

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 a health center receiving funds under section 329, 330, or 340 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.

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Supersedes Approval Date 6/9/92 Effective Date 1/1/92
TN No. 90-20

HCFA ID: 7986E

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.

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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

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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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SUPERSEDES 92-28

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 or 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 of 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.

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SUPERSEDES (NEW)

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.

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2.b. RURAL HEALTH CLINIC SERVICES

Limitations

Services are subject to retrospective reduction or denial if adequate medical justification is not provided in medical records. Other ambulatory services such as dental, pharmacy, EPSDT, etc., are subject to limitations specific to the individual program.

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.

2.c. FEDERALLY QUALIFIED HEALTH CENTERS (COMMUNITY HEALTH CENTER SERVICES (CHCS))

Limitations

Services are subject to retrospective reduction or denial if adequate medical justification is not provided in medical records. Other ambulatory services such as dental, pharmacy, EPSDT, etc., are subject to limitations specific to the individual program.

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.

3. OTHER LABORATORY AND X-RAY SERVICES as prescribed in 42 CFR 440.30.

Non-Covered Services

1. X-ray services furnished by a portable x-ray service.
2. Services provided in laboratories or x-ray facilities which do not meet the definition of an independent laboratory or x-ray facility.
3. Services or procedures referred to another testing facility.
4. Services furnished by a state or public laboratory.

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SUPERSEDES 89-30

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.

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SUPERSEDES (NEW)
Received: 6/13/90

- 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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Supersedes

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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.

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.

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Supersedes

TN No.: 07-008Approval Date: 08-10-11Effective Date: 10/01/10

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).

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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.

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 X 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 X With Limitations

4d. Tobacco Cessation Counseling Services for Pregnant Women

Provided: _____ No limitations X 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 X 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 X 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 X With Limitations

• Description provided on attachment.

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Supersedes
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4.c. FAMILY PLANNING SERVICES

Limitations

Family planning clinics must meet standards set forth in the Memorandum of Agreement between the Division of Physical Health, Georgia Department of Human Resources, and Medicaid administration.

Initial and annual family planning examinations are provided to include complete patient history and pelvic examination with the following evaluative services:

Breast examination.

Hemoglobin or hematocrit.

Blood pressure.

Urinalysis for sugar and protein.

Pap smear when appropriate.

Culture for N. gonorrhoea when appropriate.

Serologic test for syphilis when appropriate.

Pregnancy test if indicated.

Discussion and distribution of a contraceptive method is included.

Intrauterine device monitoring, if IUD is present.

Physician Office Visits

The Medicaid Program covers two office visits and 12 laboratory tests per recipient per fiscal year to a physician for pure family planning purposes. Examples of "pure" family planning procedures are IUD insertion/removal, diaphragm fitting, vasectomy, tubal ligation, birth control pills, artificial insemination and laparoscopic procedures. Additional visits may be prior authorized when medically necessary.

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 contact records and case management.

TRANSMITTAL 89-52
APPROVED 3.9.90
EFFECTIVE 11.1.89
SUPERSEDES 87-12

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.

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Supersedes
TN No. : New

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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.

TN No. 09-010
Supersedes TN No. 09-004 Approval Date: 03-15-10 Effective Date: 10-09-09

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-anatitrypsin 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.

5a PHYSICIAN SERVICES (continued)

Non-Covered Services

- 1. Cosmetic surgery
- 2. Services provided by a portable x-ray service.
- 3. Laboratory services furnished by the state or a public laboratory
- 4. 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.
- 5. 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. 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 any podiatrist for office visits that exceed 12 per recipient per calendar year except in the case of EPSDT recipients for whom additional medical necessity services must be documented and provided to the Department.
- 2. 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.
- 3. The Medicaid program will not provide reimbursement to a podiatrist for more than one inpatient hospital visit per recipient per day of hospitalization.
- 4. 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.
- 5. Reimbursement for injectable drugs is restricted to those listed in the Physicians' Injectable Drug List.

Prior Approval

Ail 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.

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Supersedes TN No.	<u>03-006</u>				

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 provided by a portable x-ray service.
3. Services performed outside the scope of the practice of Podiatry as outlined in the applicable State law.
4. Experimental services or procedures or those which are not recognized by the profession or the U.S. Public Health Service as universally accepted treatment.
5. 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.
6. 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.

