

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



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

June 22, 2015

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

RE: Title XIX State Plan Amendment (SPA), Transmittal # GA 15-001

Dear Dr. Wiant:

We have reviewed the proposed Georgia State Plan Amendment 15-001, which was submitted to the Atlanta Regional Office on May 20, 2015. The SPA allows reimbursement to the federally qualified health centers and rural health centers for the purchase of long acting reimbursable contraceptives (LARCs) and separate reimbursement to the practitioners for the insertion of the LARCs.

Based on the information provided, the Medicaid State Plan Amendment 15-001 was approved on June 19, 2015. The effective date of this amendment is May 15, 2015. We are enclosing the approved HCFA-179 and the plan pages.

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

Sincerely,

A handwritten signature in black ink that reads "Jackie Glaze".

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

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

1. TRANSMITTAL NUMBER
15-001

2. STATE
GEORGIA

3. PROGRAM IDENTIFICATION: FQHC/RHC Long Acting Reversible Contraceptives (LARCs)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
May 15, 2015

5. TYPE OF PLAN MATERIAL (Check One):
 NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
Social Security Act Section 1902 (bb)

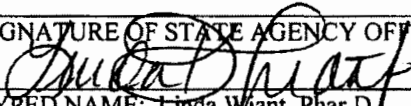
7. FEDERAL BUDGET IMPACT:
FFY 2015 \$ 592,759
FFY 2016 \$2,766,209

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):
Attachment 4.19B Pages 1b, 1b (a), 5q and 5q (a)

10. SUBJECT OF AMENDMENT: FQHC and RHC Reimbursement for the Purchase of LARCs

11. GOVERNOR'S REVIEW (Check One):
 GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: Governor's Office review is not required.
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Linda Wiant, Phar.D.
14. TITLE: Chief, Division of Medical Assistance Plans
15. DATE SUBMITTED:

16. RETURN TO:
Department of Community Health
Division of Medicaid
2 Peachtree Street, NW, 36th Floor
Atlanta, Georgia 30303-3159

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 05-20-15

18. DATE APPROVED: 06-19-15

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
05-15-15

20. SIGNATURE OF REGIONAL OFFICIAL:


21. TYPED NAME: Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children Health Opns

23. REMARKS: Approved with following changes to block # 8 and 9 authorized by the state on e-mail dated 06/01/15.
Block # 8 changed to read: Attachment 4.19-B pages 1b, 1b(a), 5q and 5q(a)new.
Block# 9 changed to read: Attachment 4.19-B pages 1b, 1b(a) and 5q.

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

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
OR SERVICES

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.