost report cannot be used to set a billing rate the per diem rate will be established as follows:

- a. When changes in ownership occur, new owners will receive the prior owner's per diem until a cost report basis can be used to establish a new per diem rate. (See Supplement 3 to Attachment 4.19-D)
- b. Newly enrolled facilities will be reimbursed the lower of: projected costs; or 90% of the appropriate cost center ceilings, plus a growth allowance and the appropriate Property and Related Net Per Diem until a cost report is submitted which can be used to establish a rate.
- c. In all other instances (except as noted below for newly constructed facilities) where the Division determines that a cost report cannot be used to set a reimbursement rate, the Total Allowed Per Diem Billing Rate



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will be resolved as described in the provisions discussed below for unauditible cost reports.

The Total Allowed Per Diem Billing Rate for facilities with more than 50 beds determined by the Division to be newly constructed facilities is equal to 95% of the four Non-Property and Related Standard Per Diem amounts plus the appropriate growth allowance and Property and Related Net Per Diem.

The Property and Related Net Per Diem referred to in subsections (a) through (c) above is equal to either the Fair Rental Value Rate as determined on page 20 of this Supplement in the section titled “*Property and Related Reimbursement.*”

- d. In all other instances where the Division determines that a cost report cannot be used to set a reimbursement rate, the Total Allowed Per Diem Billing Rate will be resolved as described in the provisions discussed below for unauditible cost reports. If the Division determines that a cost report which was to be used to set a reimbursement rate is unauditible (i.e., the Division’s auditors cannot render an opinion using commonly accepted auditing practices), or unreliable (See Supplement 3 to Attachment 4.19-D), the Division may reimburse the facility the lower of the following:

The last Total Allowed Per Diem Billing Rate issued prior to the reimbursement period to be covered by the unauditible cost report; the Total Allowed Per Diem Billing rate calculated from the unauditible cost report; or,

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The Total Allowed Per Diem Billing Rate calculated according to 90% of the four Non-Property and Related Standard Per Diem amounts plus the appropriate growth allowance and Property and Related Net Per Diem.

Once a cost report/GL-PL Insurance Supplemental Report becomes auditable and appropriate, the Total Allowed Per Diem Billing Rate will then be calculated using the audited cost report/GL-PL Insurance Supplemental Report as a basis. The resulting reimbursement rate will then be applied to the appropriate period.

- e. If a case mix score cannot be determined for a facility, the average score for all facilities may be used in a rate calculation. If a facility's number of MDS assessments for Medicaid patients in a quarter is less than 10% of the MDS assessments for all patients, the Department may elect to use the average case mix score for facilities.

### **Other Rate Adjustments**

#### **Quality Improvement Initiative Program**

Facilities must enroll in the Quality Improvement Program to receive the following incentives:

- a. A staffing adjustment equal to 1% of the Allowed Per Diem for Routine and Special Services may be added to a facility's rate. To qualify for such a rate adjustment, a facility's Nursing Hours and Patient Days Report must demonstrate that the facility meets the minimum staffing requirements presented on page 24 of this Supplement in section titled "*Additional Care Services, Required Nursing House.*"

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- b. For the most recent calendar quarter for which MDS information is available, Brief Interview for Mental Status (BIMS) scores for Medicaid patients will be measured, as determined by the Division. An adjustment factor may be applied to a facility's Routine and Special Services Allowed Per Diem based on the percentage of Medicaid patients whose BIMS scores are less than or equal to 5. The adjustment factors are as follows:

% of Medicaid Patients	Adjustment Factor
<20%	0%
20% - <30%	1%
30%-<45%	2.5%
45%-100%	5.5%

- c. A quality incentive adjustment may be added to a facility's rate utilizing the following set of indicators.

1. Clinical Measures:

The source of data is the Centers for Medicare and Medicaid Services' (CMS) website. Each measure is worth 1 point if the facility-specific value is in excess of the statewide average.

- (a) Percent of High Risk Long-Stay Residents Who Have Pressure Sores.
- (b) Percent of Long-Stay Residents Who Were Physically Restrained.
- (c) Percent of Long-Stay Residents Who Have Moderate to Severe Pain.
- (d) Percent of Short-Stay Residents Who had Moderate to Severe Pain.

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- (e) Percent of Residents Who Received Influenza Vaccine.
- (f) Percent of Low Risk Long-Stay Residents Who Have Pressure Sores.

2. Alternative Clinical Measures:

Facilities that do not generate enough data to report on the CMS website (due to not meeting the minimum number of assessments for a reporting in a quarter) will use the following measures from the My InnerView (MIV) Quality Profile. The values used from MIV Quality Profile will be compared to the MIV Georgia average values for those measures. Each measure is worth 1 point if the facility-specific value is in excess of the MIV Georgia average.

- (a) Chronic Care Pain – Residents without unplanned weight loss/gain.
- (b) PAC Pain – Residents without antipsychotic medication use.
- (c) High Risk Pressure Ulcer – Residents without acquired pressure ulcers.
- (d) Physical Restraints – Residents without acquired restraints.
- (e) Vaccination: Flu – Residents without falls.
- (f) Low Risk Pressure Ulcer – Residents without acquired catheters.

3. Non-Clinical Measures:

Each measure is worth 1 point as described.

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- a. Participation in the Employee Satisfaction Survey.
- b. Most Current Family Satisfaction Survey Score for “Would you recommend this facility?” Percentage of combined responses either “excellent” or “good” to meet or exceed the state average of 85% combined.
- c. Quarterly average for RNs/LVNs/LPNs Stability (retention) to meet or exceed the state average.
- d. Quarterly average for CNAs/NA Stability (retention) to meet or exceed the state average.
- e. AHCA Active Bronze Quality Award Winner per the AHCA Active Bronze Quality Award Winner list.

4. Additional Quality Points Available

The following measures are worth the specified number of points as described in the two criteria below in addition to the 1% or 2% available incentive.

- (a) AHCA Active Silver Quality Award winner per the AHCA Active Silver quality Award Winner List will earn an additional incentive equal to 1%.
- (b) AHCA Active Gold quality Award winner per the AHCA Active Gold Quality Award Winner List will earn an additional incentive equal to 2%.
- (c) A Nursing Center who has earned and is currently accredited as a Joint Commission Accredited Nursing Care Centers will earn an additional incentive equal to 2%.

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To qualify for a quality incentive adjustment equal to 1% of the Allowed Per Diem for Routine and Special Services for the most recent calendar quarter, the facility must obtain a minimum of three (3) points in the following combination: One (1) point must come from clinical measures, one (1) point from the non-clinical measure, and a third point from either the clinical or non-clinical measures.

To qualify for a quality incentive adjustment equal to 2% of the Allowed Per Diem for Routine and Special Services, for the most recent calendar quarter, the facility must obtain a minimum of six (6) points in the following combination: Three (3) points must come from the clinical measures, one (1) point from the non-clinical measures, and two (2) points from either the clinical or non-clinical measures.

An additional 1% incentive, not to exceed a total quality add-on of 4% can be earned by a facility that is an active AHCA Silver Award Winning Center. An additional 2% incentive, not to exceed a total quality add-on of 5% can be earned by a facility that is an active AHCA Gold Award Winning Center of Joint Commissioner Accredited.

NOTE: Facilities placed on the Special Focus List generated by CMS will not earn the DCH 1% Quality Incentive until the following conditions have been met:

1. The facilities next standard survey and/or complaint survey, after being placed on the list, does not have a deficiency cited over Level E scope and severity; and

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2. The facilities second standard survey and/or complaint survey, after being placed on the list, does not have a deficiency cited over Level E scope and severity; or
3. If the facility is removed from the special focus list by CMS for any other reason.

### **Supplemental Quality Incentive Payments**

Effective August 13, 2021, the Division will provide supplemental quality incentive payments to eligible skilled nursing facilities that demonstrate improvement in the quality of care rendered to members. Utilizing calendar year 2020 data as the baseline, nursing facilities that demonstrate improvement in the four categories identified below will be eligible for a supplemental payment. Nursing facilities must demonstrate improvement in at least one or more of the areas noted below in order to receive the supplemental payment. The supplemental payment will be based on the percentage of improvement ranked by decile for each of the four categories listed below.

- High-Risk Long Stay Residents with pressure ulcers
- Long-stay residents who received an antianxiety or hypnotic medication
- Long-stay residents who received an antipsychotic medication
- Long-stay residents with a urinary tract infection

Supplemental payments will be distributed to eligible nursing facilities twice per year. However, in year one (SFY2022), eligible nursing facilities will only receive one payment. For each subsequent year after calendar year 2020, the base year will be adjusted annually to reflect improvement against the prior year. For example, CY2021 would be paid out against improvement against CY2020, CY2022 would be paid out against CY2021, and CY2023 against improvement in CY2022. Only

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those facilities who demonstrate improvement will be eligible for the add on payment.

**Property and Related Reimbursement**

1. Effective for dates of service on and after July 1, 2012, the Property and Related Net Per Diem shall be the amount computed using the Fair Rental Value (FRV) reimbursement system described below. Under a FRV system, a facility is reimbursed on the basis of the established current value of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest, and rent/lease expenses. The FRV system shall establish a nursing facility's bed value based on the age of the facility, its location, and its total square footage.
2. The Property and Related Net Per Diem established under the FRV System shall be calculated as follows:
  - (a) Effective for dates of service on and after July 1, 2014 the value per square foot shall be based on the \$187.12 construction cost for nursing facilities, as derived from the 2012 RSMeans Building Construction cost data for Nursing Homes (national index for open shop construction). The Value per Square Foot shall be adjusted by using the RSMeans Location factors based on the facility's zip code as well as by a Construction Cost Index which is set at 1.0. The resulting product is the Adjusted Cost per Square Foot.
  - (b) A Facility Replacement Value is calculated by multiplying the Adjusted Cost per Square Foot by



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- (c) the Allowed Total Square Footage. The latter figure is the lesser of a nursing facility's actual square footage (computed using the gross footage method) compared to the number of licensed beds times 700 square feet (the maximum allowed figure per bed).
- (d) An Equipment Value is calculated by multiplying the number of licensed beds by \$6,000 (the amount allowed per bed) and by an initial Equipment Cost Index of 1.000.
- (e) A Depreciation Replacement Value is calculated by depreciating the sum of the Facility Replacement Value and the Equipment Value. The amount depreciated is determined by multiplying the Adjusted Facility Age discussed in this Supplement by a 2% Facility Depreciation Rate. The Initial Adjusted Facility Age will be the lesser of the calculated facility age or 25 years.
- (f) The Land Value of a facility is calculated by multiplying the Facility Replacement Value by 15% to approximate the cost of the land.
- (g) A Rental Amount is calculated by summing the facility's Depreciated Replacement Value and the Land Value and multiplying the figure by a Rental Rate which is 9.0% effective July 1, 2009.
- (h) The Annual Rental Amount is divided by the greater of the facility's actual cumulative resident days during the 2012 cost reporting period or 85% of the licensed bed capacity of the facility multiplied by 365. The resulting figure constitutes

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- (i) the Property and Related Net Per Diem established under the FRV system.

An example of how the Property and Related Net Per Diem is calculated is presented in the following table. Example Calculation of Initial Fair Rental Value Per Diem:

Ref.	Data Element	Example Data	Source of Data
A	Facility Name	XYZ Nursing Home	Department Data
B	Medicaid Provider ID	12345678A	Department Data
C	Rate Setting Year	2012	Department Criteria
D	Adjusted Base Year	1989	Department Data
E	Licensed Nursing Facility Beds	138	Department Data
F	Nursing Facility Square Footage	68,857	Department Data
G	Nursing Facility Zip Code	30312	Department Data
H	Total Patient Days	48,552	Department Data
I	Per Bed Square Footage Limit	700	Department Criteria
J	Maximum Allowed Square Footage	96,600	E x I

K	Allowed Total Square Footage	68,857	Lesser of F or J
L	Rate year RS Means Cost per Square Foot	\$146.08	RS Means lookup based on Rate Year
M	RS Means Location Factor	0.9	RS Means lookup based on Zip code (G)
N	Construction Cost Index	1.0708	Department Criteria
O	Adjusted Cost per Square Foot	\$140.78	L x M x N
P	Facility Replacement Value	9,693,688	K x O
Q	Equipment Allowance	6,000	Department Criteria
R	Equipment Cost Index	1	Department Criteria
S	Equipment Value	\$828,000.00	E x Q x R
T	Facility Value Excluding Land	\$10,521,688	P + S
U	Bed Additions and Facility Renovations	0	Separate calculations affecting the nursing Facility
V	Nursing Facility Age	21	(see D and V) C-D (D is based on initial age adjusted by additions/renovations per U)
W	Maximum Years for FRV Age	25	Department Criteria
X	FRV Adjusted Facility Age	23	Lesser V or W

Y	Facility Depreciation Rate	2.00%	Department Criteria
Z	Depreciation Using FRV Adjusted Age	\$4,839,976	T x X x Y
AA	Depreciated Replacement Value	\$5,681,712	T – Z
AB	Land Percentage	15.00%	Department Criteria
AC	Land Value	\$1,454,053	P x AB
AD	Depreciated Replacement Value & Land	\$7,135,765	AA + AC
AE	Rental Value	9.00%	Department Criteria
AF	Rental Amount	\$642,218	AD x AE
AG	Minimum Occupancy Percentage	85.00%	Department Criteria
AH	Bed Days at Minimum Occupancy	42.815	E x 365 x AG
AI	Total Allowed Patient Days	48,552	Higher of H or AH
AJ	Fair Rental Value per Diem	\$13.22	AF/AI

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3. The Property and Related Net Per Diem may be updated annually on July 1, effective for dates of service on or after July 1, 2010 as follows:
  - a. The value per square foot shall be based on the construction cost for nursing facilities, as derived from the most recent RSMeans Building Construction cost data available on June 1<sup>st</sup> of each year. The Value per Square Foot shall be adjusted by using the RSMeans Location factors based on the facility's zip code and by using a cost index to correspond to annual state appropriations.
  - b. A complete facility replacement, which includes either relocating to a newly constructed facility or gutting a complete facility and rebuilding it, will result in a new base year correlating to the date in which the facility went into operation. All partial replacements will be treated as renovations and will have their base year adjusted based on the methodology proscribed for a renovation.
  
4. A Renovation Construction Project shall mean a capital expenditure (as defined in this Supplement that exceeds \$500 per existing licensed bed and has been filed with the Office of Health Planning as a New Construction Project under the authority of Ga. Comp. R. & Regs. r. 290-5-8:
  - a. Allowable capital expenditures include the costs of buildings, machinery, fixtures, and fixed equipment (see Table 5 in Estimated Useful Lives

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- b. of Depreciable Hospital Assets) Revised 2008 Edition), published by Health Forum, Inc., for a complete listing of allowable items) constituting any New Construction Project as referenced in paragraph 4 above. The exception, to this requirement is for telemedicine terminals, solar panels, tankless water heaters, and low flow toilets. Capital expenditures are asset acquisitions that meet the criteria of §108.1 of the Provider Reimbursement Manual (CMS-15-1) or are betterments or improvements which meet the criteria of §108.2 of the  
  
Provider Reimbursement Manual (CMS-15-1) or which materially (a) expand the capacity, (b) reduce the operating and maintenance costs, (c) significantly improve safety, or (d) promote energy conservation.
5. For purposes of the FRV calculation, the age of the facility shall be determined as follows:
- (a) The age of each facility shall be determined as of July 1, 2014 by comparing the 2014 rate setting year to the later of the facility's year of construction or the year the building was first licensed as a nursing facility; provided, however, that such age will be reduced for Construction Projects, or bed additions that occurred subsequent to the initial construction or conversion of the facility, but prior to July 1, 2014.

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- (b) For periods subsequent to July 1, 2014, the FRV adjusted age as determined by the provisions in this Supplement will be reduced on a quarterly basis to reflect new Renovation Construction Projects or bed additions that were completed after July 1, 2014, and placed into service during the preceding quarter. The rate adjustment for Renovation Projects or bad additions will be effective the first day of the calendar quarter subsequent to final approval of the completed project by the Department. Bed reductions will not be used to determine a facility's adjusted age. Once initial rates are established under the FRV reimbursement system, subsequent calculations of the FRV adjusted age will be determined by subtracting the adjusted base year (derived by calculating the impact of bed additions and facility renovations) from the rate setting year. The FRV adjusted age may be recalculated each July 1 to make the facility one year older, up to the maximum age of 25 years and will be done in concert with the calculations of the Value per Square Foot as in this Supplement in the section titled "*Property and Related Reimbursement.*" Age adjustments and Rate adjustments are not synonymous.
- (c) If a facility has added beds, the age of these additional beds will be averaged in with the age of the remaining beds, and the weighted average age of all beds will be used as the facility's age. An example of how an addition would reduce the age of the facility is presented in the following table:

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## Example Calculation of the Impact of an Addition on a Nursing Facility's Base Year

Ref	Data Element	Example	Source of Data
A	Facility Name	XYZ Nursing Home	Department Data
B	Medicaid Provider ID	12345678A	Department Data
C	Year Bed Additions Were Completed	1981	Department Criteria
D	Base Year Prior to Additions	1970	Based on Initial Age adjusted by Prior Bed Additions and Facility Renovations
E	Existing Beds prior to Bed Additions	130	Department Data
F	Number of Beds Added	8	Department Data
G	Age of Existing Beds when Additions Were Completed	11	C-D
D	Adjust Base Year	1989	Department Data
E	Licensed Nursing Facility Beds	138	Department Data
F	Nursing Facility Square Footage	68857	Department Data
G	Nursing Facility Zip Code	30312	Department Data



H	Weighted Average of Existing Beds	1430	E x G
I	Total Beds After Bed Additions were Completed	138	E + F
J	Base Year Age Adjustment	10.36	H/I
K	New Base Year	1,971.00	C- J (rounded)

- (d) If a facility performed a Renovation Construction Project as defined in this Supplement on page 17 in the section titled “*Property and Related Reimbursement*” the cost of the Project will be converted to an equivalent number of replacement beds by dividing the value of the renovation by the depreciable bed replacement value.
- i. The renovation completion date will be used to determine the year of the renovation.
  - ii. An Age Index factor will be used to calculate a bed replacement cost for any renovation occurring prior to July 1, 2009. The Age Index factor is derived by using the 2009 Edition of the RSMeans and dividing the Historical Cost Index for 2009.
  - iii. To determine the accumulated depreciation per bed, 2 percent per year will be used for a maximum number of 25 depreciable years.

In no case will the consideration of a Renovation Construction Project reduce the age of the facility to a number less than zero.

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An example of how the cost of a Renovation Construction Project would be converted to an equivalent number of replacement beds and a new base year is presented in the following table:

## Example Calculation of the Impact of a Renovation on a Nursing Facility's Base Year

Ref	Data Element	Example	Source of Data
A	Facility Name	XYZ Nursing Home	Department Data
B	Medicaid Provider ID	12345678A	Department Data
C	Rate Setting Year	2009	Department Data
D	Year Renovation was Completed	2003	Department Data
E	Base Year Prior to Renovation	1981	Based on Initial Age Adjusted by Prior Bed Addition and Facility Renovations
F	Licensed Number Facility Beds	138	Department Data
G	Facility Square Footage	40,060	Department Data
H	Nursing Facility Zip Code	30442	Department Data

I	Renovation Amount	\$372,662.00	Department Criteria
J	Renovation Year RS Means Cost Index	132.00	RS Means lookup based on Year Renovation Completed
K	Rate Year RS Means Cost Index	185.90	RSMeans lookup based on Rate year
L	Facility Age Index Factor	0.7101	J/K
M	Rate Year RS Means Cost per Square Foot	\$141.10	RS Means lookup based on Rate Year
N	Maximum Square Feet per Bed	700	Department Criteria

O	Allowed Facility Square Footage	40,060	Lesser of G or (F x N)
P	Facility Cost Prior to Adjustments	\$5,652,446.00	M x O
Q	RS Means Location Factor	0.77	RS Means lookup based on Zip Code (H)
R	Adjusted Facility cost	\$3,090,461.00	P x L x Q
S	Age of Beds at Time of Renovation	22	D – E
T	Maximum Bed Replacement Years	25	Department Criteria

U	Allowed Age of Beds	22	Lesser of S or T
V	Initial Aging Depreciation Rate	2.00%	Department Criteria
W	Allowed Facility Depreciation	\$1,359,803.00	$R \times U \times V$
X	Adjusted Bed Replacement Cost	\$12,541.00	$(R-W)/F$
Y	New Bed Equivalents	29.72	$I/X$ (but limit is F)
Z	Total beds to be Weighed	108.28	$F - Y$
AA	Weighted Average of Beds	2,382.26	$Z \times S$
AB	Base Year Age Adjustment	17.26	$AA/F$
AC	New Base Year	1986	$D - AB$ (rounded)

Overall Limitations on Total Allowed Per Diem Billing Rate

In no case shall the Total Allowed Per Diem Billing Rate, whether determined pursuant to the provisions of this Supplement or the Nursing Facility manual, exceed the facility's customary charges to the general public for those services reimbursed by the Division.