TRANSMITTAL 91-41
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EFFECTIVE 11-1-91
SUPERSEDES 89-32

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 ± 1.00 diopter, in any meridian.
2. Lenses with less than a ± 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).

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APPROVED 10-22-92
EFFECTIVE 10-01-92
SUPERSEDES 92-20

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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TN No. 92-033

State/Territory: GEORGIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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. Psychologists' Services
 Not provided.

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*

c. Medical supplies, equipment, and appliances suitable for use in the
home.

Provided: No limitations With limitations*

*Description provided on attachment.

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Supersedes 90-37 Approval Date 6/9/92 Effective Date 1/1/92
TN No. 90-37

HCFA ID: 7986E

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.

State/Territory: GEORGIA

**AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY**

- 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 OTIHER PRACTITIONER'S SERVICES

B. 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 Injectable Drug List.

Prior Approval

More than twelve medically necessary offices or nursing home visits per year (January 1 through December 31) for anyone recipient.

Non-Covered Services

1. Services provided by a portable x-ray service.
2. Laboratory services furnished by the State or a public laboratory.
3. 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.
4. Any procedure outside the legal scope of OB/GYN, CRNA, Adult, or Gerontological Nurse practitioner services
5. Services not covered under the physicians' program.

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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TN No. 91-45

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

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

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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. A 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:

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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 stale 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.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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.

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Supersedes
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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)

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SUPERSEDES 86-4

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.

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TN No. 89-034

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: 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: 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:

(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.

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TN No. 00-003

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.

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TN No. 01-018

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.

TN No.: 06-006
Supersedes
TN No.: NEW

Approval Date: 08/31/06 Effective Date: 07/01/06

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.

TRANSMITTAL 93-64
APPROVED 3-11-94
EFFECTIVE 7-1-93
SUPERSEDES NEW

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.

TN No. 93-44

Approval Date 3-11-94

Supersedes TN No. NEW

Effective Date 7-1-93

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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.

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 or weight gain.
- B) Agents used to promote fertility.
- C) Agents used for cosmetic purposes or hair growth.
- D) Agents used to promote smoking cessation.

Coverage of Smoking/Tobacco Cessation Drugs for Pregnant Women

The Medicaid agency will provide coverage of prescription and over-the-counter (OTC) tobacco/smoking cessation covered outpatient drugs for pregnant women as recommended in "Treating Tobacco Use and Dependence: 2008 A Clinical Practice Guideline" published by the Public Health Service in May 2008 or any subsequent modification of such guideline.

X Agents when used to promote smoking cessation (except that covered outpatient drugs shall be covered for pregnant women as recommended in "Treating Tobacco Use and Dependence: 2008 A Clinical Practice Guideline" published by the Public Health Service in May 2008 or any subsequent modification of such guideline)

X Nonprescription drugs (except that covered outpatient drugs shall be covered for pregnant women as recommended in "Treating Tobacco Use and Dependence: 2008 A Clinical Practice Guideline" published by the Public Health Service in May 2008 or any subsequent modification of such guideline)

12a. PRESCRIBED DRUGS (cont'd)

E) Drugs identified by the Health Care Financing Administration (HCFA) as less than effective (DESI), as provided under Section 1927(k)(2).

F) Barbiturates, except Seconal, Phenobarbital and Mebaral.

G) Legend Prescription Vitamins and Mineral Products with the following exceptions:

a) 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

H) 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)
- PEN-X
- KLOUT
- Vitamin E for recipients <21 years of age with documented medical necessity
- Coenzyme Q for recipients <21 years of age with documented medical necessity
- Ibuprofen suspension for members <21
- Diphenhydramine
- Insulin
- Meclizine
- Generic over-the-counter (OTC) non-sedating antihistamines, H-2 Receptor antagonists, topical antifungals and proton pump inhibitors.

To receive reimbursement for medications dispensed to ESRD patients, pharmacy providers must use only products from manufacturers participating in the drug rebate program. The following products are available to ESRD patients and require Prior Approval before dispensing:

Aluminum Hydroxide, Docusate Calcium, Docusate Sodium, and Sodium Bicarbonate. Please review the Preferred Drug List (PDL) for other ESRD drugs requiring Prior Approval at www.mmis.georgia.gov → Pharmacy → Other Documents.