Payment in Full for Covered Services

The facility must accept as payment in full for covered services the amount determined in accordance with Section 1002, Nursing Facility Manual.

## **REIMBURSEMENT FOR NURSING FACILITY SERVICES**

### **Adjustments to Rates**

Payment rates for state-owned nursing facilities will be adjusted to 100% of service costs. This provision will apply in addition to all others in this chapter and will supersede those that are in direct conflict only to the extent that they are not capable of simultaneous application.

### **Additional Care Services**

#### **Required Nursing Hours**

The **minimum required** number of nursing hours per patient day for all nursing facilities is 2.00 actual working hours. The **minimum expected** nursing hours are 2.50 to qualify for the 1% add-on. (See 1002.4)

#### **Failure to Comply**

- a. The **minimum standard** for nursing hours is **2.00**.
- b. Facilities found not in compliance with the 2.00 nursing hours will be cited for being out of compliance with a condition of participation. This will lead to imposition of a civil monetary penalty, denial of reimbursement for newly admitted patients, or suspension or termination whichever is appropriate as determined by the Division.
  
- c. The **minimum expected** for nursing hours is **2.50** for participation in the Quality Improvement Program.

**REIMBURSEMENT FOR NURSING FACILITY  
SERVICES**

**Medicare Crossover Claims**

The maximum allowable payment for Medicare nursing facility coinsurance (crossover) claims will be the nursing facility's Medicaid specific per diem rate in effect for the dates of service of the crossover claims. The crossover claims will not be subsequently adjusted due to subsequent per diem rate adjustments. This section is also included in Chapter 1100 of the Manual.

**Upper Payment Limit Rate Adjustments for Government Owned or Operated Nursing Facilities**

For payments on or after January 1, 2001, State government –owned or operated facilities and non-State government owned or operated facilities will be eligible for rate payment adjustments, subject to the availability of funds. The rate payment adjustments will be subject to federal upper payment limits and will be based on amounts that would be paid for services under Medicare payment principles. These rate payment adjustments will be made on a quarterly basis in a manner that will not duplicate compensation provided from payments for individual patient claims.

**Payments Rates for Patient Leave Days or Bed Hold Days**

Effective for dates of service on and after July 1, 2004, payments for patient leave days or for bed hold days during a patient's hospitalization will be made at 75% of the rate paid for days when a

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patient is onsite at a facility. Because patient leave days and bed hold days are not subject to the nursing home provider fee, the payment rate for patient leave days and bed hold days will exclude any compensation for the provider fee.

**Nurse Aide Training and Testing Costs**

The Division will reimburse nursing facilities, on a full time equivalent (FTE) basis, up to \$738 for each individual who has completed a state-approved training and competency program for nurse aides. At the facilities request, Interim payments of \$.25 per Medicaid patient day will be made quarterly to the facility to cover the cost of providing nurse aide testing and training.

**PART II, POLICIES AND PROCEDURES FOR  
NURSING FACILITY SERVICES**

**APPENDIX D**

**UNIFORM CHART OF ACCOUNTS, COST REPORTING,  
REIMBURSEMENT PRINCIPLES AND OTHER REPORTING REQUIREMENTS**

Revised 01/01/2006

General

This appendix discusses the use of a uniform chart of accounts, the annual submission of a cost report, the principles of reimbursement which comprise the basis for the financial reporting requirements of facilities participating in the Georgia Medicaid Program and other reporting requirements. The Georgia Division of Medical Assistance Uniform Chart of Accounts as comprised on the date of service is incorporated by reference herein. A copy is available from the Division upon request. Cost reports and instructions are made available to each facility near the end of the reporting period. The reimbursement principles discussed in this appendix are selected from the Centers for Medicare and Medicaid Services Provider Reimbursement Manual (CMS-15-1). Copies of the Manual, which provide a detailed description of allowable costs, are available from the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

1. Uniform Chart of Accounts

The Georgia Division of Medical Assistance requires that all nursing facilities participating in the Medicaid Program utilize the classification of accounts shown in the Uniform Chart of Accounts in reporting its financial operations in the cost reporting system. While it is not mandatory that books of original entry or ledgers be maintained in accordance with the Uniform Chart of Accounts, facilities are strongly encouraged to do so. The Uniform Chart of Accounts has been designed to meet management needs for budgeting information, information flow, internal control, responsibility accounting and financial reporting. Also, it has been designed in such a manner that accounts may be added or deleted to tailor the financial information to the facility's needs.

Should a facility elect to maintain its books of original entry or ledgers in a manner other than that specified in the Uniform Chart of Accounts, the facility is required to have available a detailed description of how its accounting system differs. This description of differences must be used by the facility for converting the output of its reporting system into the format specified in the Uniform Chart of Accounts. This description of differences and conversion of reporting information into the proper format are considered to be essential components of a facility's accounting records. When such information is needed but not maintained, a facility's cost report will be determined to be unacceptable

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for fulfilling reporting requirements and penalties described in Section 2.b and 2.g of this appendix will be imposed.

## 2. Cost Reporting

Reimbursement of expenses incurred by nursing facilities in the provision of care to Medicaid recipients is accomplished through the mechanism of the cost report. This document reports historical costs and details recipient occupancy data experienced during the fiscal year. The following cost reporting requirements apply to providers of nursing facility services and all home offices who allocate costs to nursing facilities:

- a. Each nursing facility must annually file a cost report with the Division of Medical Assistance which covers a twelve-month period ending June 30th. Cost reports must be e-mailed to the Division on or before September 30th. (See Hospital-based facility exception in 2(d) below.)
- b. If such cost reports are not filed by September 30th, the Division shall have the option of either terminating the provider agreement upon thirty days written notice or imposing a penalty of \$50.00 per day for the first thirty days and a penalty of \$100.00 per day for each day thereafter until an acceptable cost report is received by the Division. The only condition in which a penalty will not be imposed is if written approval for an extension is obtained from the Program Manager of Nursing Home Reimbursement Services prior to September 30.
- c. If a cost report is received by the Division prior to September 30th but is unacceptable, it will be returned to the facility for proper completion. No penalty will be imposed if the properly completed report is filed by the September 30th deadline. However, the above described penalties may be imposed after the September 30th deadline until an acceptable cost report is received by the Division.
- d. Hospital-based facilities using Medicare fiscal year ending dates between July and April must submit cost reports to the Division on or before September 30. Facilities using fiscal year ending dates between May and June must submit cost reports on or before November 30. The financial information to be included on the Medicaid cost report must be taken in total from the provider's most recent Medicare cost report that precedes June 30. The rules regarding unacceptability and timeliness described above in sections b, and c. also apply to hospital-based facilities' cost reports.

Approval for extensions beyond the September 30 or November 30 deadline, where applicable, will be granted only if the provider's operations are "significantly adversely affected" because of circumstances beyond the provider's control (i.e., a flood or fire that causes the provider to halt operations). Each provider must submit a written request specifying the hospital-based facility and the reason for the extension.

- e. To be acceptable, a cost report must be complete and accurate, include all applicable schedules, and be correctly internally cross-referenced. Further, the amount per book

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column for Schedules B and C must agree with the amounts recorded in the facility's general ledger, however, there may have to be certain groupings of the general ledger amounts to agree with the cost report line items. Estimated amounts used for a conversion to a June 30th year-end are not acceptable. Reported costs of interest paid to non-related parties must be reduced by non-related parties must be reduced by an amount equal to the lesser of (1) interest paid to non-related parties; or (2) investment income other than the exceptions identified in CMS-15, Section 202.2. Reported costs of special services must be reduced, as indicated on Schedule B-1A, by an amount resulting from revenue received from sources other than the Division for these services. Adjustments will be based on auditable records of charges to all patients as required by cost report instructions.

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- f. Any changes to the amount of or classification of reported costs and patient day information must be made within 30 days after the applicable September 30, November 30h, or approved extended submission deadline. Amended cost reports submitted after these deadlines will not be accepted unless they have been requested by the Division. If the original cost report is used to set reimbursement rates, the provider has up to 30 days from the implementation of the original cost report to request changes to the amount of or classification of reported costs and patient day information in accordance with the appeal procedures outlined in Appendix I (Billing rate and Disallowance of Cost from the Cost Report). Adjustments to amounts or changes in classification of reported costs in prior years will not be considered.
- g. Late cost report penalties will be invoiced through the Accounting Section of the Division for the total amount of the assessed penalty. The provider must submit payment to the Division. Penalties not properly paid will be deducted from the monthly reimbursement check. The assessments will not be refunded.
- h. New facilities, which have less than twelve but not less than six months of actual operating cost experience, will only submit cost data for their actual months of operation as of June 30. New facilities that have less than six months of actual operating cost experience are not required to submit a cost report. Facilities in which there has been a change of ownership must submit a separate report for each owner. The subsequent owner will be reimbursed based on the previous owner's cost report (with an adjustment in the property cost center only) until a new cost report is received from the new owner and determined reliable and appropriate. The Division will determine whether each submitted cost report is appropriate and reliable as a basis for computing the Allowed Per Diem billing rate and may calculate a facility's Allowed Per Diem billing rate in accordance with Section 1002.3.

For ownership changes effective with at least six months of patient day data on the applicable June 30 fiscal year cost report, the initially submitted cost report will be used to establish the new owner's rate when the comparable cost reports are used to set rates. For the periods prior to the use of the new owner's cost report, the new owner will receive rates based on the previous owner's approved cost report data,

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with the appropriate Fair Rental Value property reimbursement rate. If the new owner's initial cost report contains less than six months of patient day data, when the initial cost report period reports are used to set rates, the new owner will receive a rate based on the previous owner's last approved cost report inflated to current costs, as determined by the Division, or the costs from the new owner's initial cost report, whichever is lower. If the ownership change is between related parties, when the initial cost report period reports are used to set rates, the old owner's cost report and new owner's cost report for the year of the ownership change may be combined and considered in determining the minimum rate for the new owner.

- i. Reported costs must conform to Divisional instructions, or in the absence of specific instructions, to the allowable costs discussed in the CMS-15.1. Reported costs are subject to audit verification by the Division, State or Federal auditors or their agents. Providers using computerized information systems for accounting or other purposes must make this information available in a suitable electronic format if requested by the Division or its agents. Where such audit verifications determine that the cost report was prepared based upon inadequate accounting records, the facility will be required to correct its records and submit a corrected cost report. A penalty will be imposed on the facility for the costs incurred by the Division for any additional audit work performed with the corrected cost report.
- j. For audit examinations described in (i) above, it is expected that a facility's Accounting records will be available within the State. Should such records be maintained at a location outside the State, the facility will be required to pay for travel costs incurred for any examination conducted at the out-of-state location.
- k. Should a cost report submitted to the Nursing Home Unit for review need explanation or clarification, appropriate work papers or letters of explanation should be attached.

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- i. All cost reports are to be emailed to [nhcostreport@dch.ca.gov](mailto:nhcostreport@dch.ca.gov). Correspondence concerning the cost reports may be mailed to the following address:  
Program Manager  
Nursing Home Services Unit  
39th Floor  
Division of Financial Management  
2 Peachtree Street, N.W.  
Atlanta, GA 30303-3159

3. Reimbursement Principles

The objective of a system of reimbursement based on reasonable costs is to reimburse the institution for its necessary and proper expenses incurred related to patient care. As a matter of general reimbursement principle, costs with respect to individuals covered by the Medicaid Program will not be borne by those not covered and costs with respect to individuals not

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covered by the Medicaid Program will not be borne by the Program. The principles of cost reimbursement require that institutions maintain sufficient financial records and statistical data for proper determination of costs payable under the Program. Such records and data must be maintained for a period of at least three years following the date of submission of the cost report

4. Case Mix Index Reports

- a. MDS Data for Quarterly Patient Listing - Using Minimum Data Set (MDS) information submitted by a facility, the Division will prepare a Case Mix Index Report, listing information for patients in a facility on the last day of a calendar quarter. A preliminary version of the report will be distributed to a nursing facility about the middle of the following quarter after each calendar quarter end. The preliminary version of the report will be distributed with instructions regarding corrections to patient payer source information that a nursing facility may submit for consideration before the final version of the report is prepared and distributed.
- b. RUG Classification - For each patient included in the quarterly Case Mix Index Report, the most recent MDS assessment will be used to determine a Resource Utilization Group (RUG) classification. Version 5.12, with 34 grouper and index maximizer, the RUG classification system will be used to determine a patient's RUG category.
- c. Payer Source - For each patient included in the quarterly Case Mix Index Report, a payer source will be identified. As described in section D.4.a, a facility will have the opportunity to submit updated payer source information for changes that may occur by the last day of the calendar quarter.
- d. Relative Weights and Case Mix Index Scores for All Patients - For each patient included in the quarterly Case Mix Index Report, a relative weight will be assigned by the Division. Exhibit D-1 identifies the relative weights for each RUG category. This data will be used to determine a case mix score for all patients in a facility.
- e. Relative Weights and Case Mix Index Scores for Medicaid Patients - For each Medicaid patient included in the quarterly Case Mix Index Report, a Medicaid relative weight will be assigned by the Division. Exhibit D-1 identifies the relative weights for each RUG category. This data will be used to determine a case mix score for Medicaid patients in a facility.
- f. CPS Scores - For each patient included in the quarterly Case Mix Index Report, the most recent MDS assessment will be used to determine a Cognitive Performance Scale (CPS) score.
- g. Corrections to MDS and Payer Source Information Corrections to MDS and payer source information used in payment rate calculations applicable to prior dates of service that result from appeals or audit adjustments may be processed as adjustments to rate calculations in a subsequent period. If the impact of the correction is significant, the Division may elect to process the correction by a retrospective adjustment to prior payments.

5. Nursing Hours and Patient Day Report

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Rev. 09/11 Except for ICF-MR's, each nursing facility must submit a Nursing Hours and Patient Day Report for each calendar quarter, within one month after the end of the quarter. The required information will be submitted in accordance with a format and instructions as distributed by the Division. A facility's request to correct or amend a nursing home provider fee report will be limited to a 30 day period following the report's due date. Corrections to nursing hours and patient day data used in payment rate calculations applicable to prior dates of service that result from appeals or audit adjustments may be processed as adjustments to rate calculations in a subsequent period. If the impact of the correction is significant, the Division may elect to process the correction by a retrospective adjustment to prior payments.

If a facility does not submit a report or does not submit a report when due, a late fee of \$10 per day may be assessed.

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6. Fair Rental Value System

A request for a Fair Rental Value rate increase that is the result of a Renovation Construction Project, bed addition or replacement subsequent to July 1, 2009, must be submitted to the Department after completion of the project. The Department shall have sixty (60) days to approve or deny any such request. Any corresponding Fair Rental Value rate increase shall take effect at the beginning of the quarter following the quarter in which the request for a Fair Rental Value rate increase is approved by the Department. The request must be completed on the *Initial Start Up & Fair Rental Value System Reimbursement Update Request Form* (FRVS). The request must be submitted to:

Program Manager, Division of Financial Management  
Department of Community Health  
Nursing Home Reimbursement Services  
2 Peachtree Street, N.W.  
39th Floor  
Atlanta, Georgia 30303

An electronic version of the Initial Start Up & Fair Rental Value System Reimbursement Update Request Form should also be emailed to [FRVS@dch.ga.gov](mailto:FRVS@dch.ga.gov).

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## EXHIBIT D-1

	Category	Classification	Code	Case Mix Index for All Patients	Case Mix Index for Medicaid Patients
1	Extensive	Extensive Special Care 3 / ADL > 6	SE3	2.839	2.896
2	Extensive	Extensive Special Care 2 / ADL > 6	SE2	2.316	2.362
3	Rehabilitation	Rehabilitation All Levels / ADL 17-18	RAD	2.284	2.330
4	Extensive	Extensive Special Care 1 / ADL > 6	SE1	1.943	1.982
5	Rehabilitation	Rehabilitation All Levels / ADL 14-16	RAC	1.936	1.975
6	Special Care	Special Care / ADL 17-18	SSC	1.877	1.915
7	Rehabilitation	Rehabilitation All Levels / ADL 9-13	RAB	1.772	1.807
8	Special Care	Special Care / ADL 15-16	SSB	1.736	1.771
9	Special Care	Special Care / ADL 4-14	SSA	1.709	1,743
10	Rehabilitation	Rehabilitation All Levels / ADL 4-8	RAA	1.472	1.501
11	Clinically Complex	Clinically Complex with Depression / ADL 17-18	CC2	1.425	1.454
12	Clinically Complex	Clinically Complex / ADL 17-18	CC1	1.311	1.337
13	Clinically Complex	Clinically Complex with Depression / ADL 12-16	CB2	1.247	1.272
14	Physical	Physical Function with Nursing Rehab / ADL 16-18	PE2	1.188	1.212
15	Clinically Complex	Clinically Complex / ADL 12-16	CB1	1.154	1.177
16	Physical	Physical Function with Nursing Rehab / ADL 11-15	PD2	1.095	1.117

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	Category	Classification	Code	Case Mix Index for All Patients	Case Mix Index for Medicaid Patients
17	Impaired Cognition	Cognitive Impairment with Nursing Rehab / ADL 6-10	IB2	1.061	1.082
18	Clinically Complex	Clinically Complex with Depression / ADL 4-11	CA2	1.043	1.064
19	Physical	Reduced Physical Function / ADL 16-18	PE1	1.077	1.077
20	Behavioral Problems	Behavior Problem with Nursing Rehab/ ADL 6-10	BB2	1.021	1.041
21	Physical	Reduced Physical Function / ADL 11-15	PD1	0.990	0.990
22	Impaired Cognition	Cognitive Impairment / ADL 6-10	IB1	0.938	0.957
23	Physical	Physical Function with Nursing Rehab / ADL 9-10	PC2	0.937	0.956
24	Clinically Complex	Clinically Complex / ADL 4-11	CA1	0.934	0.953
25	Behavioral Problems	Behavior Problem / ADL 6-10	BB1	0.866	0.883
26	Physical	Physical Function with Nursing Rehab / ADL 6-8	PB2	0.824	0.841
27	Physical	Reduced Physical Function / ADL 9-10	PC1	0.865	0.865
28	Impaired Cognition	Cognitive Impairment with Nursing Rehab / ADL 4-5	IA2	0.777	0.777
29	Behavioral Problems	Behavior Problem with Nursing Rehab / ADL 4-5	BA2	0.750	0.750
30	Physical	Reduced Physical Function / ADL 6-8	PB1	0.749	0.749

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	Category	Classification	Code	Case Mix Index for All Patients	Case Mix Index for Medicaid Patients
31	Impaired Cognition	Cognitive Impairment / ADL 4-5	IA1	0.703	0.703
32	Physical	Physical Function with Nursing Rehab / ADL 4-5	PA2	0.637	0.637
33	Behavioral Problems	Behavior Problem / ADL 4-5	BA1	0.612	0.612
34	Physical	Reduced Physical Function / ADL 4-5	PA1	0.575	0.575

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	Category	Classification	Code	Case Mix Index for All Patients	Case Mix Index for Medicaid Patients
		ADL 4-5			
33	Behavioral Problems	Behavior Problem / ADL 4-5	BA1	0.612	0.612
34	Physical	Reduced Physical Function / ADL 4-5	PA1	0.575	0.575

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**Exhibit D-2**  
**Detailed Description of Data Presented in Case Mix Index Reports**

Selection criteria for quarterly "Listing of Residents" reports - Residents are determined by identifying individuals for whom an MDS assessment has been received and for whom no subsequent discharge tracking document has been received. It is assumed that residents for whom a periodic assessment is more than 3 months past due have been discharged and these individuals are not included in this report. The following data elements are selected from the most recent assessment data for patients residing in the nursing home on the last day of a calendar quarter:

AO310a – Reasons for assessment as reported in section AO310 of the MDS

Section a, primary reason for assessment

- 1 = admission assessment
- 2 = quarterly review assessment
- 3 = annual assessment
- 4 = significant change in status
- 5 = significant change to prior comprehensive assessment
- 6 = significant correction to prior quarterly assessment
- 99 = not OBRA required assessment

Section b, codes for assessments required for Medicare PPS or the State

- 1 = 5 day scheduled assessment
- 2 = 14 day scheduled assessment
- 3 = 30 day scheduled assessment
- 4 = 60 day scheduled assessment
- 5 = 90 day scheduled assessment
- 6 = readmission/return assessment
- 7 = unscheduled assessment used for PPS
- 99 = not PPS assessment

Resident Name - Self explanatory

SSN - Resident's social security number

Completion Date (ZO500b) - For assessments, this is the date completed as reported in section ZO500b of the MDS. For discharge tracking, this is the date of discharge. For re-entry tracking, this is the date of re-entry.

RUG Code – RUG classification code (see "Case Mix Index for All Patients" in Exhibit D-1) from application of 34 grouper with index maximizing

RUG Category - Description of RUG classification (see Exhibit D-1)

TN No.: 12-003

Supersedes

TN No.: NEW

Approval Date: SEP -6 2012

Effective Date: 02-01-2012

Resident ID - Identification number assigned to resident by MDS reporting system

Medicaid Cognitive Add-On - Identifies residents with Brief Interview for Mental Status (BIMS) scores less than or equal to 5. In the absence of BIMS scores, identifies residents with Cognitive Performance Scale (CPS) scores of moderately severe to very severe.

Payment Source -- Primary source of payment for services to residents based on information included in MDS assessment data. If the MDS data includes a Medicaid identification number or Medicaid pending designation, Medicaid is assumed to be the resident's payment source. If a Medicaid identification number is not present and a Medicare identification number is present, Medicare is assumed to be the payment source. If neither a Medicaid nor Medicare identification number is present, the payment source is identified as "other." A facility may submit a correction entry to the Division to note any changes to a patient's payment source that may not be reflected in MDS data. Such correction entries for payment status will be assumed to be permanent unless a subsequent correction entry is submitted for a resident.

Number of Residents, Overall CMI Averages and Medicaid CMI Average - The number of residents and average case mix index score, based on relative weights for "Case Mix Index for All Patients" in Exhibit D-1, are listed for 3 categories of residents by payment source - Medicaid, Medicare and Other. For Medicaid patients, an average case mix index score, based on relative weights for "Case Mix Index for Medicaid Patients," is also listed.

Number and % of Residents Included in Cognitive Add-On The number and percentage of Medicaid residents with BIMS scores less than or equal to 5 and residents with Cognitive Performance Scale scores of moderately severe to very severe.

**PART II, POLICIES AND PROCEDURES FOR  
NURSING FACILITY SERVICES**

**APPENDIX I**

**NURSING FACILITY ADMINISTRATIVE REVIEWS**

Application

This section describes appeals procedures for certain nursing facility (including ICF/MR) situations.

Pre-Admission Approval

- a. Upon application for pre-admission approval, the nursing facility and the applicant/recipient or an authorized representative shall be given written notification of the Division's determination. Upon denial of pre-admission approval, the applicant/recipient or an authorized representative may obtain a reconsideration by the Division by so requesting in writing.

All requests for reconsideration must be received by the Department of Community Health Program Specialist no later than ten (10) days following receipt of the initial denial and must be accompanied by additional medical documentation to justify a reconsideration. All such requests are to be addressed to:

Attn: Program Specialist  
Department of Community Health  
Aging and Special Populations Floor 37  
2 Peachtree Street, NW  
Atlanta, Georgia 30303-3159

- a. A decision on the request for reconsideration will be accomplished within fifteen (15) working days of its receipt by the Specialist. The applicant/recipient and the nursing facility will be notified in writing of the reconsideration decision by the Division.
- b. If an applicant/recipient disagrees with the Division's decision, that person, or an authorized representative, may file a request for a hearing. All such requests must be received by the local county Department of Family and Children Services Office or the Fair Hearings Unit of the Department of Human Services no later than thirty (30) days after the date of the notice of decision.
- c. An initial decision on any matter with respect to which a hearing is requested shall be rendered in writing by a Hearing Officer of the Fair Hearings Unit. Should such a decision be adverse to the medical assistance applicant/recipient,

that person or representative may appeal the decision by filing an appeal with the Hearing Officer for Final Appeals in accordance with directions from the Fair Hearings Unit.

- d. If an aggrieved applicant/recipient of medical assistance exhausts all the administrative remedies provided, judicial review of the decision may be obtained in the same manner and under the same standards which are applicable to those contested cases which are reviewable pursuant to O.C.G.A, Section 50-13-19.

Rev. 07/06

Billing Rate and Disallowance of Cost from the Cost Report

Reimbursement rates (billing rates) for nursing facilities (NF and ICF/MR) are established pursuant to the provisions discussed in Supplement 2 to Attachment 4.19-D. A billing rate calculation notice will be sent to a provider each time a rate is initially calculated for a given cost report period or is subsequently adjusted as a result of audit or review by the Division or its agent. A billing rate calculation will also be sent to a provider on a quarterly basis for rate changes that are a result of the case-mix reimbursement methodology (i.e. CPS, CMI, and nursing hour changes). Nursing facilities rates and percentiles will be based on costs reported by the providers which are reviewed by the Division or its agent. Cost reports and adjustments determined appropriate by the Division will be used to establish rates. Those cost reports and adjustments determined appropriate prior to initial establishment of the annual percentile ceilings (as described in Supplement 2 to Attachment 4.19-D) shall be used in calculation of the percentiles. Those cost reports and adjustments determined appropriate subsequent to initial establishment of the annual percentile ceilings shall be used to adjust rates only; percentile ceilings will not be adjusted.

Rev. 07/06

Any provider wishing to appeal its rate as initially established, its subsequent rate change as a result of audit or review, or its quarterly rate change as a result of the case-mix reimbursement methodology must follow the process set out in subsections (a) - (c) below:

Rev. 07/06

- a. Should a provider wish to appeal a decision of the Division regarding a billing rate calculation, including related disallowances from the cost report, the provider must file a written request for reconsideration with the Division. All such requests must be received by the Division within thirty (30) days of the date of the billing rate calculation notice. Requests received after this deadline shall not be considered. If no request for reconsideration is received by the Division by the deadline, the provider shall be deemed to have waived its right to a hearing concerning the calculation of the billing rate and related disallowances from the cost report. Initially established rate calculated for a given cost report period and

their related disallowances can only be appealed within 30 days after the rates are initially established.

The written request must address all questioned disallowance(s) and other specific point(s) of dispute and must be accompanied by supporting documents or other evidence to justify reconsideration. Requests for reconsideration must be directed to:

Rev. 07/06      Program Manager  
Nursing Home Reimbursement, 39th Floor  
Division of Medical Assistance  
2 Peachtree Street, N.W.  
Atlanta, GA 30303-3159

Rev. 07/06      The Program Manager of the Nursing Home Reimbursement Unit will have one hundred twenty days (120) from the date of receipt of the reconsideration request to render a decision unless the Program Manager determines there are extenuating circumstances (e.g., multiple facilities are involved or the rate change is a result of a federal disallowance) or additional information is required. If the Program Manager (or any authorized staff of the Nursing Home Unit) requests additional information, the nursing facility must submit to this information to the Unit within thirty (30) days of the date of such request. The Program Manager will have ninety (90) days from the date of receipt of the additional information to render a decision concerning the written requests or inquiries submitted by a nursing facility. Failure of a nursing facility to provide information within the specified time frame requested by the Division will result in the denial of the nursing facility's appeal by the Program Manager. Failure of the Program Manager to respond within the time frames described herein will result in approval of the nursing facility's request.

- a. The provider must file a request for a reconciliation conference if it wishes to appeal the Division's reconsideration decision. All such requests must be in writing and must be received within thirty (30) days from the date of the notice of the reconsideration decision. Requests received after this deadline shall not be considered. If no request for a reconciliation conference is received by the Division by the deadline, the provider shall be deemed to have waived its right to a hearing concerning the calculation of the billing rate and related disallowances from the cost report. All such requests must be directed to the address noted in subsection a) above.

Conferences will be scheduled at the Division's office. The Division Director will have sixty (60) days from the date of the reconciliation conference to render a decision unless both parties to the conference agree to extend the time limitation.

If the provider appeals a rate adjustment which is the result of a cost report adjustment(s) determined appropriate subsequent to the establishment of

percentile ceilings, the change will not be effected until the date of the Division's reconciliation conference decision. To the extent that such a rate change decreases a rate granted prior to review, it shall be affected by retroactive rate adjustment rather than through a request for refund or by recoupment.

Rev. 07/01/06

If the provider disagrees with the reconciliation conference decision, the provider may obtain a hearing on the matter by filing a written request there for with the Legal Services Section of the Division in accordance with O.C.G.A. §49-4-153.

**Sanctions**

In addition to the termination and suspension as a Medicaid provider, the Division may impose the sanctions described below.

**Nursing Facilities**

- a. The Division may sanction a nursing facility for failure to submit the required cost report as outlined in Supplement 3 of Attachment 4.19-D.
- b. The Division may deny reimbursement for services to ICF/MR recipients admitted to a facility on or after the effective date specified on written notice to that facility that it is not in compliance with Subsection 106.8 of the Part I, Policies and Procedure for Medicaid/PeachCare for Kids manual.

If the Division or its agent has determined that conditions in the facility have neither damaged nor immediately endanger the health, safety, or welfare of a recipient, the effective date of the notice shall be no earlier than five days after the date of receipt by the facility, during which time the facility will have the opportunity to correct the cited conditions.

The Division's action shall be predicated on a report from the agent, under its contract with the Division to perform on-site reviews of nursing facilities, which takes into account the medical, safety, environmental, and physical needs of the facility's residents. The denial of reimbursement shall remain in effect until such time as the Division determines, after subsequent on-site review, that the facility is meeting the aforementioned needs of its residents and is no longer damaging or endangering the health, safety, or welfare of any recipient. This denial shall not apply to temporarily hospitalized recipients previously residing in a facility, placed on such notice, who return to the facility after the date of notice. Neither shall it apply to persons who resided in the facility prior to the date of notice, and subsequently become Medicaid eligible.

A facility which has received notice of the Division's denial of reimbursement for newly admitted patients may appeal such action in the manner described in O.C.G.A. §49-4-153. However, nothing in this provision shall impede the authority of the Division to deny payment for new admissions or suspend or terminate a facility's participation under Section 402, Part I, Policies and Procedures for Medicaid/PeachCare for Kids manual.

- c. The Division may deny reimbursement for services to recipients in nursing facilities, who are admitted after the facility's receipt of notice that its participation in the program will be terminated by the Department of Community Health, under its own volition or as a result of an action taken by the Healthcare Facility Regulation Division of the Department of Community Health, or by the Health Care Financing Administration of the U.S. Department of Health and Human Services.

The Division may impose any or all of the remedies when a nursing facility fails to meet a Program Requirement as defined therein.

TN No.: 12-003

Supersedes

TN No.: NEW

Approval Date: SEP - 6 2012

Effective Date: 02-01-2012



CLAIM NUMBER	TYPE OF CLAIM	DEFINITION
01 (UB-82)	Hospital (Inpatient & Outpatient) Hospice Dialysis (Facilities) Swing-Beds	All services for one recipient within one bill or document.
02 (HCFA 1500)	Physicians' Physician Assistants Laboratories Nurse Midwives Birthing Centers Nurse Practitioners Podiatrists Psychologists Rural Health Clinics Community Health Centers Ambulatory Surgical Centers Orthotics or Prosthetics Durable Medical Equipment Case Management - Perimatal Case Management – Mental Health Mental Health Clinics Vision Care Home Health Services Community Care Services Wavered Services	All services for one recipient within one bill or document.
03 08 09 10 14 16 17 18 19 ADA 1999 version 2000	Family Planning (Tape) Anesthesia Ambulance NET EPSDT Cross-Over: Inpatient Cross-Over: Outpatient Cross-Over: Nursing Home Cross-Over: Other Dental Services	All services for one recipient within one bill or document
13 15	Pharmacy Nursing Home	A line item of service

TN No. 01-026

Supersedes

TN No. 90-44Approval Date NOV 08 2001Effective Date JUL 01 2001

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Citation	Condition or Requirement
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	<p data-bbox="479 451 1396 478"><u>4.19-F Disease Management Enhanced Primary Care Case Management Fee</u></p> <p data-bbox="479 514 1396 667">Disease Management Enhanced Primary Care Case Management is designed to incorporate a disease management component to Georgia Better Health Care (GBHC), as an enhancement to the basic Primary Care Providers. Through this Enhanced Primary Care Case Management Program the health outcomes of the population will improve, while medical cost will decrease.</p> <p data-bbox="479 709 1396 898">The Enhanced Primary Care Case Management organization will facilitate and maintain contact with enrolled members to promote their self-management of their disease/condition; patient and provider adherence to evidence-based clinical guidelines; twenty-four hour call nurse; and stratify management programs for members to determine at least three levels of intervention that will be applied to the entire population.</p> <p data-bbox="479 940 1396 1123">The reimbursement payment rate for case management services is a provider-specific monthly amount that is applicable for each eligible for which services are provided during a month. The rate is determined by the lower of the vendor's competitive bid or the rate established based upon an actuarially sound evaluation of services to be provided, including both face-to-face and ancillary contacts. This rate may be updated periodically.</p>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

Requirements for Third Party Liability -  
Identifying Liable Resources

The State agency takes reasonable measures to determine the legal liability of third parties to pay for services under the Plan.

The State provides for assignment of rights to benefits and cooperation in establishing paternity and obtaining medical support and payments as a condition of Medicaid eligibility.

The State has a written agreement with the Department of Human Resources (DHR) and Social Security Administration (SSA) which provides for collection and updating information regarding third party resources during the initial and redetermination processes, respectively. The applicant or recipient is required to furnish health insurance information to identify legally liable third party resources so that claims may be processed under third party liability payment provisions.

Data collected includes health insurance information when benefits are available to the recipient. Health insurance information may consist of the name of the policyholder; the relationship of the policyholder to the recipient or applicant, the Social Security Number (SSN) of the policyholder, the name and address of the insurance company and the policy number. This information collected during the initial and redetermination eligibility process is forwarded to the State Medicaid Agency for review and verification by phone or letter. Once verified, this information is added to the TPL Data Base. Additionally, the names and SSNs of absent or custodial parents of Medicaid recipients are collected to the extent that such information is available and is incorporated into the TPL Data Base to identify potential third party resources through data exchange activities.

The State agency, under written agreement, conducts quarterly data exchanges with the following agencies to identify Medicaid recipients and obtain information on absent or custodial parents of Medicaid recipients who are employed and their employer(s):

1. The Georgia Department of Labor (DOL), the State Wage Information Collection Agency (SWICA);
2. Beneficiary Earnings Exchange Record (BEER), to obtain the SSA wage and earning file information;

- 3. Child Support and Recovery Unit (CSRU), and
- 4. The State Workers' Compensation Agency

The State Agency conducts data exchanges with the Defense Enrollment Eligibility Reporting System (DEERS) yearly.

The State agency obtains health insurance information from the Title IV-A Agency, the Department of Human Resources (DHR), on case referral forms which are completed on each Medicaid applicant or recipient during the eligibility intake or redetermination process, respectively. Referral forms also provide the names(s) and social security number(s) on absent or custodial parents of Medicaid recipients which are incorporated in the third party liability data base to identify potential health insurance resources through employment leads obtained from data exchange activities.

Due to the absence of common identifying elements (names and social security numbers) which are needed to conduct data exchange activities, the State agency obtains a quarterly State motor vehicle accident report file from the Georgia Department of Public Safety. The report provides an alphabetical listing of names of persons injured in accidents involving motor vehicles and is used to research positive leads involving these types of injuries to establish the existence of legally liable third parties.

Diagnosis and trauma code edits are conducted in each weekly claims processing cycle to identify those paid claims for Medicaid recipients that contain diagnosis codes 800 through 999 (ICD 9-CM) except for diagnosis code 994.6.

The State agency conducts, within 45 days, follow-up activity to identify and verify the existence of health insurance resources on leads obtained from data exchanges with the Department of Labor (DOL); the Beneficiary Earnings Exchange Record (BEER); the Child Support Recovery Unit (CSRU); and the Defense Enrollment Eligibility Reporting System (DEERS). Letters are prepared and mailed to the employer(s) to verify the availability of health insurance. Verified health insurance information is incorporated into the eligibility casefile, the third party resource data files and the third party recovery file within 30 days from the date the State agency receives health insurance coverage verification.

Timeliness of follow-up activity is measured from the date the State agency receives the lead to the date the State agency initiates action to validate the existence of the TPL resource. Verified TPL information is incorporated into the TPL data base within 30 days after receipt of verified TPL information.

The State agency conducts within 60 days follow-up activity to identify legally liable third parties on leads obtained from Title IV-A referrals and data exchanges with the State Board of Workers' Compensation. Timeliness of follow-up activity is measured from the date the state agency receives the lead to the date the State agency receives verified health insurance coverage. Insurance information is incorporated into the eligibility case file and third party data base and recovery file within 30 days from the date the agency receives third party resource verification, so that claims may be processed under the third party liability provision specified in 433.139(b) through (f).

TRANSMITTAL	89-39
APPROVED	7.30.90
EFFECTIVE	10.1.89
SUPERSEDES	87-8

Accident questionnaires are mailed weekly to Medicaid members on all paid claims which involve trauma or accident related diagnosis codes. Follow-up actions are conducted within 60 days of receipt of responses to questionnaires which establish the probable existence of a liable third party. This information is incorporated into the case file; eligibility file and third party resource file within 30 days after verification of the third party's ongoing responsibility.

The State agency maintains a listing of all closed case data which reflects the primary trauma diagnosis and the amount of third party collections. The data compiled is reviewed semi-annually to identify those trauma codes that yield the highest third party collections to prioritize follow-up activities.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

Requirements for Third Party Liability  
Payment of Claims

The State uses a coordination of benefits cost avoidance method of claims processing when third party liability is identified at the time a claim is filed. A coverage specific matrix is utilized to cost avoid claim payment for categories of service covered by third party resources. Claims are rejected and returned to the provider if the service being billed is most likely covered by a legally responsible third party as defined in 42 C.F.R. 433.136. If, after the provider bills the legally responsible third party and a balance remains or the claim is denied payment for a substantive reason, the provider can submit a claim to the State Medicaid Agency for payment of the balance, up to the maximum Medicaid payment amount established for the service. There are no thresholds used to trigger the cost avoidance process.

With certain exceptions, cost avoidance procedures will be applied to all services and claims, including claims for prenatal services, labor and delivery, and postpartum care services. Cost avoidance procedures will not be applied to claims for preventive pediatric care (including EPSDT), and the state will make payments without regard to potential third-party liability for pediatric preventive services, unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days.

Additionally, cost avoidance procedures will not be applied to claims covered by absent parent-maintained insurance under Part D of Title IV of the Act. The state shall make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 100 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services, except that the State may make such payment within 30 days after such date if the State determines doing so is cost-effective and necessary to ensure access to care. The State seeks reimbursement from insurance carriers through a monthly system generated post-payment billing process when the existence of third-party liability is not known at the time of billing. A threshold of \$100.00 per member or what is deemed cost effective by the Department must be met prior to seeking reimbursement from Health insurance resources.