12a. PRESCRIBED DRUGS (cont'd)

- I) Branded benzodiazepines and all formulations of Klonopin Wafer, Xanax XR, Niravam, and Doral are excluded. Most other generic benzodiazepines are covered with a limitation for adult members to three (3) prescriptions per rolling year. Prior approval with appropriate documentation is required to extend therapy beyond three (3) prescriptions per rolling year. Members <21 years of age are allowed access to all covered benzodiazepines without a prescription limit.
- J) Legend agents when used for the symptomatic relief of cough and colds for members 21 years of age and over.
- K) Legend Vitamin A derivatives for members ≥ 21 years old when used for cosmetic purposes.
- L) Agents prescribed for any indication that is not medically accepted.
- M) Drugs from manufacturers that do not have a signed rebate agreement.
- N) Any Medicare Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

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 submitted to CMS on September 25, 2009, 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 manufacturers' 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.

TN No: 09-006
Supersedes
TN No: 08-001

Approval Date: 09-25-09

Effective Date: 07-01-09

**Amendment to Supplemental Drug-Rebate Agreement
Between
The State of Michigan, First Health Services Corporation
And**

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: _____ 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 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, 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 1 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 (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 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: Teresa R. DiMarco, President
With a copy to: Legal Department
4300 Cox Road
Glen Allen, Virginia 23060

Notice to Manufacturer will be sent to:

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:

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 Peeples
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: _____

By: _____

Name: _____

Name: _____

Title: _____

Title: _____

Date: _____

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 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 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:

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.

TRANSMITTAL 91-46
APPROVED 1-28-92
EFFECTIVE 11-1-91
SUPERSEDES (NEW)

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.

TRANSMITTAL 92-20
APPROVED 7-1-92
EFFECTIVE 4-1-92
SUPERSEDES 87-16

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.

TN No. 93-025
Supersedes
TN No. 91-27

Approval Date 8-7-95

Effective Date 4-1-93

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 the 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

TN No. 02-002

Supersedes Approval Date

AUG 20 2002

Effective Date

JUL 01 2002

TN No. 00-020

13. a) **DIAGNOSTIC, b) SCREENING, c) PREVENTIVE SERVICES (continued)**

Non-Covered Services (continued)

Family Planning services

Radiological procedures performed by a portable x-ray service

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 reports, 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

TN No. 02-002

Supersedes Approval Date

AUG 20 2002

Effective Date

JUL 01 2002

TN No. 00-020

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.

TN No. 01-024

Supersedes

Approval Date

MAY 30 2002

Effective Date

JUL 01 2001TN No. 93-025

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.

TN No. 01-024

Supersedes

Approval Date

MAY 30 2002

Effective Date

JUL 01 2001TN No. 00-002

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 selfhelp, 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.

TN No. 01-024
Supersedes
TN No. 93-025

Approval Date

MAY 30, 2002

Effective Date

JUL 01 2001

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 selfhelp, 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.

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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 eligibles with mental illness and substance abuse 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 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/
- prevent the escalation of a problem 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 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 (CQL), and/or State certification. Additionally, where agencies provide services in a 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 and adhere to Georgia law and the scope of practice definitions of licensure boards.

The participants are given freedom of choice to choose a qualified, enrolled Provider Agency and practitioner within that agency. A toll-free access number provides information regarding the available services and providers to participants and family members seeking behavioral healthcare services. The Department of Behavioral Health & Developmental Disabilities regional and central 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.

Table of Practitioners Employed by Provider Agencies:

Professional Title	Minimum Level of Education/Degree/ Experience Required	License/ Certification Required	Supervision	State Code
Physician	Graduate of medical or osteopathic college	Licensed by the Georgia Composite Board of Medical Examiners	No. Additionally, can supervise others	43-34-20 to 43-34-37
Psychiatrist	Graduate of medical or osteopathic college and a residency in psychiatry approved by the American Board of Psychiatry and Neurology	Licensed by the Georgia Composite Board of Medical Examiners	No. Additionally, can supervise others	43-34-20 to 43-34-37
Physician's Assistant (PA)	Completion of a physician's assistant training program approved by the Georgia Composite Board of Medical Examiners -- at least 1 year of experience in behavioral healthcare required to supervise CPRP, CPS, or PP staff	Licensed by the Georgia Composite Board of Medical Examiners	Physician delegates functions through Board-approved job description.	43-34-100 to 43-34-108
Advanced Practice Registered Nurse (APRN): Clinical Nurse Specialist/Psychiatric-Mental Health (CNS-PMH) and Nurse Practitioner (NP)	R.N. and graduation from a post-basic education program for Nurse Practitioners Master's degree or higher in nursing for the CNS/PMH -- Nurse Practitioners must have at least 1 year of experience in behavioral healthcare to supervise CPRP, CPS, or PP staff	Current certification by American Nurses Association, American Nurses Credentialing Center or American Academy of Nurse Practitioners and authorized as an APRN by the Georgia Board of Nursing	Physician delegates advanced practice functions through Board-approved nurse protocol agreements.	43-26-1 to 43-26-13, 360-32
Licensed Pharmacist	Graduated and received an	Licensed by the Georgia	No	26-4

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	undergraduate degree from a college or school of pharmacy; completed a Board-approved internship and passed an examination.	State Board of Pharmacy		
Registered Nurse (RN)	Georgia Board of Nursing-approved nursing education program -- at least 1 year of experience in behavioral healthcare required to supervise CPRP, CPS, or PP	Licensed by the Georgia Board of Nursing	Physician	43-26-1 to 46-23-13
Licensed Practical Nurse (LPN)	Graduation from a nursing education program approved by the Georgia Board of Licensed Practical Nursing.	Licensed by Georgia Board of Licensed Practical Nursing	Physician or RN	43-26-30 to 43-26-43
Licensed Dietician (LD)	- Bachelor's degree or higher with a degree in dietetics, human nutrition, food and nutrition, nutrition education or food systems management. - Satisfactory completion of at least 900 hours of supervised experience in dietetic practice	Licensed by Georgia Board of Licensed Dieticians	No	43-11A-1 to 43-11A-19
Qualified Medication Aide (QMA)	Completion of a prescribed course conducted by the Georgia Department of Technical and Adult Education and pass examination for qualified medication aides approved by the Georgia Board of Licensed Practical Nursing.	Certified by the Georgia Board of Licensed Practical Nursing	Supervised by RN performing certain medication administration tasks as delegated by RN or LPN.	43-26-50 to 43-26-60
Psychologist	Doctoral Degree	Licensed by the Georgia Board of Examiners of Psychologists	No. Additionally, can supervise others	43-39-1 to 43-39-20
Licensed Clinical Social Worker (LCSW)	Masters degree in Social Work plus 3 years' supervised full-time work in the practice of social work after the Master's degree.	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	No. Additionally, can supervise others	43-10A
Licensed Professional Counselor (LPC)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	No. Additionally, can supervise others	43-10A
Licensed Marriage and Family Therapist	Master's degree	Licensed by the Georgia Composite Board of	No. Additionally, can supervise others	43-10A

TN No. 11-007
Supersedes
TN No. 07-004

Approval Date: 06-04-12

Effective Date October 1, 2011

(LMFT)		Professional Counselors, Social Workers, and Marriage and Family Therapists		
Licensed Master's Social Worker (LMSW)	Master's degree in Social Work	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Under direction and supervision of an appropriately licensed/credentialed professional.	43-10A
Licensed Associate Professional Counselor (LAPC)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Under direction and supervision of an appropriately licensed/credentialed professional	43-10A
Licensed Associate Marriage and Family Therapist (LAMFT)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Under direction and supervision of an appropriately licensed/credentialed professional	43-10A
Certified Clinical Alcohol and Drug Counselor (CCADC)	Master's degree; Also requires minimum of 2 years or 4,000 hours experience in direct alcohol and drug abuse treatment with individual and/or group counseling and a total of 270 hours of addiction-specific education and 300 hours of supervised training.	Certification by the Alcohol and Drug Certification Board of Georgia; International Certification and Reciprocity Consortium / Alcohol and Other Drug Abuse (IC&RC)	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Georgia Certified Alcohol and Drug Counselor Level III (GCADC III)	Master's degree; Also must have been certified by a national organization and have taken a written and oral examination in the past and must have been continuously certified for a period of 2 years; Must meet the standards outlined in the Ga. Code rules posted on the licensing board website: Perform the 12 core functions; Education and training; Supervised practicum; Experience and supervision	Certification by the Alcohol and Drug Certification Board of Georgia (ADACB-GA)	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Master Addiction Counselor (MAC) National Board of Certified Counselors (NBCC)	Master's Degree Documentation of a minimum of 12 semester hours of graduate coursework in the area of OR 500 CE hours	Certification by the National Board of Certified Counselors (NBCC) Nationally Certified Counselor	Services limited to those practices sanctioned by the certifying board and shall in any event be	43-10A-7