The State seeks reimbursement from verified liable third parties on claim payments involving accidental injuries when total potential recovery is \$250.00 or greater. Liens are filed if the recovery amount involves \$500.00 or more in Medicaid expenditures. No threshold is applied to the identification of paid claims with trauma diagnoses.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

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Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

SEE ATTACHED

Georgia Department of Medical Assistance  
Cost Effective Determination  
Alternative Guidelines  
Attachment to Att. 4.22-C

- I. The State of Georgia uses the following methods to determine the cost effectiveness of paying group health insurance premiums for Medicaid recipients:

1. Cost Effectiveness Based on Expenditure Projection

The determination of cost effectiveness is based on the comparison of the amount of the annual premium, deductibles, coinsurance, policyholder cost sharing obligations, and additional administrative costs against the average annual cost of Medicaid expenditures for the recipient's eligibility aid category on a statewide basis. It is used as an initial screening step for all Medicaid recipients who have group health insurance benefits to determine whether it is cost effective to purchase. The Medicaid Management Information System (MMIS) is utilized to obtain the average annual Medicaid costs statewide by aid category. A client's case is determined cost effective if the amount of the premium, deductibles, coinsurance, cost sharing obligation, and administrative costs are less than the Medicaid expenditures for an equivalent set of services.

2. Cost Effectiveness Based on Client Diagnosis

The determination of cost effectiveness is based on the comparison of premium amounts and policyholder obligations against the actual claims experience of the recipient. Documentation of actual expenditures consists of Explanation of Benefits (EOB's) from the recipient's health carrier for previous charges relating to a specific diagnosis or Medicaid expenditures for previous periods of the client's eligibility. This method is used when the method described in #1 above does not prove to be cost effective. Such diagnoses would include cancer, chronic heart disease, congenital heart disease, end stage renal disease and AIDS. This list will be expanded as diagnoses associated with long term care are identified. This method of cost effective determination is also appropriate for short term high expense treatments. A client's case is considered as cost effective when actual claim expenditures associated with the diagnosis exceed the premium amounts and policyholder obligations.

TRANSMITTAL	94-009
APPROVED	10-6-94
EFFECTIVE	7-1-94
SUPERSEDES	New



- II. Because Federal Financial Participation (FFP) is available for the payment of premiums for Medicaid recipients enrolled in a cost effective group health plan:
1. Medicaid will pay the health insurance premiums for Medicaid recipients with policies likely to be cost effective to the Medicaid program. Payments shall be made directly to the insurer providing the coverage, the employer or to the Medicaid recipient or guardian.
  2. Medicaid will pay the Medicaid allowable amount for all items and services provided the Medicaid recipient under the state Plan that are not covered under the group health plan.
  3. Medicaid will provide for the payment of premiums when cost effective for non-eligible family members to enroll a Medicaid eligible family member in the group health plan.
  4. Medicaid will treat the group health plan as a third party resource in accordance with Georgia Medicaid TPL cost avoidance policies.
  5. The health carrier, employer, recipient or non-Medicaid eligible family member will immediately notify this agency of any event that might affect the policyholder status of the cost effectiveness of the Health Insurance policy.
  6. Medicaid will receive referrals for potential candidates for the payment of premiums. Referral systems have been established through high cost hospital providers, AID Atlanta and the local Department of Family and Children Services.

TRANSMITTAL	94-009
APPROVED	10-6-94
EFFECTIVE	7-1-94
SUPERSEDES	New

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: GEORGIA

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE  
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

TN No.: 07-002

Supersedes:

TN No.: New

Approval Date: 09/05/07

Effective Date: 07/01/07

State/Territory: GEORGIA

Citation

Sanctions for Psychiatric Hospitals

1902(y) (1),  
1902 (Y) (2) (A),  
and Section  
1902(y) (3)  
of the Act  
(P.L. 101-508,  
Section 4755 (a)(2))

(a) The state assures that the requirements of section 1902 (y) (1), section 1902(y) (2) (A), and section 1902 (y) (3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.

1902(y)(1)(A)  
of the Act

(b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.

1902(y) (1) (B)  
of the Act

(c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may:

1. terminate the hospital's participation under the State plan; or
2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or
3. terminate the hospital's participation under the State plan and provide that no payment will be made under the state plan with respect to any individual admitted to such hospital after the effective date of the finding.

1902 (y) (2) (A)  
of the Act

(d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

**STATE PLAN UNDER TITLE III OF THE SOCIAL SECURITY ACT**

STATE: GEORGIA

**INCOME AND ELIGIBILITY VERIFICATION SYSTEM  
PROCEDURES REQUESTS TO OTHER STATE AGENCIES**

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The Department of Community Health matches with the Social Security Administration through the BENDEX and SDX processes. These matches have been performed for several years and are not required to be modified by the IEVS requirements as the Department contracts with the Social Security Administration and the Department of Human Services for the determination of eligibility.

The Department of Human Services, Division of Family and Children Services, conducts the following matches as part of the eligibility process:

1. Social Security Administration
  - a) BENDEX matches are completed for enumeration purposes and to obtain TITLE II information. Match is completed monthly for new applications and on individuals for who ss-5's have been completed. An annual match is conducted for all active individuals.
  - b) BEER matches are completed for income and wage information. Match is completed monthly for new application and annually on all recipients.
  - c) The State has an eligibility system that provides for quarterly data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including Federal, Veterans Affairs and matching with medical assistance programs operated by other States for the purpose of eligibility determinations of public programs. The information that is requested will be exchanged with other States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.
2. Internal Revenue Services matches are completed for unearned income (interest and dividends) information. Match is done monthly on all applications and annually for all recipients.
3. Department of Labor (DOL) wage and unemployment compensation benefit (UCB) matches are excluded from follow-up because the data available through IVES has previously been made available through on-line computer matches.

Georgia DOL wage and UCB files are accessed on-line through Clearinghouse during the application process and at each standard and alternate review. Excluding matches in which IVES information has been made available through on-line matches eliminates duplication of effort and maximizes staff effectiveness.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS  
TO HOMELESS INDIVIDUALS

Medicaid eligibility cards are mailed through the United States Postal Service to the mailing addresses specified by the Social Security Administration or the Department of Family and Children Services. The following are considered acceptable mailing addresses:

General delivery at a United States Post Office;

A box or other rented space at a United States Post Office;

Residence of a guardian or representative payee; or

Location of a temporary shelter administered by a religious or service organization.

Eligibility cards returned by the Postal Service, including those considered undeliverable, are kept on file in each county office of the Department of Family Children Services. Eligible individuals can appear there in person to receive their eligibility cards.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS  
FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

The Official Code of Georgia Annotated concerning advance directives is included herein as pages 1a through 25a of Attachment 4.34-A. Definitions can be referenced at the code cites listed below:

- living will 31-32-2
- durable power of attorney 31-36-2
- witness requirements 31-32-3 and 31-36-5
- proxy designation 31-36-4
- process information 31-32-3 and 31-36-5
- State forms 31-32-3 and 31-36-10
- conscientious objection 31-32-9 and 31-36-7

## CHAPTER 32

### LIVING WILLS

<p>Sec.</p> <p>31-32-1. Legislative findings.</p> <p>31-32-2. Definitions.</p> <p>31-32-3. Execution; witnesses; form.</p> <p>31-32-4. Patients in hospitals or skilled nursing facilities.</p> <p>31-32-8. Conditions precedent withholding or withdrawal of life-sustaining procedures; physician's failure or refusal to comply with living will.</p>	<p>Sec.</p> <p>31-32-9. Living will as not constituting suicide; effect of living will on insurance; restriction on health care facilities' preparing living wills.</p> <p>31-32-11. Effect of chapter on other legal rights and duties.</p>
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**Law reviews.** - For article, "If Nancy Cruzan Had Lived in Georgia: A Summary of Georgia Law Regarding the Right to Die," see 27 Ga. St. B.J. 194 (1991). For article, "Experimenting With the 'Right to Die in the Laboratory of the States,'" see 25 Ga. L. Rev. 1253 (1991).

For comment, "Living Will Statutes in Light of Cruzan v. Director, Missouri Department of Health: Ensuring that a Patient's Wishes Will Prevail", see 40 Emory L.J. 1305 (1991).

#### 31-32-1. Legislative findings.

(a) The General Assembly finds that modern medical technology has made possible the artificial prolongation of human life.

(b) The General Assembly further finds that, in the interest of protecting individual autonomy, such prolongation of life for persons with a terminal condition, a coma, or a persistent vegetative state may cause loss of patient dignity and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient.

(c) The General Assembly further finds that there exists considerable uncertainty in the medical and legal professions as to the legality of terminating the use of life-sustaining procedures in certain situations.

(d) In recognition of the dignity and privacy which patients have a right to expect, the General Assembly declares that the laws of the State of Georgia shall recognize the right of a competent adult person to make a written directive, known as a living will, instructing his physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition, a coma, or a persistent vegetative state. (Code 1981, § 31-32-1, enacted by Ga. L. 1984, p. 1477, § 1; Ga. L. 1992, p. 1926, § 1.)

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**The 1992 amendment**, effective April 16, 1992, in subsections (b) and (d), inserted “, a coma, or a persistent vegetative state”.

**Law reviews.** - For note on 1992 amendment of this Code section, see 9 Ga. St. U.L. Rev. 270 (1992).

**31-32-2. Definitions.**

As used in this chapter, the term:

(1) “Attending physician” means the physician who has been selected by or assigned to the patient and who has assumed primary responsibility for the treatment and care of the patient; provided, however, that if the physician selected by or assigned to the patient to provide such treatment and care directs another physician to assume primary responsibility for such care and treatment, the physician who has been so directed shall, upon his or her assumption of such responsibility, be the “attending physician.”

(2) “Coma” means a profound state of unconsciousness caused by disease, injury, poison, or other means and for which it has been determined that there exists no reasonable expectation of regaining consciousness. The procedure for establishing a coma is as follows: two physicians, one of whom must be the attending physician, who, after personally examining the declarant, shall certify in writing, based upon conditions found during the course of their examination, that:

(A) The declarant has been in a profound state of unconsciousness for a period of time sufficient for the declarant's physicians to conclude that the unconscious state will continue; and

(B) There exists no reasonable expectation that the declarant will regain consciousness.

(3) “Competent adult” means a person of sound mind who is 18 years of age or older.

(4) “Declarant” means a person who has executed a living will authorized by this chapter.

(5) “Hospital” means a facility which has a valid permit or provisional permit issued under Chapter 7 of this title and which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled or sick persons.

(6) “Life-sustaining procedures” means any medical procedures or interventions, which, when applied to a patient in a terminal condition or in a coma or persistent vegetative state with no reasonable expectation of regaining consciousness or significant cognitive function, would serve only to prolong the dying process and where, in the

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judgment of the attending physician and a second physician, death will occur without such procedures for interventions. The term "life-sustaining procedures" may include, at the option of the declarant, the provision of nourishment and hydration, but shall not include the administration of medication to alleviate pain or the performance of any medical procedure deemed necessary to alleviate pain.

(7) "Living will" means a written document voluntarily executed by the declarant in accordance with the requirements of Code Section 31-32-3 or 31-32-4.

(8) "Patient" means a person receiving care or treatment from a physician.

(9) "Persistent vegetative state" means a state of severe mental impairment in which only involuntary bodily functions are present and for which there exists no reasonable expectation of regaining significant cognitive function. The procedure for establishing a persistent vegetative state is as follows: two physicians, one of whom must be the attending physician, who, after personally examining the declarant, shall certify in writing, based upon conditions found during the course of their examination, that:

(A) The declarant's cognitive function has been substantially impaired; and

(B) There exists no reasonable expectation that the declarant will regain significant cognitive function.

(10) "Physician" means a person lawfully licensed in this state to practice medicine and surgery pursuant to Article 2 of Chapter 34 of Title 43.

(11) "Reasonable expectation" means the result of prudent judgment made on the basis of the medical judgment of a physician.

(12) "Skilled nursing facility" means a facility having a valid permit or provisional permit issued under Chapter 7 of this title and which provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis.

(13) "Terminal condition" means incurable condition caused by disease, illness, or injury which, regardless of the application of life-sustaining procedures, would produce death. The procedure for establishing a terminal condition is as follows: two physicians, one of whom must be the attending physician, who, after personally examining the declarant, shall certify in writing, based upon conditions found during the course of their examination, that:

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- (A) There is no reasonable expectation for improvement in the condition of the declarant; and
- (B) Death of the declarant from these conditions will occur as a result of such disease, illness, or injury. (Code 1981, § 31-32-2, enacted by Ga. L. 1984, p. 1477, § 1; Ga. L. 1992, p. 1926, §2.)

**The 1992 amendment**, effective April 16, 1992, added present paragraph (2); redesignated former paragraphs (2) through (4) as present paragraphs (3) through (5); rewrote former paragraph (5) and redesignated it as present paragraph (6); redesignated former paragraphs (6) and (7) as present paragraphs (7) and (8); added present paragraph (9); redesignated former paragraph (8) as present paragraph (10); added present paragraph (11); redesignated former paragraphs (9) and (10) as present paragraphs (12) and (13); and, in

paragraph (13), in the second sentence of the introductory paragraph, inserted one of whom must be the attending physician." and added", char" preceding the colon, and in subparagraph (B), substituted "will occur as a result of such disease, illness, or injury" for "is imminent".  
**Law reviews** - For annual survey of law of wills, trusts, and administration of estates, see 44 Mercer L. Rev. 445 (1992). For note on 1992 amendment of this Code section, see 9 Ga. St. U.L. Rev. 270 (1992).

**31-32-3. Execution; witnesses; form.**

(a) Any competent adult may execute a document directing that, should the declarant have a terminal condition, life-sustaining procedures be withheld or withdrawn. Such living will shall be signed by the declarant in the presence of at least two competent adults who, at the time of the execution of the living will, to the best of their knowledge:

- (1) Are not related to the declarant by blood or marriage;
- (2) Would not be entitled to any portion of the estate of the declarant upon the declarant's decease under any testamentary will of the declarant, or codicil thereto, and would not be entitled to any such portion by operation of law under the rules of descent and distribution of this state at the time of the execution of the living will;
- (3) Are neither the attending physician nor an employee of the attending physician nor an employee of the hospital or skilled nursing facility in which the declarant is a patient;
- (4) Are not directly financially responsible for the declarant's medical care; and
- (5) Do not have a claim against any portion of the estate of the declarant.

(b) The declaration shall be a document, separate and self-contained. Any declaration which constitutes an expression of the declarant's intent shall be honored, regardless of the form used or when executed. Declarations executed on or after March 28, 1986, shall be valid indefinitely unless revoked. A declaration similar to the following form or in substantially the form specified under prior law shall be presumed on its face to be valid and effective:

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"LIVING WILL

Living will made this \_\_\_\_\_ day of \_\_\_\_\_ (month, year).

I, \_\_\_\_\_ being of sound mind, willfully and voluntarily make known my desire that my life shall not be prolonged under the circumstances set forth below and do declare:

1. If at any time I should (check each option desired):  
 ( ) have a terminal condition,  
  
 ( ) become in a coma with no reasonable expectation of regaining consciousness, or  
  
 ( ) become in a persistent vegetative state with no reasonable expectation of regaining significant cognitive function,

as defined in and established in accordance with the procedures set forth in paragraphs (2), (9), and (13) of Code Section 31-32-2 of the Official Code of Georgia Annotated, I direct that the application of life-sustaining procedures to my body (check the option desired):

- ( ) including nourishment and hydration,
- ( ) including nourishment but not hydration, or
- ( ) excluding nourishment and hydration,

be withheld or withdrawn and that I be permitted to die;

2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this living will shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal;
3. I understand that I may revoke this living will at any time;
4. I understand the full import of this living will, and I am at least 18 years of age and am emotionally and mentally competent to make this living will; and
5. If I am a female and I have been diagnosed as pregnant, this living will shall have no force and effect unless the fetus is not viable and I indicate by initialing after this sentence that I want this living will to be carried out. (Initial)

Signed \_\_\_\_\_

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\_\_\_\_\_(City), \_\_\_\_\_(County), and \_\_\_\_\_(State of  
Residence).

I hereby witness this living will and attest that:

- (1) The declarant is personally known to me and I believe the declarant to be at least 18 years of age and of sound mind;
- (2) I am at least 18 years of age;
- (3) To the best of my knowledge, at the time of the execution of this living will, I:
  - (A) Am not related to the declarant by blood or marriage;
  - (B) Would not be entitled to any portion of the declarant's estate by any will or by operation of law under the rules of descent and distribution of this state;
  - (C) Am not the attending physician of declarant or an employee of the attending physician or an employee of the hospital or skilled nursing facility in which declarant is a patient;
  - (D) Am not directly financially responsible for the declarant's medical care; and
  - (E) Have no present claim against any portion of the estate of the declarant;
- (4) Declarant has signed this document in my presence as above instructed, on the date above first shown.

Witness \_\_\_\_\_

Address \_\_\_\_\_

Witness \_\_\_\_\_

Address \_\_\_\_\_

Additional witness required when living will is signed in a hospital or skilled nursing facility.

I hereby witness this living will and attest that I believe the declarant to be of sound mind and to have made this living will willingly and voluntarily.

Witness: \_\_\_\_\_  
Medical director of skilled nursing facility or staff physician not participating in care of the patient or chief of the hospital medical staff or staff physician or hospital designee not participating in care of the patient."

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(Code 1981, § 31-32-3, enacted by Ga. L. 1984, p. 1477, § 1; Ga. L. 1986, p. 445, § 2; Ga. L. 1989, p. 1182, § 1; Ga. L. 1992, p. 1926, § 3; Ga. L. 1993, p. 91, § 31.)

**The 1992 amendment**, effective April 16, 1992, in subsection (b), rewrote the introductory language, rewrote paragraphs 1 and 5 of the living will form, and inserted "or hospital designee" near the end of the form,

**The 1993 amendment**, effective March 22, 1993, in the introductory language of subsection (b), substituted "March 28" for "March 18", in the living will form contained in subsection (b), substituted "paragraphs (2), (9), and (13)" for "paragraphs (2), (9), and (10)", and, in item 1 of the

living will form contained in subsection (b), substituted "( ) including nourishment but not hydration, or" for "( ) including hydration but not nourishment, or".

**Code Commission notes.** --- Pursuant to Code Section 28-9-5, in 1992, "above-instructed" was substituted for "above-instructed" in paragraph (4) of the witness statement form in subsection (b).

**Law reviews.** --- For note on 1992 amendment of this Code section, see 9 Ga. St. U.L. Rev. 270 (1992).

#### **31-32-4. Patients in hospitals or skilled nursing facilities.**

A living will shall have no force or effect if the declarant is a patient in a hospital or skilled nursing facility at the time the living will is executed unless the living will is signed in the presence of the two witnesses as provided in Code Section 31-32-3 and, additionally, is signed in the presence of either the chief of the hospital medical staff, any physician on the medical staff who is not participating in the care of the patient, or a person on the hospital staff who is not participating in the care of the patient designated by the chief of staff and the hospital administrator, if witnessed in a hospital, or the medical director or any physician on the medical staff who is not participating in the care of the patient, if witnessed in a skilled nursing facility. (Code 1981, § 31-32-4, enacted by Ga. L. 1984, p. 1477, § 1; Ga. L. 1989, p. 1182, § 2; Ga. L. 1992, p. 1926, § 4.)

**The 1992 amendment**, effective April 16, 1992, near the middle of the Code section, substituted a comma for "or" following "medical staff" and inserted after the next comma "or a person on the hospital staff who is not participating in the care of

the patient designated by the chief of staff and the hospital administrator,".

**Law reviews.** --- For note on 1992 amendment of this Code section, see 9 Ga. St. U.L. Rev. 270 (1992).

#### **31-32-8. Conditions precedent to withholding or withdrawal of life-sustaining procedures; physician's failure or refusal to comply with living will.**

(a) Prior to effecting a withholding or withdrawal of life-sustaining procedures from a patient pursuant to a living will, the attending physician:

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(1) Shall determine that, to the best of his knowledge, the declarant patient is not pregnant, or if she is, that the fetus is not viable and that the declarant's living will specifically indicates that the living will is to be carried out;"

(2) Shall, without delay after the diagnosis of a terminal condition of the declarant, take the necessary steps to provide for the written certification required by Code Section 31-32-2 of the declarant's terminal condition, coma, or persistent vegetative state;

(3) Shall make a reasonable effort to determine that the living will complies with subsection (b) of Code Section 31-32-3; and

(4) Shall make the living will and the written certification of the terminal condition, coma, or persistent vegetative state a part of the declarant patient's medical records.

(b) The living will shall be presumed, unless revoked, to be the directions of the declarant regarding the withholding or withdrawal of life-sustaining procedures. No person shall be civilly liable for failing or refusing in good faith to effectuate the living will of the declarant patient. The attending physician who fails or refuses to comply with the declaration of a patient pursuant to this chapter shall endeavor to advise promptly the next of kin or legal guardian of the declarant that such physician is unwilling to effectuate the living will of the declarant patient. The attending physician shall thereafter at the election of the next of kin or the legal guardian of the declarant:

- (1) Make a good faith attempt to effect the transfer of the qualified patient to another physician who will effectuate the declaration of the patient; or
- (2) Permit the next of kin or legal guardian to obtain another physician who will effectuate the declaration of the patient. (Code 1981, § 31-32-8, enacted by Ga. L. 1984, p. 1477, § 1; Ga. L. 1992, p. 1926, § 5.)

**The 1992 amendment**, effective April 16, 1992, in subsection (a), made the following changes: in paragraph (1), added all of the language following "pregnant"; in paragraph (2), substituted all of the present language following "provide for" for "written certification by said physician

of the declarant's terminal condition"; and, in paragraph (4), inserted ", coma, or persistent vegetative state".

**Law reviews.** --- For note on 1992 amendment of this Code section, see 9 Ga. St. U.L. Rev. 270 (1992).

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**31-32-9. Living will as not constituting suicide; effect of living will on insurance; restriction on health care facilities' preparing living wills.**

(a) The making of a living will pursuant to this chapter shall not, for any purpose, constitute a suicide.

(b) The making of a living will pursuant to this chapter shall not restrict, inhibit, or impair in any manner the sale, procurement, issuance, or enforceability of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the making of a living will pursuant to this chapter or by the withholding or withdrawal of life-sustaining procedures from an insured patient, nor shall the making of such a living will or the withholding or withdrawal of such life-sustaining procedures operate to deny any additional insurance benefits for accidental death of the patient in any case in which the terminal condition of the patient is the result of accident, notwithstanding any term of the policy to the contrary.

(c) No physician, hospital, skilled nursing facility, or other health provider and no health care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or nonprofit hospital service plan shall require any person to execute a living will as a condition for being insured for, or receiving, health care services.

(d) No hospital, skilled nursing facility, or other medical or health care facility shall prepare or offer to prepare living wills unless specifically requested to do so by a person desiring to execute a living will. For purposes of this article, a person in the custody of the Department of Corrections shall not be deemed to be a patient within the meaning of this article, nor shall a correctional facility be deemed to be a hospital, skilled nursing facility, nor any other medical or health care facility. (Code 1981, § 31-32-9, enacted by Ga. L. 1984, p. 1477, § 1; Ga. L. 1985, p. 455, § 1; Ga. L. 1992, p. 1926, § 6.)

**The 1992 amendment**, effective April 16, 1992, in the first sentence of subsection (d), substituted "shall prepare or offer to prepare" for "shall prepare, offer to prepare, or otherwise provide forms for"; and added the second sentence of subsection (d).

**Code Commission notes.** - Pursuant to Code Section 28-9-5. in 1992, "this article" was substituted for "this Article" twice in subsection (d).

**Law reviews.** - For note on 1992 amendment of his Code section, see 9 Ga. St. U.L. Rev. 270 (1992).

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**31-32-11. Effect of chapter on other legal rights and duties.**

(a) Nothing in this chapter shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this chapter are cumulative.

(b) Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing or to permit any affirmative or deliberate act or omission to end life other than to permit the process of dying as provided in this chapter. Furthermore, nothing in this chapter shall be construed to condone, authorize, or approve abortion.

(c) This chapter shall create no presumption concerning the intention of an individual who has not executed a declaration to consent to the use or withholding of life-sustaining procedures in the event of a terminal condition, a coma, or a persistent vegetative state.

(d) Unless otherwise specifically provided in a durable power of attorney for health care, a declaration under this chapter is ineffective and inoperative as long as there is an agent available to serve pursuant to a durable power of attorney executed in accordance with the provisions of Chapter 36 of this title, the "Durable Power of Attorney for Health Care Act," which grants the agent authority with respect to the withdrawal or withholding of life-sustaining or death-delaying treatment under the same circumstances as those covered by a declaration under this chapter. (Code 1981, § 31-32-11, enacted by Ga. L. 1984, p. 1477, § 1; Ga. L. 1992, p. 1926, § 7.)

**The 1992 amendment**, effective April 16, 1992, at the end of subsection (c), added ", a coma, or a persistent vegetative state"; and added subsection (d).

**Law reviews.** --- For note on 1992 amendment of this Code section, see 9 Ga. St. U.L. Rev. 270 (1992).

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31-36-1 DURABLE POWER OF ATTORNEY FOR HEALTH CARE 31-36-2

**CHAPTER 36**

**DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

Sec.		Sec.	
31-36-1.	Short title.	31-36-8.	Immunity from liability or disciplinary action; death not constituting suicide or homicide.
31-36-2.	Legislative findings.		
31-36-3.	Definitions.	31-36-9.	Penalties for violations.
31-36-4.	Delegation of health care powers to agent; death of principal; rights regarding life-sustaining or death-delaying procedures.	31-36-10.	Form of power of attorney for health care; authorized powers.
31-36-5.	Execution of agency; health care provider not qualified as agent; limitations on authority of agent.	31-36-11.	Applicability of chapter; principal with living will; priority of agent's authority.
31-36-6.	Revocation or amendment of agency	31-36-12.	Prior agency or act of agent not affected.
31-36-7.	Duties and responsibilities of health care provider.	31-36-13.	Construction of chapter in relation to Title 53.

**Effective date.** --- This chapter became effective July 1, 1990.

31, Chapter 32. Cardiopulmonary resuscitation, Title 31, Chapter 39.

**Cross references.** --- Living wills, Title

**31-36-1. Short title.**

This chapter shall be known and may be cited as the "Durable Power of Attorney for Health Care Act." (Code 1981, § 31-36-1, enacted by Ga. L. 1990, p. 1101, § 1.)

**31-36-2. Legislative findings.**

(a) The General Assembly recognizes the right of the individual to control all aspects of his or her personal care and medical treatment, including the right to decline medical treatment or to direct that it be withdrawn. However, if the individual becomes disabled, incapacitated, or incompetent, his or her right to control treatment may be denied unless the individual, as principal, can delegate the decision-making power to a trusted agent and be sure that the agent's power to make personal and health care decisions for the principal will be effective to the same extent as though made by the principal.

(b) This recognition of the right of delegation for health care purposes must be stated to make it clear that its scope is intended to be as broad as the comparable right of delegation for property and financial matters. However, the General Assembly recognizes that powers con-

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cerning health care decisions are more sensitive than property matters and that particular rules and forms are necessary for health care agencies to ensure their validity and efficacy and to protect health care providers so that they will honor the authority of the agent at all times. Nothing in this chapter shall be deemed to authorize or encourage euthanasia, suicide, or any action or course of action that violates the criminal laws of this state or the United States.

(c) in furtherance of these purposes, the General Assembly enacts this chapter, setting forth general principles governing health care agencies, as well as a statutory short form durable power of attorney for health care, intending that when a power in substantially the form set forth in this chapter is used, health care providers and other third parties who rely in good faith on the acts and decisions of the agent within the scope of the power may do so without fear of civil or criminal liability to the principal, the state, or any other person. However, the form of health care agency set forth in this chapter is not intended to be exclusive, and other forms of powers of attorney chosen by the principal that comply with Code Section 31-36-5 may offer powers and protections similar to the statutory short form durable power of attorney for health care. (Code 1981, § 31-36-2, enacted by Ga. L. 1990, p. 1101, § 1.)

**31-36-3. Definitions.**

As used in this chapter, the term:

- (1) "Attending physician" means the physician who has primary responsibility at the time of reference for the treatment and care of the patient.
- (2) "Health care" means any care, treatment, service, or procedure to maintain, diagnose, treat, or provide for the patient's physical or mental health or personal care.
- (3) "Health care agency" or "agency" means an agency governing any type of health care, anatomical gift, autopsy, or disposition of remains for and on behalf of a patient and refers to the power of attorney or other written instrument defining the agency, or the agency itself, as appropriate to the context.
- (4) "Health care provider" or "provider" means the attending physician and any other person administering health care to the patient at the time of reference who is licensed, certified, or otherwise authorized or permitted by law to administer health care in the ordinary course of business or the practice of a profession, including any person employed by or acting for any such authorized person.
- (5) "Hospital" means a facility which has a valid permit or provisional permit issued under Chapter 7 of this code and which is primar-

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ily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons.

(6) "Patient" means the principal.

(7)"Skilled nursing facility." means a facility which has a valid permit or provisional permit issued under Chapter 7 of this title and which provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. (Code 1981, §31-36-3, enacted by Ga. L. 1990, p. 1101, § 1.)

**31-36-4. Delegation of health care powers to agent; death of principal; rights regarding life-sustaining or death-delaying procedures.**

The health care powers that may be delegated to an agent include, without limitation, all powers an individual may have to be informed about and to consent to or refuse or withdraw any type of health care for the individual. A health care agency may extend beyond the principal's death if necessary to permit anatomical gift, autopsy, or disposition of remains. Nothing in this chapter shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life sustaining or death-delaying procedures in any lawful manner, and the provisions of this chapter are cumulative in such respect. (Code 1981, § 31-36-4, enacted by Ga. L. 1990, p. . 1101, § 1.)

**31-36-5. Execution of agency; health care provider not qualified as agent; limitations on authority of agent.**

(a) A health care agency shall be in writing and signed by the principal or by some other person in the principal's presence and by the principal's express direction. A health care agency shall be attested and subscribed in the presence of the principal by two or more competent witnesses who are at least 18 years of age. In addition, if at the time a health care agency is executed the principal is a patient in a hospital or skilled nursing facility, the health care agency shall also be attested and subscribed in the presence of the principal by the principal's attending physician.

(b) No health care provider may act as agent under a health care agency if he or she is directly or indirectly involved in the health care rendered to the patient under the health care agency.

(c) An agent under a health care agency shall not have the authority to make a particular health care decision different from or contrary to the

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patient's decision, if any, if the patient is able to understand the general nature of the health care procedure being consented to or refused, as determined by the patient's attending physician based on such physician's good faith judgment (Code 1981, § 31-36-5, enacted by Ga. L. 1990, p. 1101, §1.)

**31-36-6. Revocation or amendment of agency.**

(a) Every health care agency may be revoked by the principal at any time, without regard to the principal's mental or physical condition, by any of the following methods:

- (1) By being obliterated, burned, torn, or otherwise destroyed or defaced in a manner indicating an intention to revoke;
- (2) By a written revocation of the agency signed and dated by the principal or by a person acting at the direction of the principal; or
- (3) By an oral or any other expression of the intent to revoke the agency in the presence of a witness 18 years of age or older who, within 30 days of the expression of such intent, signs and dates a writing confirming that such expression of intent was made.

(b) Unless the health care agency expressly provides otherwise, if, after executing a health care agency, the principal marries, such marriage shall revoke the designation of a person other than the principal's spouse as the principal's agent to make health care decisions for the principal; and if, after executing a health care agency, the principal's marriage is dissolved or annulled, such dissolution or annulment shall revoke the principal's former spouse as the principal's agent to make health care decisions for the principal.

(c) A health care agency which survives disability shall not be revoked solely by the appointment of a guardian or receiver for the principal. Absent an order of a court of competent jurisdiction directing a guardian to exercise powers of the principal under an agency that survives disability, the guardian has no power, duty, or liability with respect to any personal or health care matters covered by the agency.

(d) A health care agency may be amended at any time by a written amendment executed in accordance with the provisions of subsection (a) of Code Section 31-36-5.

(e) Any person, other than the agent, to whom a revocation or amendment of a health care agency is communicated or delivered shall make all reasonable efforts to inform the agent of that fact as promptly as possible. (Code 1981, § 31-36-6, enacted by Ga. L. 1990, p. 1101, § 1.)

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APPROVED	12-4-91
EFFECTIVE	12-1-91
SUPERSEDES	(NEW)

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**31-36-7. Duties and responsibilities of health care provider.**

Each health care provider and each other person with whom an agent deals under a health care agency shall be subject to the following duties and responsibilities:

(1) It is the responsibility of the agent or patient to notify the health care provider of the existence of the health care agency and any amendment or revocation thereof. A health care provider furnished with a copy of a health care agency shall make it a part of the patient's medical records and shall enter in the records any change in or termination of the health care agency by the principal that becomes known to the provider. Whenever a provider believes a patient is unable to understand the general nature of the health care procedure which the provider deems necessary, the provider shall consult with any available health care agent known to the provider who then has power to act for the patient under a health care agency;

(2) A health care decision made by an agent in accordance with the terms of a health care agency shall be complied with by every health care provider to whom the decision is communicated, subject to the provider's right to administer treatment for the patient's comfort or alleviation of pain; but, if the provider is unwilling to comply with the agent's decision, the provider shall promptly inform the agent who shall then be responsible to make the necessary arrangements for the transfer of the patient to another provider. A provider who is unwilling to comply with the agent's decision will continue to afford reasonably necessary consultation and care in connection with the pending transfer;

(3) At the patient's expense and subject to reasonable rules of the health care provider to prevent disruption of the patient's health care, each health care provider shall give an agent authorized to receive such information under a health care agency the same right the principal has to examine and copy any part or all of the patient's medical records that the agent deems relevant to the exercise of the agent's powers, whether the records relate to mental health or any other medical condition and whether they are in the possession of or maintained by any physician, psychiatrist, psychologist, therapist, hospital, nursing home, or other health care provider, notwithstanding the provisions of any statute or rule of law to the contrary; and

(4) If and to the extent a health care agency empowers the agent to:

(A) Make an anatomical gift on behalf of the principal under Article 6 of Chapter 5 of Title 44, the "Georgia Anatomical Gift Act," as now or hereafter amended;

(B) Authorize an autopsy of the principal's body; or

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(C) Direct the disposition of the principal's remains, the anatomical gift, autopsy approval, or remains disposition shall be deemed the act of the principal or of the person who has priority under law to make the necessary decisions and each person to whom a direction by the agent in accordance with the terms of the agency is communicated shall comply with such direction to the extent it is in accord with reasonable medical standards or other relevant standards at the time of reference. (Code 1981, § 31-36-7, enacted by Ga. L. 1990, p. 1101, § 1.)

**31-36-8. Immunity from liability or disciplinary action; death not constituting suicide or homicide.**

Each health care provider and each other person who acts in good faith reliance on any direction or decision by the agent that is not clearly contrary to the terms of a health care agency will be protected and released to the same extent as though such person had dealt directly with the principal as a fully competent person. Without limiting the generality of the foregoing, the following specific provisions shall also govern, protect, and validate the acts of the agent and each such health care provider and other person acting in good faith reliance on such direction or decision:

(1) No such provider or person shall be subject to any type of civil or criminal liability or discipline for unprofessional conduct solely for complying with any direction or decision by the agent, even if death or injury to the patient ensues;

(2) No such provider or person shall be subject to any type of civil or criminal liability or discipline for unprofessional conduct solely for failure to comply with any direction or decision by the agent, as long as such provider or person promptly informs the agent of such provider's or person's refusal or failure to comply with such direction or decision by the agent. The agent shall then be responsible to make the necessary arrangements for the transfer of the patient to another health care provider. A health care provider who is unwilling to comply with the agent's decision will continue to afford reasonably necessary consultation and care in connection with the pending transfer;

(3) If the actions of a health care provider or person who fails to comply with any direction or decision by the agent are substantially in accord with reasonable medical standards at the time of reference and the provider cooperates in the transfer of the patient pursuant to paragraph (2) of Code Section 31-36-7, the health care provider or person shall not be subject to any type of civil or criminal liability or discipline for unprofessional conduct for failure to comply with the agency;

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(4) No agent who, in good faith, acts with due care for the benefit of the patient and in accordance with the terms of a health care agency, or who fails to act, shall be subject to any type of civil or criminal liability for such action or inaction;

(5) If the authority granted by a health care agency is revoked under Code Section 31-36-6, a person will not be subject to criminal prosecution or civil liability for acting in good faith reliance upon such health care agency unless such person had actual knowledge of the revocation; and

(6) If the patient's death results from withholding or withdrawing life-sustaining or death-delaying treatment in accordance with the terms of a health care agency, the death shall not constitute a suicide or homicide for any purpose under any statute or other rule of law and shall not impair or invalidate any insurance, annuity, or other type of contract that is conditioned on the life or death of the patient, any term of the contract to the contrary notwithstanding. (Code 1981, § 31-36-8, enacted by Ga. L. 1990, p. 1101, § 1.)

**31-36-9. Penalties for violations.**

All persons shall be subject to the following sanctions in relation to health care agencies, in addition to all other sanctions applicable under any other law or rule of professional conduct:

(1) Any person shall be civilly liable who, without the principal's consent, willfully conceals, cancels, or alters a health care agency or any amendment or revocation of the agency or who falsifies or forges a health care agency, amendment, or revocation;

(2) A person who falsifies or forges a health care agency or willfully conceals or withholds personal knowledge of an amendment or revocation of a health care agency with the intent to cause a withholding or withdrawal of life-sustaining or death-delaying procedures contrary to the intent of the principal and thereby, because of such act, directly causes life-sustaining or death-delaying procedures to be withheld or withdrawn, shall be subject to prosecution for criminal homicide as provided for in Chapter 5 of Title 16; and

(3) Any person who requires or prevents execution of a health care agency as a condition of ensuring or providing any type of health care services to the patient shall be civilly liable and guilty of a misdemeanor and shall be punished as provided by law. (Code 1981, § 31-36-9, enacted by Ga. L. 1990, p. 1101, § 1.)

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**31-36-10. Form of power of attorney for health care; authorized powers.**

(a) The statutory health care power of attorney form contained in this subsection may be used to grant an agent powers with respect to the principal's own health care; but the Statutory health care power is not intended to be exclusive or to cover delegation of a parent's power to control the health care of a minor child, and no provision of this chapter shall be construed to bar use by the principal of any other or different form of power of attorney for health care that complies with Code Section 31-36-5. If a different form of power of attorney for health care is used, it may contain any or all of the provisions set forth or referred to in the following form. When a power of attorney in substantially the following form is used, including the notice paragraph in capital letters at the beginning, it shall have the meaning and effect prescribed in this chapter. The statutory health care power may be included in or combined with any other form of power of attorney governing property or other matters:

"GEORGIA STATUTORY SHORT FORM

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

NOTICE: THE PURPOSE OF THIS POWER OF ATTORNEY IS TO GIVE THE PERSON YOU DESIGNATE (YOUR AGENT) BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU, INCLUDING POWER TO REQUIRE, CONSENT TO, OR WITHDRAW ANY TYPE OF PERSONAL CARE OR MEDICAL TREATMENT FOR ANY PHYSICAL OR MENTAL CONDITION AND TO ADMIT YOU TO OR DISCHARGE YOU FROM ANY HOSPITAL, HOME, OR OTHER INSTITUTION; BUT NOT INCLUDING PSYCHOSURGERY, STERILIZATION, OR INVOLUNTARY HOSPITALIZATION OR TREATMENT COVERED BY TITLE 37 OF THE OFFICIAL CODE OF GEORGIA ANNOTATED. THIS FORM DOES NOT IMPOSE A DUTY ON YOUR AGENT TO EXERCISE GRANTED POWERS; BUT, WHEN A POWER IS EXERCISED, YOUR AGENT WILL HAVE TO USE DUE CARE TO ACT FOR YOUR BENEFIT AND IN ACCORDANCE WITH THIS FORM. A COURT CAN TAKE AWAY THE POWERS OF YOUR AGENT IF IT FINDS THE AGENT IS NOT ACTING PROPERLY. YOU MAY NAME COAGENTS AND SUCCESSOR AGENTS UNDER THIS FORM, BUT YOU MAY NOT NAME A HEALTH CARE PROVIDER WHO MAY BE DIRECTLY OR INDIRECTLY INVOLVED IN RENDERING HEALTH CARE TO YOU UNDER THIS POWER, UNLESS YOU EXPRESSLY LIMIT THE DURATION OF THIS POWER IN THE MANNER PROVIDED BELOW

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OR UNTIL YOU REVOKE THIS POWER OR A COURT ACTING ON YOUR BEHALF TERMINATES IT, YOUR AGENT MAY EXERCISE THE POWERS GIVEN IN THIS POWER THROUGHOUT YOUR LIFETIME, EVEN AFTER YOU BECOME DISABLED, INCAPACITATED, OR INCOMPETENT. THE POWERS YOU GIVE YOUR AGENT, YOUR RIGHT TO REVOKE THOSE POWERS, AND THE PENALTIES FOR VIOLATING THE LAW ARE EXPLAINED MORE FULLY IN CODE SECTIONS 31-36-6, 31-36-9, AND 31-36-10 OF THE GEORGIA 'DURABLE POWER OF ATTORNEY FOR HEALTH CARE ACT OF WHICH THIS FORM IS A PART (SEE THE BACK OF THIS FORM). THAT ACT EXPRESSLY PERMITS THE USE OF ANY DIFFERENT FORM OF POWER OF ATTORNEY YOU MAY DESIRE. IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

DURABLE POWER OF ATTORNEY made this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_\_

1. I, \_\_\_\_\_  
(insert name and address of principal)

hereby appoint \_\_\_\_\_  
(insert name and address of agent)

as my attorney in fact (my agent) to act for me and in my name in any way I could act in person to make any and all decisions for me concerning my personal care, medical treatment, hospitalization, and health care and to require, withhold, or withdraw any type of medical treatment or procedure, even though my death may ensue. My-agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to make a disposition of any part or all of my body for medical purposes, authorize an autopsy of my body, and direct the disposition of my remains.