TN No. 11-007
Supersedes
TN No. 07-004

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Effective Date October 1, 2011

	specifically in addictions. Three years supervised experience as an addictions counselor at no fewer than 20 hours per week. Two of the three years must have been completed after the counseling master's degree was conferred. A passing score on the Examination for Master Addictions Counselors (EMAC).	(NCC) credential – must be Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	limited to the provision of chemical dependency treatment	
Master Addiction Counselor, (MAC) through National Association of Alcohol and Drug Counselors, (NAADC)	Master's degree; 500 contact hours of specific alcoholism and drug abuse counseling training). Three years full-time or 6,000 hours of supervised experience, two years or 4,000 hours of which must be post master's degree award. Passing score on the national examination for the MAC	Certification by the National Association Alcohol & Drug Counselors' Current state certification /licensure in alcoholism and/or drug abuse counseling. Passing score on the national examination for the MAC	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Certified Alcohol and Drug Counselor (CADC)	Bachelor's degree; Also requires minimum of 2 years or 4,000 hours experience in direct alcohol and drug abuse treatment with individual and/or group counseling and a total of 270 hours of addiction-specific education and 300 hours of supervised training	Certification by the Alcohol and Drug Certification Board of Georgia (ADACB-GA) International Certification and Reciprocity Consortium / Alcohol and Other Drug Abuse (IC&RC)	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Georgia Certified Alcohol and Drug Counselor II (GCADC II)	Bachelors degree; Must be certified by a national organization and have taken a written and oral examination; Must have been continuously certified for a period of 2 years; Must meet the standards outlined in the Ga. Code rules posted on the licensing board website: Perform the 12 core functions; Education and training; Supervised practicum; Experience and supervision	Certification by the Alcohol and Drug Certification Board of Georgia (ADACB-GA)	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Certified Addiction Counselor, Level II (CAC-II)	Bachelor's degree; Requires 3 years of experience in practice of chemical dependency/abuse counseling; 270 hours education in addiction field; and 144 hours	Certification by the Georgia Addiction Counselors' Association	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the	43-10A-7

	clinical supervision		provision of chemical dependency treatment	
Certified Addiction Counselor, Level I (CAC-I)	High School Diploma/Equivalent; Requires 2 years of experience in the practice of chemical dependency/abuse counseling; 180 hours education in addiction field; and 96 hours clinical supervision.	Certification by the Georgia Addiction Counselors' Association	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment, Under supervision of a Certified Clinical Supervisor	43-10A-7
Registered Alcohol and Drug Technician I, II, III	High school diploma or its equivalent and must be enrolled in a junior college, college or university. Must document a minimum of one (1) year or two thousand (2000) hours experience of direct service (alcohol and drug counseling). Once the RADT has completed 30 college credit hours he/she is eligible to take the ICRC written exam. Upon passing the ICRC Written exam, a RADT-II certificate is issued. Once the RADT-II has completed 60 college credit hours, he/she is eligible to take the oral case presentation. Upon successful completion of the oral case presentation, receives a RADT-III certificate is issued. Upon completion of BS degree and experience a CADC will be issued	Registered/certified by the Alcohol and Drug Certification Board of	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment, Under supervision of a Certified Clinical Supervisor; CADC; CCADC, LPC, LCSW	43-10A-7
Addiction Counselor Trainees	High school diploma/equivalent and actively pursuing certification as CAC-I, CAC-II, RADT I, II, III; CADC or CCADC or other addiction counselor certification recognized by practice acts.	Employed by an agency or facility that is licensed to provide addiction counseling	Under supervision of a Certified Clinical Supervisor (CCS); CADC; CCADC	
Certified Psychiatric Rehabilitation Professional (CPRP)	High school diploma/equivalent, Associates Degree, Bachelor's Degree,	Certified by the US Psychiatric Rehabilitation	Under supervision of an appropriately licensed/credentialed	

TN No. 11-007
Supersedes
TN No. 07-004

Approval Date: 06-04-12

Effective Date October 1, 2011

	Graduate Degree with required experience working in Psychiatric Rehabilitation (varies by level and type of degree)	Association (USPRA, formerly IASPRS)	professional	
Certified Peer Specialist (CPS)	Self-identified consumers who are in recovery from mental illness and/or substance use disorders; and High school diploma/equivalent	Certification by the Georgia Certified Peer Specialist Project Requires a minimum of 40 hours of Certified Peer Specialist Training (including, for examples, how to facilitate Recovery Dialogues and Utilize and teach problem solving techniques) and successful completion of a certification exam (which demonstrates competency in Recovery). A minimum of 6 hours of Continuing Education is required annually.	Services shall be limited to those not requiring licensure, but are provided under the supervision of an appropriately licensed/credentialed professional.	
Paraprofessional (PP)	College training in one of the behavioral or social sciences, or completion of standardized training program for paraprofessionals approved by the Department of Community Health.	Completion of a minimum of 40 hours of paraprofessional training and successful completion of all written exams and competency-based skills demonstrations.	Under supervision of an appropriately licensed/credentialed professional	

Limitations

Rehabilitation services do not include reimbursement for room and board and reimbursement will not be provided for services provided to individuals in an IMD. 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 12 weeks to 12 months. 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 External Review 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 comprehensive clinical assessment with the individual, which must include the individual's perspective, and may also include consumer-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 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.

Distinct Billable Services:

Description	Practitioners
Behavioral Health Assessment by a non-physician	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); 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 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).

Service Plan Development

The service plan development process results in a written, individualized service plan. The plan is formulated through a collaborative process with the individual that includes all necessary treatment and rehabilitative services. The individualized service plan includes the treatment objectives/outcomes, the expected frequency and duration of each service, the type of practitioner providing the service and its location, and the schedule of updates to the

TN No. 11-007
Supersedes
TN No. 07-004

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Effective Date October 1, 2011

individualized service plan. Service plans must be reviewed at least annually or when there is a change in the individual's service needs. Each service 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.

Distinct Billable Services:

Description	Practitioners
Mental Health Service Plan Development by a non-physician	<p>Practitioner Level 2: Psychologist, APRN, PA</p> <p>Practitioner Level 3: LCSW, LPC, LMFT, RN</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, 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, psychology, or criminology (addictions counselors may only perform these functions related to treatment of addictive diseases).</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).</p>

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 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.

TN No. 11-007

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TN No. 07-004

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Effective Date October 1, 2011

Distinct Billable Services:

Description	Practitioners
Psychiatric Diagnostic Examination	<p>Practitioner Level 1: Physician/Psychiatrist</p> <p>Practitioner Level 2: Psychologist CNS-PMH (Clinical Nurse Specialist in Psychiatric/Mental Health), Nurse Practitioner, Physician Assistant</p> <p>Practitioner Level 3: An RN who is a fully matriculated CNS-PMH (Clinical Nurse Specialist in Psychiatric/Mental Health), Nurse Practitioner, or Physician Assistant student in an approved nursing education program and who is an applicant for authorization for advanced practice nursing in accordance with the Official Code of GA.</p>
Interactive Psychiatric Diagnostic Interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication	<p>Practitioner Level 1: Physician/Psychiatrist</p> <p>Practitioner Level 2: Psychologist CNS-PMH (Clinical Nurse Specialist in Psychiatric/Mental Health), Nurse Practitioner, Physician Assistant</p> <p>Practitioner Level 3: An RN who is a fully matriculated CNS-PMH (Clinical Nurse Specialist in Psychiatric/Mental Health), Nurse Practitioner, or Physician Assistant student in an approved nursing education program and who is an applicant for authorization for advanced practice nursing in accordance with the Official Code of GA.</p>
Psychological Testing – Psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology e.g. MMPI, Rorschach, WAIS (per hour of psychologists or physicians time, both face-to-face with the patient and times interpreting test results and preparing the report)	Practitioner Level 2: Psychologist
Psychological Testing – Psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (e.g. MMPI, Rorschach, WAIS) with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face.	<p>Practitioner Level 3: LCSW, LPC, LMFT in conjunction with Psychologist</p> <p>Practitioner Level 4: 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</p>

Crisis Intervention Services

This service entails a face-to-face short-term intervention with individuals in an active state of crisis. Interventions include a brief, situational assessment; verbal interventions to de-

TN No. 11-007
Supersedes
TN No. 07-004

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Effective Date October 1, 2011

escalate the crisis; assistance in immediate crisis resolution; mobilization of natural 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 Service 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 consumer'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 consumer is located outside the clinic.