THE ABOVE GRANT OF POWER IS INTENDED TO BE AS BROAD AS POSSIBLE SO THAT YOUR AGENT WILL HAVE AUTHORITY TO MAKE ANY DECISION YOU COULD MAKE TO OBTAIN OR TERMINATE ANY TYPE OF HEALTH CARE, INCLUDING WITHDRAWAL OF NOURISHMENT AND FLUIDS AND OTHER LIFE-SUSTAINING OR DEATH-DELAYING MEASURES, IF YOUR AGENT BELIEVES SUCH ACTION WOULD BE CONSISTENT WITH YOUR INTENT AND DESIRES. IF YOU WISH TO LIMIT THE SCOPE OF YOUR AGENT'S POWERS OR PRESCRIBE SPECIAL RULES TO LIMIT THE POWER TO MAKE AN ANATOMICAL GIFT, AUTHORIZE AUTOPSY, OR DISPOSE

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OF REMAINS, YOU MAY DO SO IN THE FOLLOWING PARAGRAPHS.

2. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations (here you may include any specific limitations you deem appropriate, such as your own definition of when life-sustaining or death-delaying measures should be withheld; a direction to continue nourishment and fluids or other life-sustaining or death-delaying treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electroconvulsive therapy, or amputation):

\_\_\_\_\_

THE SUBJECT OF LIFE-SUSTAINING OR DEATH-DELAYING TREATMENT IS OF PARTICULAR IMPORTANCE. FOR YOUR CONVENIENCE IN DEALING WITH THAT SUBJECT, SOME GENERAL STATEMENTS CONCERNING THE WITHHOLDING OR REMOVAL OF LIFE-SUSTAINING OR DEATH-DELAYING TREATMENT ARE SET FORTH BELOW. IF YOU AGREE WITH ONE OF THESE STATEMENTS, YOU MAY INITIAL THAT STATEMENT, BUT DO NOT INITIAL MORE THAN ONE:

I do not want my life to be prolonged nor do I want life-sustaining or death-delaying treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved, and the quality as well as the possible extension of my life in making decisions concerning life-sustaining or death-delaying treatment.

Initialed \_\_\_\_\_

I want my life to be prolonged and I want life-sustaining or death-delaying treatment to be provided or continued unless I am in a coma, including a persistent vegetative state, which my attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered such an irreversible coma, I want life-sustaining or death-delaying treatment to be withheld or discontinued.

Initialed \_\_\_\_\_

I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery, or the cost of the procedures.

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Initialed \_\_\_\_\_

THIS POWER OF ATTORNEY MAY BE AMENDED OR REVOKED BY YOU AT ANY TIME AND IN ANY MANNER WHILE YOU ARE ABLE TO DO SO. IN THE ABSENCE OF AN AMENDMENT OR REVOCATION, THE AUTHORITY GRANTED IN THIS POWER OF ATTORNEY WILL BECOME EFFECTIVE AT THE TIME THIS POWER IS SIGNED AND WILL CONTINUE UNTIL YOUR DEATH AND WILL CONTINUE BEYOND YOUR DEATH IF ANATOMICAL GIFT, AUTOPSY, OR DISPOSITION OF REMAINS IS AUTHORIZED, UNLESS A LIMITATION ON THE BEGINNING DATE OR DURATION IS MADE BY INITIALING AND COMPLETING EITHER OR BOTH OF THE FOLLOWING:

3. ( ) This power of attorney shall become effective on \_\_\_\_\_ (insert a future date or event during your lifetime, such as court determination of your disability, incapacity, or incompetency, when you want this power to first take effect).

4. ( ) This power of attorney shall terminate on \_\_\_\_\_ (insert a future date or event, such as court determination of your disability, incapacity, or incompetency, when you want this power to terminate prior to your death).

IF YOU WISH TO NAME SUCCESSOR AGENTS, INSERT THE NAMES AND ADDRESSES OF SUCH SUCCESSORS IN THE FOLLOWING PARAGRAPH:

5. If any agent named by me shall die, become legally disabled, incapacitated, or incompetent, or resign, refuse to act, or be unavailable, I name the following (each to act successively in the order named) as successors to such agent:

\_\_\_\_\_

IF YOU WISH TO NAME A GUARDIAN OF YOUR PERSON IN THE EVENT A COURT DECIDES THAT ONE SHOULD BE APPOINTED, YOU MAY, BUT ARE NOT REQUIRED TO, DO SO BY INSERTING THE NAME OF SUCH GUARDIAN IN THE FOLLOWING PARAGRAPH. THE COURT WILL APPOINT THE PERSON NOMINATED BY YOU IF THE COURT FINDS THAT SUCH APPOINTMENT WILL SERVE YOUR BEST INTERESTS AND WELFARE. YOU MAY, BUT ARE NOT REQUIRED TO, NOMINATE AS YOUR GUARDIAN THE SAME PERSON NAMED IN THIS FORM AS YOUR AGENT.

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6. If a guardian of my person is to be appointed, I nominate the following to serve as such guardian:

\_\_\_\_\_  
(insert name and address of nominated guardian of the person)

7. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Signed \_\_\_\_\_

(Principal)

The principal has had an opportunity to read the above form and has signed the above form in our presence. We, the undersigned, each being over 18 years of age, witness the principal's signature at the request and in the presence of the principal, and in the presence of each other, on the day and year above set out.

Witnesses:

Addresses:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional witness required when health care agency is signed in a hospital or skilled nursing facility.

I hereby witness this health care agency and attest that I believe the principal to be of sound mind and to have made this health care agency willingly and voluntarily.

Witness:

\_\_\_\_\_  
Attending Physician

Address:

\_\_\_\_\_  
\_\_\_\_\_

YOU MAY, BUT ARE NOT REQUIRED TO, REQUEST YOUR AGENT AND SUCCESSOR AGENTS TO PROVIDE SPECIMEN SIGNATURES BELOW. IF YOU INCLUDE SPECIMEN SIGNATURES IN THIS POWER OF ATTORNEY, YOU MUST COMPLETE THE CERTIFICATION OPPOSITE THE SIGNATURES OF THE AGENTS.

Specimen signatures of agent and successor(s)

I certify that the signature of my agent and successor(s) is correct

\_\_\_\_\_  
(Agent)

\_\_\_\_\_  
(Principal)

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(Successor agent)	(Principal)
(Successor agent)	(Principal)

(b) The foregoing statutory health care power of attorney form authorizes, and any different form of health care agency may authorize, the agent to make any and all health care decisions on behalf of the principal which the principal could make if present and under no disability, incapacity, or incompetency, subject to any limitations on the granted powers that appear on the face of the form, to be exercised in such manner as the agent deems consistent with the intent and desires of the principal. The agent will be under no duty to exercise granted powers or to assume control of or responsibility for the principal's health care; but when granted powers are exercised, the agent will be required to use due care to act for the benefit of the principal in accordance with the terms of the statutory health care power and will be liable for negligent exercise. The agent may act in person or through others reasonably employed by the agent for that purpose but may not delegate authority to make health care decisions. The agent may sign and deliver all instruments, negotiate and enter into all agreements, and do all other acts reasonably necessary to implement the exercise of the powers granted to the agent. Without limiting the generality of the foregoing, the statutory health care power form shall, and any different form of health care agency may, include the following powers, subject to any limitations appearing on the face of the form:

- (1) The agent is authorized to consent to and authorize or refuse, or to withhold or withdraw consent to, any and all types of medical care, treatment, or procedures relating to the physical or mental health of the principal, including any medication program, surgical procedures, life-sustaining or death-delaying treatment, or provision of nourishment and fluids for the principal, but not including psychosurgery, sterilization, or involuntary hospitalization or treatment covered by Title 37;
- (2) The agent is authorized to admit the principal to or discharge the principal from any and all types of hospitals, institutions, homes, residential or nursing facilities, treatment centers, and other health care institutions providing personal care or treatment for any type of physical or mental condition, but not including psychosurgery, sterilization, or involuntary hospitalization or treatment covered by Title 37;
- (3) The agent is authorized to contract for any and all types of health care services and facilities in the name of and on behalf of the principal and to bind the principal to pay for all such services and facilities, and the agent shall not be personally liable for any services or care contracted for on behalf of the principal;

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- (4) At the principal's expense and subject to reasonable rules of the health care provider to prevent disruption of the principal's health care, the agent shall have the same right the principal has to examine and copy and consent to disclosure of all the principal's medical records that the agent deems relevant to the exercise of the agent's powers, whether the records relate to mental health or any other medical condition and whether they are in the possession of or maintained by any physician, psychiatrist, psychologist, therapist, hospital, nursing home, or other health care provider, notwithstanding the provisions of any statute or other rule of law to the contrary; and
- (5) The agent is authorized to direct that an autopsy of the principal's body be made; to make a disposition of any part or all of the principal's body pursuant to Article 6 of Chapter 5 of Title 44, the "Georgia Anatomical Gift Act," as now or hereafter amended; and to direct the disposition of the principal's remains. (Code 1981, § 31-36-10, enacted by Ga. L. 1990, p. 1101, § 1.)

**31-36-11. Applicability of chapter, principal with living will; priority of agent's authority.**

This chapter applies to all health care providers and other persons in relation to all health care agencies executed on and after July 1, 1990. This chapter supersedes all other provisions of law or parts thereof existing on July 1, 1990, to the extent such other provisions are inconsistent with the terms and operation of this chapter, provided that this chapter does not affect the provisions of law governing emergency health care. If the principal has a living will under Chapter 32 of this title, as now or hereafter amended, the living will shall not be operative so long as an agent is available who is authorized by a health care agency to deal with the subject of life-sustaining or death-delaying procedures for and on behalf of the principal. Furthermore, unless the health care agency provides otherwise, the agent who is known to the health care provider to be available and willing to make health care decisions for the patient has priority over any other person, including any guardian of the person, to act for the patient in all matters covered by the health care agency. (Code 1981, § 31-36-11, enacted by Ga. L. 1990, p. 1101, § 1.)

**31-36-12. Prior agency or act of agent not affected.**

This chapter does not in any way affect or invalidate any health care agency executed or any act of an agent prior to July 1, 1990, or affect any claim, right, or remedy that accrued prior to July 1, 1990. (Code 1981, § 31-36-12, enacted by Ga. L. 1990, p. 1101, § 1.)

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**31-36-13** DURABLE POWER OF ATTORNEY FOR HEALTH CARE **31-36-13**

**31-36-13. Construction of chapter in relation to Title 53.**

This chapter is wholly independent of the provisions of Title 53, relating to wills, trusts, and the administration of estates, and nothing in this chapter shall be construed to affect in any way the provisions of said Title 53. (Code 1981, § 31-36-13, enacted by Ga. L. 1990, p. 1101, § 1.)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement of Compliance for Nursing Facilities

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State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404 (b)(1):

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TN No. 95-034

Supersedes

TN No. New

Approval Date 3-8-96

Effective Date 7-1-95



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

CRITERIA FOR THE APPLICATION OF SPECIFIED REMEDIES FOR  
SKILLED NURSING AND INTERMEDIATE CARE FACILITIES  
(When and how each remedy is applied, the amounts of any fines,  
and the severity of the remedies)

See Attached Rules of Department of Medical Assistance, Chapter  
350-3. Attachment 4.35-A pages 1a through 1r.

**Sanctions for Nursing Facilities**

**Chapter 350-3**

**RULES  
OF  
DEPARTMENT OF MEDICAL ASSISTANCE**

**CHAPTER 350-3  
SANCTIONS FOR NURSING FACILITIES**

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**350-3-.01 Definitions.**

(1) "Complaint Investigation" means a survey or visit to determine the validity of allegations of resident abuse, neglect or misappropriation of resident property, or of other noncompliance with applicable federal and state requirements.

(2) "Deficiency" means a failure of compliance with a Program Requirement. The fact that a deficiency no longer exists at the time of the Survey or complaint investigation which identifies it shall not negate its status as a deficiency for the purpose of imposing a civil monetary penalty or requesting a Plan of Correction.

(3) "Finding" means a determination, as the result of a survey or complaint investigation of the facility, that noncompliance with a Program Requirement could or should have been prevented or has not yet been identified by the facility, is not being corrected by proper action by the facility, or cannot be justified by special circumstances unique to the facility or the resident.

(4) "Initial finding" means the first time that a deficiency or deficiencies is recorded by a surveyor as the result of a survey or complaint investigation. Initial findings may be records of deficiencies that occurred prior to the date of the survey visit even if the deficiencies no longer exist at the time of the current survey.

(5) "Monitor" means a person or organization placed in a facility by the Department or the State Survey Agency for the purpose of overseeing a facility's correction of deficiencies or to ensure orderly closure of a

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facility. A monitor shall have practical long-term care experience related to the aspect(s) for which the facility is being monitored.

(6) "Nursing Facility" means an institution (or a distinct part of an institution) which

(a) is primarily engaged in providing to residents

1. skilled nursing care and related services for residents who require medical or nursing care,

2. rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

3. on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and

(b) is not primarily for the care and treatment of mental diseases; and

(c) is enrolled as a provider in the Georgia Medical Assistance program.

(7) "Program Requirement" means any requirement contained in Subsection 1919(b), (c), or (d) of the Social Security Act of 1935, as amended, including but not limited to the provisions implemented by the Omnibus Budget Reconciliation Act of 1987, P.L. 100-203.

(8) "Repeat deficiency" is a deficiency related to resident care which recurs within eighteen (18) months of its citing in an Initial Finding, and which is found at a follow-up visit, complaint investigation, subsequent survey, or otherwise.

(9) "Repeated noncompliance" means a finding of substandard quality of care on three (3) consecutive annual surveys.

(10) "Resurvey" means a follow-up visit to determine whether the deficiencies found in a survey or complaint investigation have been corrected.

(11) "Scope" means the frequency, incidence, or extent of the occurrence of a deficiency in a facility.

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(12) "Severity is the seriousness of a deficiency, which means the degree of actual or potential negative impact on a resident (as measured by negative outcomes or rights violations) or the degree to which his/her highest practicable physical, mental, or psychosocial well-being has been compromised.

(13) "State Survey Agency" means the Georgia Department of Human Resources.

(14) "Subsequent finding" means a violation or deficiency found on a resurvey. The deficiency must exist at the time of the resurvey or revisit. If a deficiency cited in an Initial Finding is found upon resurvey or revisit, a rebuttable presumption arises that the deficiency continued throughout the period of time between the initial survey or visit and the resurvey or revisit.

(15) "Substandard quality of care" means a finding by the Department or the State Survey Agency of one or more deficiencies, the existence of which limit(s) the facility's ability to deliver adequate care or services.

(16) "Survey" means a review of a case-mix stratified sample of nursing facility residents to determine the quality of care furnished as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities, and social participation, and sanitation, infection control, and physical environment. Such survey shall include an exit interview in which the surveyor and the facility shall attempt to resolve any conflicts regarding findings by the surveyor(s).

(17) "Surveyor" means a professional authorized by the State Survey Agency to conduct surveys or complaint investigations to determine compliance with Program Requirements.

(18) "Termination of the facility's participation" means exclusion of a facility from participation as a provider under the Georgia State Plan for Medical Assistance as a result of one or more deficiencies.

Authority Ga. L. 1977, p. 384, et seq.; 394; O.C.G.A Sec. 49-4-142(a). Administrative History. Original Rule entitled "Definitions" was filed on April 11, 1978; effective May 1, 1978. Amended: Filed January 8, 1981; effective January 28, 1981. Repealed: ER. 350-3-0.3-.01 adopted. F. Oct. 5, 1989; eff. Sept. 29, 1989, the date of adoption, to remain in effect for 120 days or until adoption of a permanent Rule superseding said Emergency Rule, as specified by the Agency, Repealed: Permanent Rule of same title adopted. F. Oct. 4, 1989; eff. Nov. 1, 1989, as specified by the Agency,

**350-3-.02 Remedies.** If the Department finds that a facility does not or did not meet a Program Requirement governing nursing facilities,

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it may impose the following remedies, independently or in conjunction with others, subject to the provisions of this Chapter for notice and appeal.

- (a) Termination of the facility's participation.
- (b) Denial of Medicaid payments for services rendered by the facility to any recipient admitted to the facility after notice to the facility. This remedy shall remain in effect until the Department determines that the facility has achieved substantial compliance with all Program Requirements, or until another remedy is substituted for it. A facility subject to this remedy may request termination of the remedy on the ground that it has achieved substantial compliance with program requirements. The Department shall respond to the request by terminating the remedy, requesting additional information if documentation of substantial compliance is considered insufficient, or conducting a resurvey within twenty (20) days of receipt of the request. This remedy shall not be imposed with respect to temporarily hospitalized recipients previously residing in a facility placed on such notice who return to the facility after the date of notice, or with respect to residents who become Medicaid eligible after the date of notice and who resided in the facility prior to the date of notice.
- (c) Civil monetary penalties, as specified in Section .04. When penalties are imposed on a facility, such penalties shall be assessed and collected for each day in which the facility is or was out of compliance with a Program Requirement. Interest on each penalty shall be assessed and paid as specified in Section .04. For individuals, such penalties shall be assessed for each infraction, as described in Section .04(g).
- (d) Temporary management as specified in Section .05, to oversee operation of the facility and to assure the health and safety of the facility's residents while there is an orderly closure of facility or while improvements are made in order to bring the facility into compliance with all Program Requirements.
- (e) Closure of the facility and/or transfer of recipients to another facility, in the case of an emergency as described in Section .03(e).
- (f) Plan of Correction, to be drafted by the facility and submitted within a specified time to the Department. Each proposed Plan shall delineate the time and manner in which each deficiency is to be corrected. The Department shall review the proposed Plan and accept or

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reject the Plan by notice to the facility.

(g) Ban on admission of persons with certain diagnoses or requiring specialized care who are covered by or eligible for Medicare or Medicaid. Such bans may be imposed for all such prospective residents, and shall prevent the facility from admitting the kinds of residents it has shown an inability to care for adequately as documented by deficiencies.

(h) Ban on all Medicare and Medicaid admissions to the facility or to any part thereof. Such bans shall remain in effect until the Department determines that the facility has achieved substantial compliance with all Program Requirements, or until another remedy is substituted for it. A facility may request termination of this remedy in the manner described in (b) above. This remedy shall not be imposed with respect to temporarily hospitalized residents previously residing in a facility placed on such notice who return to the facility after the date of notice, or with respect to residents who become Medicaid eligible and who resided in the facility prior to the date of notice.

Authority Ga. L. 1977, pp. 384, 387; O.C.G.A. Sec. 49-4-142(a). Administrative History. Original Rule, entitled "Policy of Non-Discrimination," was filed on April 11, 1978; effective May 1, 1978. Repealed: ER. 350-3-0.3-02 adopted. F. Oct. 5, 1989; eff. Sept. 29, 1989, the date of adoption, to remain in effect for 120 days or until adoption of a permanent Rule superseding said Emergency Rule, as specified by the Agency. Repealed: Permanent Rule entitled "Remedies" adopted. F. Oct. 4, 1989; eff. Nov. 1, 1989, as specified by the Agency.

**350-3-.03 Imposition of Remedies.** In determining which remedy to impose, the Department shall consider the facility's compliance history, change of ownership, and the number, scope, and severity of the deficiencies. Subject to these considerations, the Department shall impose those remedies described in Section .02 most likely to achieve correction of the deficiencies.

(a) Immediate jeopardy. If the Department finds that the facility's deficiency or deficiencies immediately jeopardize(s) the health or safety of its residents, the Department shall:

1. appoint temporary management and impose one or more of the remaining remedies specified in Section .02; or
2. terminate the facility's Medicaid participation and, at its option, impose one or more of the remaining remedies specified in Section .02.

(b) Absence of immediate jeopardy. If the Department finds that the facility's deficiency or deficiencies do not immediately jeopardize resident health or safety, the Department may impose one or more of the

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remedies specified in Section .02.

(c) Repeated noncompliance. If the Department makes a determination of repeated noncompliance with respect to a facility, it shall deny payment for services to any individual admitted to the facility after notice to the facility. Additionally, the Department shall monitor the facility on-site on a regular, as-needed basis, (as provided in Section .06), until the facility has demonstrated to the Department's satisfaction that it is in compliance with all Program Requirements governing facilities and that it will remain in compliance.

(d) Delayed compliance. If a facility has not complied with any Program Requirement within three (3) months of the date the facility is found to have been out of compliance with such Requirement, the Department shall impose the remedy of denial of payments for services to all individuals admitted after notice to the facility.

(e) Emergencies. When the Department has determined that residents are subject to an imminent and substantial danger, it may order either closure of the facility or transfer of the recipients to another facility. The Department shall give notice of any such proposed remedy to the facility, the residents who will be affected or their representatives, the affected residents' next-of-kin or guardians, and all attending physicians. When either of these remedies is imposed, no Administrative Review shall be available and the provisions of Subsection .09(2) shall apply.

(f) Conflict of remedies. In the case of facilities participating in both Medicare and Medicaid which have been surveyed by both the State Survey Agency and the Health Care Financing Administration, or whose certification documents have been reviewed by both, and for whom the State Survey Agency and the Health Care Financing Administration disagree on the decision to impose a remedy or the choice of a remedy, the decision of the Health Care Financing Administration with regard to Medicare shall apply.

Authority Ga. L. 1977, pp. 384,394; O.C.G.A. Sec. 49-4-142(a). Administrative History. Original Rule entitled "Incorporation of Existing Rules and Regulations" was filed on April 11, 1978; effective May 1, 1978. Repealed: ER. 350-3-0.3-03 adopted. F. Oct. 5, 1989; eff. Sept. 29, 1989, the date of adoption, to remain in effect for 120 days or until adoption of a permanent Rule superseding said Emergency Rule, as specified by the Agency. Repealed: Permanent Rule entitled "Imposition of Remedies" adopted. F. Oct. 4, 1989; eff. Nov. 1, 1989, as specified by the Agency.

**350-3-.04 Civil Monetary Penalties.** Civil monetary penalties shall be based upon one or more findings of noncompliance; actual harm to a resident or residents need not be shown. Nothing shall prevent the

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Department from imposing this remedy for deficiencies which existed prior to the survey or complaint investigation through which they are identified. A single act, omission, or incident shall not give rise to imposition of multiple penalties, even though such act, omission, or incident may violate more than one Program Requirement. In such cases, the single highest class of deficiency shall be the basis for penalty. Compliance by the facility at a later date shall not result in the reduction of the penalty amount. Civil monetary penalties and any attorneys' fees or other costs associated with contesting such penalties are not reimbursable Medicaid expenses except in the case where a facility prevails, in which case reasonable attorneys' fees and costs shall be allowable. Whenever such penalties are collected, the Department shall conduct a financial field audit to ensure that there has been, and will be, no Medicaid reimbursement associated with the penalties.

(a) Classification of deficiencies. The three classes of deficiencies upon which civil monetary penalties shall be based are as follows:

1. Class A: A deficiency or combination of deficiencies which places one or more residents at substantial risk of serious physical or mental harm.
2. Class B: A deficiency or combination of deficiencies, other than Class A deficiencies, which has a direct adverse affect on the health, safety, welfare, or rights of residents; or a failure to post notices issued by the Department of imposition of remedies;
3. Class C: A deficiency or combination of deficiencies, other than Class A or B deficiencies, which indirectly or over a period of more than thirty (30) days is likely to have an adverse affect on the health, safety, welfare, or rights of residents.

(b) Amounts. When Civil Monetary Penalties are imposed, such penalties shall be assessed for each day the facility is or was out of compliance. The amounts below shall be multiplied by the total number of beds certified for participation in the Medicare and Medicaid programs according to the records of the State Survey Agency at the time of the survey. Penalties shall be imposed for each class of deficiencies identified in a survey or complaint investigation.



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<u>Class</u>	<u>Initial Finding</u>	<u>Subsequent Finding</u>	<u>Repeat Deficiency</u>
A	\$ 10.00	\$ 15.00	\$ 20.00
B	5.00	7.50	10.00
C	1.00	1.50	3.00

In any ninety (90) day period, the penalty amounts may not exceed the applicable ceiling as described immediately below. The ceiling (Initial, Subsequent, or Repeat; shall be determined by which category has the largest percentage of the deficiencies cited in the survey or complaint investigation.

<u>Bed Size</u>	<u>Initial Finding</u>	<u>Subsequent Finding</u>	<u>Repeat Deficiency</u>
0 - 50	\$ 4,000	\$ 6,000	\$ 8,000
51 - 100	6,000	9,000	12,000
101 -150	8,000	12,000	16,000
151 or more	10,000	15,000	20,000

(c) Procedure for imposing civil monetary penalties. Civil monetary penalties shall be imposed as follows:

1. Within ten (10) business days of its discovery of a deficiency, the State Survey Agency shall deliver to the Department its recommendation for assessment of a penalty as a result of such deficiency.
2. The decision to assess the penalty shall be made by a person in the Department who is not the surveyor(s) or complaint investigator(s) who reported the deficiency.

(d) Notice. The Department shall give written notice to the facility of its imposition of any such penalty within ten (10) business days of its receipt of a recommendation by the State Survey Agency for the assessment of a penalty. The notice shall inform the facility of the amount of the penalty, the basis for its assessment, and the facility's appeal rights.

(e) Payment. Within fifteen (15) business days from the date the notice is received by the facility, the facility shall pay the full amount of

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the penalty or penalties unless the facility requests Administrative Review of the decision to assess the penalty or penalties. The amount of a civil monetary penalty determined through Administrative Review shall be paid within ten (10) business days of the facility's receipt of the Administrative Review decision unless the facility requests an Administrative Hearing. The amount of the civil monetary penalty determined through a hearing shall be paid within ten (10) business days of the facility's receipt of the hearing decision. Interest at the legal rate of interest established by Georgia law shall begin to run on the later of one (1) business day after:

1. the facility's receipt of notice of the penalty; or
2. the date of issuance of the Administrative Review or Hearing decision.

Failure of a facility to pay the entire penalty as specified in this paragraph shall result in an automatic final decision and no further administrative or judicial review or hearing shall be available to the facility.

(f) Collection of civil penalties. If a facility fails or refuses to pay a penalty within the time required, the Department may collect the penalty by subtracting all or part of the penalty amount plus interest from future medical assistance payments to the facility. Additionally, the Department may subtract a fee representing the actual administrative cost of collection. Nothing herein shall prohibit the Department from obtaining judicial enforcement of its right to collect penalties and interest thereon.

(g) Imposition against individuals. Each recipient resident's functional capacity shall be assessed by the facility using an instrument specified by the Department. A civil money penalty of \$1,000 per assessment shall be imposed by the Department against any individual who willfully and knowingly certifies a material and false statement in such assessment instrument or other documents used to support the assessment. A civil money penalty of \$5,000 per assessment shall be imposed by the Department against any individual who willfully and knowingly causes another individual to certify a material and false statement in such assessment instrument or other documents used to support the assessment. Any such penalty shall be imposed by written notice to the individual according to the same provisions as set forth in Paragraphs (c) through (e) of this Section regarding deficiencies.

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(h) Use of civil monetary penalties. The Department may use collected civil monetary penalties for the following purposes:

1. protecting the health or property of residents;
2. paying costs of relocating residents;
3. maintaining the operation of a nursing facility while deficiencies are corrected or the facility is being closed; and
4. reimbursing residents for personal funds lost, which reimbursement shall not adversely affect a person's Medicaid eligibility.

Authority Ga. L. 1977, p. 384, et seq.; O.C.G.A. Sec. 49-4-1421a). Administrative History. Original Rule entitled "Procedure for Adoption of Rules" was filed on April 11, 1978; effective May 1, 1978. Amended: Filed June 18, 1979; effective July 8, 1979. Amended: Filed April 29, 1982; effective May 19, 1982. Repealed: ER. 350-3-0.3-04 adopted. F. Oct. 5, 1989; eff. Sept. 29, 1989, the date of adoption, to remain in effect for 120 days or until adoption of a permanent Rule superseding said Emergency Rule, as specified by the Agency. Repealed: Permanent Rule entitled "Civil Monetary Penalties" adopted. F. Oct 4, 1989; eff. Nov. 1, 1989, as specified by the Agency.

**350-3-.05 Temporary Management.** The Department shall impose the remedy of temporary management in situations where it finds that there is a need to oversee operation of the facility and to assure the health and safety of the facility's residents while there is an orderly closure of the facility or while improvements are made in order to bring the facility into compliance with all Program Requirements. Temporary management shall not be imposed unless other less intrusive remedies will not result in compliance, have failed to cause the facility to achieve compliance, or the Department has found that the facility's deficiency or deficiencies immediately jeopardize the health or safety of its residents.

(a) Recommendation for appointment of temporary management. Within ten (10) business days of its completion of a survey or complaint investigation, the State Survey Agency shall deliver to the Department its written recommendation for appointment of temporary management if, in the Agency's judgment, such appointment is necessary. The recommendation shall specify the grounds upon which it is based, including an assessment of the capability of the facility's current management to achieve and maintain compliance with all Program Requirements.

(b) The decision to appoint temporary management shall be made by a person, appointed by the Commissioner, who is not the surveyor or complaint investigator who discovered the deficiencies or made the recommendation for appointment.

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(c) The Department shall give written notice to the facility of its appointment of temporary management within ten (10) business days of its receipt of a recommendation for appointment from the State Survey Agency, unless the Department determines that temporary management is not necessary. When the Department has determined that the facility's deficiency or deficiencies immediately jeopardize the health or safety of its residents, no Administrative Review shall be available and the provisions of Subsection .09(2) shall apply.

(d) Who may serve. The Commissioner may appoint any person or organization which meets the following qualifications:

1. The temporary manager shall not have any pecuniary interest in or pre-existing fiduciary duty to the facility to be managed.
2. The manager must not be related, within the first degree of kinship, to the facility's owner, manager, administrator, or other management principal.
3. The manager must possess sufficient training, expertise, and experience in the operation of a nursing facility as would be necessary to achieve the objectives of temporary management. The manager must possess a Georgia nursing home administrator's license.
4. The manager must not be an existing competitor of the facility who would gain an unfair competitive advantage by being appointed as temporary manager of the facility.

(e) Powers and duties of the temporary manager.

1. The temporary manager shall have the authority to direct and oversee the correction of Program Requirement deficiencies; to oversee and direct the management, hiring, and discharge of any consultant or employee, including the administrator of the facility; to direct the expenditure of the revenues of the facility in a reasonable, prudent manner; to oversee the continuation of the business and the care of the residents; to oversee and direct those acts necessary to accomplish the goals of the Program Requirements; and to direct and oversee regular accountings and the making of periodic reports to the Department. The temporary manager shall provide reports to the Department no less frequently than monthly showing the facility's compliance status. Should the facility fail or refuse to carry out the directions of the temporary

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manager, the Department shall terminate the facility's participation and may, at its discretion, impose any other remedies described in Section .02.

2. The temporary manager shall observe the confidentiality of the operating policies, procedures, employment practices, financial information, and all similar business information of the facility, except that the temporary manager shall make reports to the Department as provided in this section.

3. The temporary manager shall be liable for gross, willful or wanton negligence, intentional acts or omissions, unexplained shortfalls in the facility's funds, and breaches of fiduciary duty. The temporary manager shall be bonded in an amount equal to the facility's revenues for the month preceding the appointment of the temporary manager.

4. The temporary manager shall not have authority to do the following:

(i) To cause or direct the facility or its owner to incur debt or to enter into any contract with a duration beyond the term of the temporary management of the facility;

(ii) To cause or direct the facility to encumber its assets or receivables, or the premises on which it is located, with any lien or other encumbrance;

(iii) To cause or direct the sale of the facility, its assets, or the premises on which it is located;

(iv) To cause or direct the facility to cancel or reduce its liability or casualty insurance coverage;

(v) To cause or direct the facility to default upon any valid obligations previously undertaken by the owners or operators of the facility, including, but not limited to, leases, mortgages and security interests; and

(vi) To incur capital expenditures in excess of \$2,000.00 without the permission of the owner or the Commissioner.

(f) Costs. All compensation and per diem costs of the temporary manager shall be paid by the nursing facility. The Department shall bill the facility for the costs of the temporary manager after termination of

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temporary management. The costs of the temporary manager for any thirty (30) day period shall not exceed one-sixth of the maximum allowable administrator's annual salary for the largest nursing facility for Medicaid reimbursement purposes. Within fifteen (15) days of receipt of the bill, the facility shall pay the bill or request Administrative Review to contest the costs for which it was billed. Such costs shall be recoverable through recoupment from future medical assistance payments in the same fashion as a benefits overpayment. The costs of temporary management and the attorneys' fees associated with contesting such costs are not reimbursable Medicaid expenses except in the case where a facility prevails in a hearing, in which case reasonable attorneys' fees and costs shall be allowable.

(g) Termination of temporary management. The Commissioner may replace any temporary manager whose performance is, in the Commissioner's discretion, deemed unsatisfactory. No formal procedure is required for such removal or replacement but written notice of any action shall be given the facility, including the name of any replacement manager. A facility subject to temporary management may petition the Commissioner for replacement of a temporary manager whose performance it considers unsatisfactory. The Commissioner shall respond to a petition for replacement within three (3) business days after receipt of said petition. Otherwise, the Department shall not terminate temporary management until it has determined that the facility has management capability to ensure continued compliance with all Program Requirements or until the Department terminates the nursing facility's participation. A facility may petition the Department for termination of temporary management. The Department shall respond to the petition within three (3) business days after receipt.

(h) "Nothing contained in this section shall limit the right of any nursing facility owner to sell, lease, mortgage, or close any facility in accord with all applicable laws.

Authority Ga. L. 1977, p. 384, et seq.; O.C.G.A. Sec. 49-4-142(a). Administrative History. Original Rule entitled "Adoption of Rules" was filed on April 11, 1978; effective May 1, 1978. Repealed: ER. 350-3-0.3-.05 adopted. F. Oct. 5, 1989; eff. Sept. 29, 1989, the date of adoption, to remain in effect for 120 days or until adoption of a permanent Rule superseding said Emergency Rule, as specified by the Agency. Repealed: Permanent Rule entitled "Temporary Management\*" adopted. F. Oct. 4, 1989; eft. Nov. 1, 1989, as specified the Agency

**350-3-.06 Monitoring.**

(1) The Department shall maintain procedures and adequate staff on-site, on a regular, as-needed basis, to monitor the facility's operations, advise the facility in its effort to come into or maintain compliance,

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to report to the licensing agency, and to investigate complaints of violations which are not easily verified on one visit.

(a) One or more monitor(s) shall be placed in the nursing facility:

1. when it has been found on three (3) standard surveys that the nursing facility has provided substandard quality of care;
2. when the facility has been under temporary management;
3. to ensure that Class A & B violations have been and continue to be corrected; or
4. when the Department has reason to question a nursing facility's compliance.

(2) The Department shall bill the facility for the expenses of monitoring at the end of the monitoring process. Within fifteen (15) days of receipt of the bill, the facility shall pay the bill or request Administrative Review to contest the costs for which it was billed. Such expenses shall be recoverable through recoupment from future medical assistance payments in the same fashion as a benefits overpayment.

(3) In the event a monitor is already in a facility pursuant to the provisions of O.C.G.A. § 31-7-2.2(b), the Department may not place a monitor in the facility.

Authority Ga. L. 1977, p. 384, et seq., O.C.G.A. Sec. 49-4-142(a). Administrative History. Original Rule entitled "Imminent Threat" was filed on April 11, 1978; effective May 1, 1978. Repealed: ER. 350-3-0.3-.06 adopted. F. Oct. 5, 1989; eff. Sept. 29, 1989, the date of adoption to remain in effect for 120 days or until adoption of a permanent Rule superseding said Emergency Rule, as specified by the Agency, Repealed: Permanent Rule entitled "Monitoring" adopted. F. Oct. 4, 1989; eff. Nov. 1, 1989, as specified by the Agency.

**350-3-.07 Notice.**

(1) The Department shall give notice of the imposition of any remedy described in this Chapter as follows:

(a) To the facility in writing, transmitted in a manner which will reasonably ensure timely receipt by the facility.

(b) To the public by transmitting printed Notices to the facility. Such Notices shall be at least 11 1/2 inches by 17 1/2 inches in size and of sufficient legibility that they may reasonably be expected to be readable by the facility's residents or their representatives. A printed notice shall

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not be transmitted or required to be posted for a Plan of Correction.

(c) To the State Long-Term Care Ombudsman by placing copies with the U.S. Postal Service of all notices to the facility.

(d) To the State Survey Agency in writing.

(2) The facility shall post a sufficient number of the Notices described in Paragraph (1)(b) in places readily accessible and visible to residents and their representatives, including but not limited to entrances, exits, and common areas, to effectively advise all present and prospective residents of the remedies which are being imposed. The Notices shall remain in place until all remedies are officially removed by the Department. Failure of a facility to comply with notice posting requirements shall constitute a Class B deficiency.

(3) A facility shall post a Notice of Administrative Hearing date, time, and location whenever the facility has requested and been granted a hearing on imposition of a remedy. The notice shall be at least 11 1/2 inches by 17 1/2 inches in size and of sufficient legibility that it may reasonably be expected to be readable by the facility's residents or their representatives. The notice shall be placed in an area readily accessible and visible to residents and their representatives.

(4) The Department shall notify the attending physician of each resident with respect to whom a finding of substandard quality of care has been made, as well as the Board of Nursing Home Administrators, by transmitting to them copies of the survey or complaint investigation reports and any notice to the facility that a remedy has been imposed. The Department also may notify any other professional licensing boards, as appropriate.

(5) Failure of the Department to effect notice as required in Subsections (1)(b), (c), (d), or (4) shall not be grounds for the facility to contest any action taken under this Chapter.

(6) All nursing facilities shall advise staff of the penalties for making false statements or causing another person to make false statements in a resident assessment. A facility must document the manner in which staff are advised of the provisions of Rule 350-3-.04(g).

(7) The Department shall compile a list of facilities against which

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remedies other than a Plan of Correction have been imposed. The list shall be prepared monthly and be available upon request. The list shall contain the names and addresses of only those facilities which did not contest imposition of remedies or against which imposition was upheld upon appeal, and shall describe the remedies imposed.

Authority Ga. L. 1977, p. 384, et seq.; O.C.G.A Sec. 49-4-142(a). Administrative History. Original Rule entitled "Effective Date of Rules" was filed on April 11, 1978; effective May 1, 1978. Repealed: ER. 350-3-0.3-07 adopted. F. Oct. 5, 1989; eff. Sept. 29, 1989, the date of adoption, to remain in effect for 120 days or until adoption of a permanent Rule superseding said Emergency Rule, as specified by the Agency. Repealed: Permanent Rule entitled "Notice" adopted. F. Oct. 4, 1989; eff. Nov. 1, 1989, as specified by the Agency.

### 350-3-.08 Administrative Review.

(1) Should the facility wish to contest imposition of a remedy, other than a Plan of Correction and except as provided in Sections .03(e) and .05(c), a written request for Administrative Review must be received by the Department within ten (10) days of the facility's receipt of notice of imposition of the remedy. The request shall state specifically each remedy disputed and, for each disputed remedy, the specific basis of the dispute. For imposition of civil monetary penalties, it shall not be a valid basis for dispute that a deficiency no longer exists. The timely filing of a request shall stay imposition of the remedy pending the Administrative Review decision, except where the Department has determined there is immediate jeopardy to the health or safety of the residents in a facility, in which case the Department may impose the remedies described in Subsections.02(b), (g) or (h), as determined appropriate by the Department. If the facility fails to file a timely request, the decision to impose a remedy or remedies shall become final and no further administrative or judicial review or hearing shall be available.

(2) The reviewing official shall be a Department employee appointed by the Commissioner and shall have authority only to affirm the decision, to revoke the decision, to affirm part and to revoke part, to order an immediate survey of the facility, to change the classification of the civil monetary penalty (for example, from A to B), or to request additional information from the State Survey Agency, the facility, or both, the Long-Term Care Ombudsman, or the family or resident council of the facility. Additional information that is requested must be supplied within ten(10) business days from the date of notice to the party of whom it is requested. Reviewing official shall be without authority to compromise the dollar amount of any civil monetary penalty within a deficiency class,

(3) The Department shall issue a written decision within ten (10)

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business days of its receipt of the request for Administrative Review. The Review shall be made solely on the basis of the State Survey Agency recommendation, the survey report, the statement of deficiencies, any documentation the facility submits to the Department at the time of its Request, and information received as a result of a request made by the reviewing official. For the purposes of such Review, a hearing shall not be held and oral testimony shall not be taken. Correction of a deficiency or deficiencies shall not be a basis for favorable reconsideration of imposition of civil monetary penalties.

Authority Ga. L. 1977, p. 384, et seq.; O.C.G.A Sec. 49-4-142(a). Administrative History. Original Rule entitled "Promulgation of Rules" was filed on April 11, 1978; effective May 1, 1978. Repealed: ER. 350-3-0.3-.08 adopted, F. Oct. 5, 1989; eff. Sept. 29, 1989, the date of adoption, to remain in effect for 120 days or until adoption of a permanent Rule superseding said Emergency Rule, as specified by the Agency. Repealed: Permanent Rule entitled "Administrative Review" adopted. F. Oct. 4, 1989; eff. Nov. 1, 1989, as specified by the Agency.

**350-3-.09 Administrative Hearing.**

(1) Should the facility wish to appeal the Administrative Review decision for remedies described in Subsections.02(a), (b), (c), (g), and (h), and for Subsection (d) where no determination of immediate jeopardy has been made, it may request an administrative hearing. Subsequent correction of a deficiency or deficiencies shall not constitute a defense to the imposition of a remedy or remedies. The hearing request shall state specifically which portion(s) of the Administrative Review decision the facility contests. A hearing shall be granted only if Administrative Review was timely requested, and a written request for a hearing has been received by the State Survey Agency within ten (10) business days of the facility's receipt of the Administrative Review decision. Failure to file a timely request shall result in the Administrative Review decision becoming final, and no further administrative or judicial review or hearing shall be available.

(2) If the Department has imposed temporary management pursuant to the provisions of Subsection .05(c), or imposed either of the remedies specified in Subsection .02(e), the facility shall be entitled to a hearing which shall commence not less than five (5) nor more than ten (10) days after the facility's receipt of notice of imposition of said remedy or remedies. No Administrative Review shall be conducted in such cases and no request for hearing shall be required. The date, time, and location of the hearing shall be included in the Notice of imposition of the remedy or remedies. A facility may waive its right to a hearing by written notice to the State Survey Agency.

(3) Except for appointment of a temporary manager (unless the

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**Sanctions for Nursing Facilities**

Department has determined that immediate jeopardy to the health or safety of a facility's residents exists), termination of a facility's participation, closure of a facility, or payment of civil monetary penalties, the imposition of remedies shall not be stayed during the pendency of any hearing.

Authority Ga. L. 1977, p. 384, et seq.; O.C.G.A. Sec. 49-4-1421a). Administrative History. Original Rule entitled "Public Notice" was filed on April 29, 1982; effective May 19, 1982. Repealed: ER. 360-3-0.3-.09 adopted. F. Oct. 5, 1989; eff. Sept. 29, 1989, the date of adoption, to remain in effect for 120 days or until adoption of a permanent Rule superseding said Emergency Rule, as specified by the Agency. Repealed: Permanent Rule entitled "Administrative Hearing" adopted. F. Oct. 4, 1989; eff. Nov. 1, 1989, as specified by the Agency.

November 1, 1989 (Rev.)

TRANSMITTAL 89-41  
APPROVED 5-24-90  
EFFECTIVE 10-1-89  
Supersedes (NEW)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement compliance for Nursing facilities

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Termination of Provider Agreement: Describe the criteria (as required at §1919 (h) (2) (A)) for applying the remedy.

Specified Remedy  
(Will use the criteria and notice requirements specified in the regulation. )

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement compliance for Nursing facilities

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Termination Management: Describe the criteria (as required at §1919 (h) (2) (A)) for applying the remedy.

Specified Remedy  
(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy  
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement compliance for Nursing facilities

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Denial of Payment for New Admissions: Describe the criteria (as required at §1919 (h) (2) (A)) for applying the remedy.

Specified Remedy  
(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy  
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement compliance for Nursing facilities

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Civil Money Penalty: Describe the criteria (as required at §1919 (h) (2) (A)) for applying the remedy.

Specified Remedy  
(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy  
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement compliance for Nursing facilities

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State Monitoring: Describe the criteria (as required at §1919 (h) (2) (A)) for applying the remedy.

Specified Remedy  
(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy  
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement compliance for Nursing facilities

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Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919 (h) (2) (A)) for applying the remedy.

Specified Remedy  
(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy  
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement compliance for Nursing facilities

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Additional Remedies: Describe the criteria (as required at §1919(h) (2) (A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

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TN No. 95-034

Supersedes

TN No. New

Approval Date: 3-8-96

Effective Date: 7-1-95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

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TN No. 91-36

Supersedes

TN No. NEW

Approval Date: 4-14-92

Effective Date: 10-1-91

HCFA ID :

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

The name of the nurse aide training and competency evaluation program or competency evaluation program certifying competency is collected for administrative purposes only.

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TN No. 91-36

Supersedes

TN No. NEW

Approval Date: 4-14-92

Effective Date: 10-1-91

HCFA ID :

## STATE PLAN UNDER TITLE XXIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

## DEFINITION OF SPECIALIZED SERVICES

## I. Specialized Services Definition

## A. For Mental Illness

Specialized services are services that are specified by the State which, in combination with services provided by the nursing facilities, results in the continuous and aggressive implementation of an individualized plan of care that--

- (i) Is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professional and, as appropriate, other professionals.
- (ii) Prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness, which necessitates supervision by trained mental health personnel; and
- (iii) Treatment is directed toward stabilization and restoration of the level of functioning that preceded the acute episode.

## B. For Mental Retardation or Related Conditions

Specialized services are services that are specified by the State which, in combination with services provided by the nursing facilities or others service providers, results in treatment which includes aggressive, consistent implementation of specialized and generic training and related services by qualified mental health or mental retardation personnel that are directed toward—the acquisition of behaviors necessary for the client to function with as much self determination and independence as possible and to prevent deceleration of regression or loss of current optimal functional status.

## C. Specialized Services Under GA'S PASRR Program are:

**Crisis Intervention Services** – Immediate response and thorough assessment of an individual's (in an active state of crisis) risk factors, mental status, and medical stability and if necessary immediately intervene to de-escalate the crisis.

**Individual, Group, Family Training/Counseling** – Therapeutic intervention or counseling by a credentialed person that addresses behavior management, development or enhancement of specific skills.

**Physician Assessment and Care Services** - Specialized medical and/or psychiatric services that include, but not limited to, evaluation and assessment of physiological phenomena, psychiatric diagnostic evaluation, medical or psychiatric therapeutic services.

**In-Service Training Services** – Training for NF staff and assistance with skill development training classes for staff that will aid in the day-to-day provision of services recommended in individual's treatment plan.

**Skills Training Services (Rehab Supports/Therapy)** - Comprehensive rehabilitative services that aid in developing daily living skills, including interpersonal skills and behavior management skills.

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 TN No.: 04-014

Supersedes

TN No.: 96-019Approval Date: 03/01/2005Effective Date: 10/01/2004

## STATE PLAN UNDER TITLE XXIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

## DEFINITION OF SPECIALIZED SERVICES

**Day Support for Adults (Community Support)** - Environmental and targeted case management aimed at assisting the person in gaining access to necessary services with the intention of developing/restoring interpersonal and community coping skills, including adaptation to home, school and work environments that allow the individual to maintain stability and independence in their daily community living.

**Case Management (Assertive Community Treatment)** - Intensive case management service that assist individuals in identifying and gaining access to all specialized services. Included in the list of services are; medication administration and monitoring, crisis assessment and social rehabilitation and skill development, personal, social and interpersonal skill training, etc., designed to assist the individual in transitioning into a community based program.

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TN No.: 04-014

Supersedes

TN No.: New

Approval Date: 03/01/2005

Effective Date: 10/01/2004

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

## CATEGORICAL DETERMINATION

The State mental health or mental retardation authority makes determinations as to whether nursing facility level of services and specialized services are needed, based on an evaluation of data concerning the individual (42 CFR 483.130). The State mental health or mental retardation authority may make determinations either through an advance group (categorical) determination or an individualized determination. A categorical determination may be made in the circumstances listed below, when sufficient and current patient information is available to clearly indicate that admission to, or residence in, a NF is needed or that the provision of specialized services is not needed. An individualized determination is performed in all other circumstances in which a Level II evaluation is needed.

Categories that the State mental health or mental retardation authority will utilize to determine that nursing facility services are needed:

1. Convalescent care from an acute physical illness which requires hospitalization and does not meet all the criteria for an exempt hospital discharge (which is not subject to preadmission screening);
2. Terminal Illness, as defined for hospice purposes in 42 CFR Sec. 418.3 and Section 483.106(b)(2);
3. Severe physical illnesses such as coma, ventilator dependence, functioning at the brain stem level, or diagnoses such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis (ALS), and congestive heart failure which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services;
4. Provisional admissions pending further assessment in cases of delirium where an accurate diagnosis cannot be made until the delirium clears, not to exceed 7 days;
5. Provisional admissions pending further assessment emergency situations requiring protective services, with placement in a nursing facility not to exceed 7 days; and
6. Very brief and finite stays of up to 7 days to provide respite to in-home caregivers to whom the individual with MI or MR is expected to return following the brief NF stay.

Categories that the State mental health or mental retardation authority will utilize to determine that specialized services are not needed:

1. When admission is for situations 4., 5., and 6. above.
2. When dementia exists in combination with mental retardation or a related condition.

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TN No.: 04-014

Supersedes

TN No.: 96-019

Approval Date: 03/01/2005

Effective Date: 10/01/2004

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Survey and Certification Education Program

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The state has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

The state survey agency has, and will continue to have, surveyors and supervisory staff participate in and conduct training sessions sponsored by various provider groups, facility staff, disciplinary associations, consumer groups and ombudsman to provide education and training on federal regulatory requirements, guidelines, survey procedures.

During the survey process, surveyors routinely provide information about the regulations and policies to staff, residents and their representatives. In order to expand current educational opportunities, the survey agency is exploring distribution of selected videos to facilities for use with staff, residents and their representatives.

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TN No. 93-001

Supersedes

TN No. New

Approval Date 4-6-93

Effective Date 1-1-93

HCFA ID: \_\_\_\_\_



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Process for the Investigation of Allegations of Resident Neglect  
and Abuse and Misappropriation of Resident Property

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The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

The survey agency has a centralized intake and referral unit to receive all complaints including allegations of abuse, neglect or misappropriations of resident property. The intake unit has a toll-free number which is required to be posted in all nursing facilities.

Each complaint/allegation is reviewed by survey agency staff. Investigations are initiated and conducted based on the seriousness of the allegation, the information available from the facility and the potential for further harm to residents.

Allegations which are confirmed are referred to the appropriate licensing boards, law enforcement or the nurse aide registry after an opportunity for an administrative hearing, as provided in OBRA.

A detailed description of the investigative process is described in Policy and Procedure memorandums kept on file at the Office of Regulatory Services, Department of Human Resources.

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TN No. 93-001

Supersedes

TN No. New

Approval Date 4-6-93

Effective Date 1-1-93

HCFA ID: \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Procedures for scheduling and conduct of Standard Surveys

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The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

The policy of conducting unannounced surveys is stressed with each new surveyor during orientation, and the survey agency has implemented various means of protecting the confidentiality of its survey schedules. These procedures include:

- not telling anyone outside of the office of scheduled survey activities or allowing such unauthorized persons to see survey schedules or related information;
- exercising caution, especially during telephone calls, in answering questions from providers or others which might lead to sharing schedule related information;
- not taking schedules or related information into facilities while surveying;
- keeping schedules filed or stored out of sight. This includes not leaving schedules or related information exposed on desk tops, in boxes or stored in labelled folders on desk tops, work tables in bookcases;
- putting schedules out of sight when not working with them.
- removing schedules and related information from view when visitors are nearby;
- delivering schedules to appropriate staff in person or in a protected manner when placed in mailboxes (i.e. placed upside down, in envelopes, or underneath other materials); and
- developing any other means of safeguarding such information which individual situations might require. In addition, it is the practice of the survey agency to vigorously pursue any allegation that a facility was informed in advance of a survey visit.

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TN No. 93-001

Supersedes

TN No. New

Approval Date 4-6-93

Effective Date 1-1-93

HCFA ID: \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Programs to Measure and Reduce Inconsistency

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The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

The survey agency has a Quality Assurance program which is designed to prevent inconsistencies from one surveyor to another, from one region to another and from one program to another. All deficiencies cited during surveys are screened for consistency at two or more levels, and training programs are developed to address identified problems.

A detailed description of the Quality Assessment program is described in Policy and Procedure memorandums kept on file at the Office of Regulatory Services, Department of Human Resources.

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TN No. 93-001

Supersedes

TN No. New

Approval Date 4-6-93

Effective Date 1-1-93

HCFA ID: \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Process for Investigations of complaints and Monitoring

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The state has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

- (i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;
- (ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or
- (iii) the State has reason to question the compliance of the facility with such requirements.

Complaints

All complaints are received by a centralized intake and referral unit and referred to the Long Term Care Section for investigations as appropriate.

Complaints alleging a serious threat to patient/resident health and safety will be investigated onsite. Using complaint procedures established in the Medicare/Medicaid State Operations Manual (SOM), allegations are investigated based on priority and, whenever feasible, are investigated in conjunction with the next scheduled survey visit.

A copy of the survey agency's complaint process can be found in the internal policy and procedure memorandums kept on file in the Department of Human Resources' Office of Regulatory Services.

Monitoring

Consistent with the criteria in (i), (ii), and (iii) above, the section 350-3-.06 of the Department's Rules and Regulations specifies the process by which the Department monitors facilities, as needed. (See Attachment 4.35-A, Pages 1m and 1n.)

In addition, the survey agency will, upon request or independently, monitor a facility on-site when there is reason to question continued compliance.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Georgia

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EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERIES

The Georgia Department of Community Health will ensure compliance with 1902(a)(68) of the act by making compliance with the provision a condition of participation in the Medicaid and SCHIP programs. To make the provision a condition of participation, the Department will incorporate it within the Part One Policy and Procedures Manual for Medicaid/PeachCare for Kids (PeachCare is the SCHIP program in Georgia). The specific wording from 1902(a)(68) will be included in the policy so as to clearly demonstrate to entities if it is applicable to them. Notification will be forwarded to all entities through an electronic message, or *banner message*. . Policy is updated on a quarterly basis and entities that participate in the Medicaid/PeachCare program are expected to review these updates. When changes in policy occur, entities are expected to comply fully at the time the policy is issued.

Initially, entities that the policy applies to will be required submit a written attestation that they have complied with Section 1902(a)(68). The Department will determine if Section 1902(a)(68) is applicable to the entity. These are entities that meet the specifications during the Federal Fiscal Year 2006 (October 1, 2005 – September 30, 2006). Entities that substantially change their policy or new entities entering the program that meet the threshold, must submit their policy to the Department's Program Integrity Unit for approval.

Compliance and oversight of this policy will be accomplished by incorporating reviews for the specific requirements of 1902(a)(68) as standard operating procedure for Utilization Reviews. These reviews are both random and selected and are conducted on an ongoing basis. This method allows for the potential review of any entity participation in the program.

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TN No. 07-001

Supersedes

TN No. New

Approval Date 04/30/07

Effective Date 01/01/07

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: GEORGIA

**Provider Screening and Enrollment**

Citation	The State Medicaid agency gives the following assurances:
1902(a)(77) 1902(a)(39) 1902(kk); P.L. 111-148 and P.L. 111-152 42 CFR 455 Subpart E	<p><b>PROVIDER SCREENING</b></p> <p><u>  X  </u> Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.</p>
42 CFR 455.410	<p><b>ENROLLMENT AND SCREENING OF PROVIDERS</b></p> <p><u>  X  </u> Assures enrolled providers will be screened in accordance with 42 CFR 455.400 <i>et seq.</i></p> <p><u>  X  </u> Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.</p>
42 CFR 455.412	<p><b>VERIFICATION OF PROVIDER LICENSES</b></p> <p><u>  X  </u> Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.</p>
42 CFR 455.414	<p><b>REVALIDATION OF ENROLLMENT</b></p> <p><u>  X  </u> Assures that providers will be revalidated regardless of provider type at least every 5 years.</p>
42 CFR 455.416	<p><b>TERMINATION OR DENIAL OF ENROLLMENT</b></p> <p><u>  X  </u> Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.</p>
42 CFR 455.420	<p><b>REACTIVATION OF PROVIDER ENROLLMENT</b></p> <p><u>  X  </u> Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.</p>

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- 42 CFR 455.422      APPEAL RIGHTS  
\_\_X\_\_ Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.
- 42 CFR 455.432      SITE VISITS  
\_\_X\_\_ Assures that pre-enrollment and post-enrollment site visits of providers who are in “moderate” or “high” risk categories will occur.
- 42 CFR 455.434      CRIMINAL BACKGROUND CHECKS  
\_\_X\_\_ Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.
- 42 CFR 455.436      FEDERAL DATABASE CHECKS  
\_\_X\_\_ Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.
- 42 CFR 455.440      NATIONAL PROVIDER IDENTIFIER  
  
\_\_X\_\_ Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.
- 42 CFR 455.450      SCREENING LEVELS FOR MEDICAID PROVIDERS  
\_\_X\_\_ Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.
- 42 CFR 455.460      APPLICATION FEE  
\_\_X\_\_ Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.
- 42 CFR 455.470      TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS  
\_\_X\_\_ Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.

State of GeorgiaCITATION OF STATE LAWS, RULES, REGULATIONS AND POLICY STATEMENTS  
PROVIDING ASSURANCE OF CONFORMITY TO FEDERAL MERIT SYSTEM STANDARDS

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## GEORGIA CITATION LISTING - Grant Aided Agencies

## I. Constitutional Provisions

- A. Article XIV, Section I, Paragraph I, The Georgia Constitution (1945), Establishes the State Personnel Board.
- B. Article III, Section VII, Paragraph XXIV, The Georgia Constitution (1945), Amendment (1967) Establish preference for Veterans.

## II. Georgia Laws

- A. Act 81 (1975), Establishes the State Merit System to oversee activities in covered agencies.
- B. Act 1398 (1976), Amends Act 81 (1975).
- C. Act 1383 (1976), Amends Act 81 (1975).

## III. Rules and Regulations of the State Personnel Board (as amended to date).

## IV. Interpretive Memorandum issued by the Commissioner of Personnel Administrative (as released to date).

## V. Certain memorandum and letters of Authorization or understanding from the United States Civil Service Commission to the Georgia State Merit System.



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