Distinct Billable Services:

Description	Practitioners
Crisis Intervention Services	Practitioner Level 1: Physician/Psychiatrist Practitioner Level 2: Psychologist, Advanced Practice Registered Nurse (APRN), Physician's Assistant (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); 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 (addictions 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).

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 service plan through

TN No. 11-007
Supersedes
TN No. 07-004

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Effective Date October 1, 2011

pharmacological management and individual psychotherapeutic services coupled with medical evaluation and pharmacological management. 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
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately <u>20-30 minutes</u> face-to-face with patient <u>with medical evaluation and management services.</u>	Practitioner Level 1: Physician/Psychiatrist
	Practitioner Level 2: CNS-PMH (Clinical Nurse Specialist in Psychiatric/Mental Health)
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately <u>45-50 minutes</u> face-to-face with patient <u>with medical evaluation and management services.</u>	Practitioner Level 1: Physician/Psychiatrist
	Practitioner Level 2: CNS-PMH (Clinical Nurse Specialist in Psychiatric/Mental Health)
Pharmacological Management	Practitioner Level 1: Physician/Psychiatrist
	Practitioner Level 2: PA or APRN (if authority to perform this task is delegated by physician through approved job description or protocol)

Nursing Assessment and Care

Nursing Assessment and Care services are face-to-face contacts with a consumer to monitor, evaluate, assess, establish nursing goals, and/or carry out physicians' orders regarding treatment and rehabilitation of the physical and/or behavioral health problems of a consumer as specified in the individualized service plan. It includes providing special nursing assessments to observe, monitor and care for physical, nutritional and psychological issues, problems, or crises manifested in the course of the consumers 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 consumer's family and/or significant others for the benefit

TN No. 11-007
Supersedes
TN No. 07-004

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Effective Date October 1, 2011

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	Practitioners
Nursing Assessment / Evaluation	Practitioner Level 2: Advanced Practice Registered Nurse (APRN) Practitioner Level 3: Registered Nurse (RN), Practitioner Level 4: Licensed Practical Nurse (LPN)
RN Services, up to 15 minutes	Practitioner Level 2: Advanced Practice Registered Nurse (APRN) Practitioner Level 3: Registered Nurse (RN)
LPN/LVN Services, up to 15 minutes	Practitioner Level 4: Licensed Practical Nurse (LPN)
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 2: Advanced Practice Registered Nurse (APRN) Practitioner Level 3: Registered Nurse (RN), Licensed Dietician (LD) Practitioner Level 4: Licensed Practical Nurse (LPN)
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 2: Advanced Practice Registered Nurse (APRN) Practitioner Level 3: Registered Nurse (RN), Licensed Dietician (LD) Practitioner Level 4: Licensed Practical Nurse (LPN)
Health and Wellness Supports (Behavioral Health Prevention Education Service (Delivery Of Services With Target Population To Affect Knowledge, Attitude and/or Behavior)	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

TN No. 11-007
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TN No. 07-004

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Effective Date October 1, 2011

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) Practitioner Level 4: Licensed Practical Nurse (LPN)
Alcohol and/or drug services; Sub-acute Detoxification (Residential Addiction Program Outpatient)	Level I (license is not required in State law) <ul style="list-style-type: none"> • 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 Level II (licensed by the State's Health Facilities Regulation authority as a Drug Treatment and Prevention program) <ul style="list-style-type: none"> • Practitioner Level 1: Physician/Psychiatrist

TN No. 11-007
Supersedes
TN No. 07-004

Approval Date: 06-04-12

Effective Date October 1, 2011

	<ul style="list-style-type: none"> • 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
Alcohol and/or drug services; Acute Detoxification (Residential Addiction Program Outpatient)	<p>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)</p> <ul style="list-style-type: none"> • 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	Practitioner
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately <u>20-30 minutes</u> face-to-face with patient (appropriate license required)	Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 2 rate)
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately <u>45-50 minutes</u> face-to-face with patient (appropriate license required)	Practitioner Level 2: Psychologist, CNS-PMH
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately <u>75-80 minutes</u> face-to-face with patient (appropriate license required)	Practitioner Level 3: LCSW, LPC, LMFT, RN
Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately <u>20-30 minutes</u> face-to-face with patient (appropriate license required)	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, 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).
Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately <u>45-50 minutes</u> 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 <u>75-80 minutes</u> face-to-face with patient (appropriate license required)	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:

Description	Practitioners
Family Outpatient Services – Behavioral health counseling and therapy (with client present)	Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 2 rate)
Family Outpatient Services – Behavioral health counseling and therapy (without client present)	Practitioner Level 2: Psychologist, CNS-PMH
Family Psychotherapy without the patient present	Practitioner Level 3: LCSW, LPC, LMFT, RN
Conjoint Family Psychotherapy with the patient present	<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; 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>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).</p>
Family - Skills training and development	<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's supervisee/trainee with at least a</p>

	<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</p> <p>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</p>
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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 Practitioner Level 4: LMSW; LAPC; LAMFT;

TN No. 11-007
Supersedes
TN No. 07-004

Approval Date: 06-04-12

Effective Date October 1, 2011

<p>Group Psychotherapy other than of a multiple family group</p>	<p>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).</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).</p>
<p>Group Skills training and development</p>	<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'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</p> <p>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</p>

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.

TN No. 11-007
Supersedes
TN No. 07-004

Approval Date: 06-04-12

Effective Date October 1, 2011

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.

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Effective Date October 1, 2011

Distinct Billable Services:

Description	Practitioners
Intensive Family Intervention	<p>Practitioner Level 2: Psychologist, CNS-PMH (reimbursed at Level 3 rate)</p> <p>Practitioner Level 3: LCSW, LPC, LMFT, RN</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; 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).</p> <p>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</p>

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	Practitioners
Psychosocial Rehabilitation	<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>

TN No. 11-007
Supersedes
TN No. 07-004

Approval Date: 06-04-12

Effective Date October 1, 2011

	<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; 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</p> <p>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</p>
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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>

TN No. 11-007
Supersedes
TN No. 07-004

Approval Date: 06-04-12

Effective Date October 1, 2011

	<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,</p> <p>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</p>
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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	Practitioners
Community Support 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; 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</p>

TN No. 11-007

Supersedes

TN No. 07-004Approval Date: 06-04-12

Effective Date October 1, 2011

	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
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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

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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 & 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	Practitioners
Peer Support	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
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: CPSs with at least a Bachelor's degree Practitioner Level 5: CPS

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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"> • 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

	<p>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.</p> <ul style="list-style-type: none"> • 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.
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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

	<p>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</p> <p>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</p>
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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	Practitioners
Assertive Community Treatment	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

State/Territory: GEORGIA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S): ALL

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*
 Not provided

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions:

X Provided: No limitations X With limitations*
 Not provided

16. Inpatient psychiatric facility services for individuals under 21 years of age (Psychiatric Residential Treatment Facilities):

X Provided: X No limitations With limitations*
 Not provided

(Description on Attachment 3.1A, page 7a.1)

17. Nurse-midwife services:

X Provided: No limitations X With limitations*
 Not provided

18. Hospice care (in accordance with section 1905(o) of the Act):

X Provided: No limitations X With limitations*
 Not provided

*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.

TN No. 04-001
Supersedes
TN No. 87-12

Approval Date 05/27/2004

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State/Territory: GEORGIA

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.

TN No.: 06-015

Supersedes:

Approval Date: 02/28/07

Effective Date: 01/01/07

TN No.: New

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 American 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, a subsequent period of 30 days, and a 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.

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APPROVED 4-12-94
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SUPERSEDES 90-47

State/Territory: Georgia

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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: 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.

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Supersedes
TN No. 92-05

Approval Date 8-2-94 Effective Date 4-1-94

State/Territory: GEORGIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an ~~eligible~~ ^{eligible} provider (in accordance with section 1920 of the Act).

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.

CERTIFIED

23. Pediatric or family nurse practitioners' services.

Provided: No limitations With limitations*

*Description provided on attachment.

TN No. 92-03
Supersedes Approval Date 6/9/92 Effective Date 1/1/92
TN No. 87-18

HCFA ID: 7986E

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. 89-25 DATE/RECEIPT 9/28/88
SUPERSEDES DATE/APPROVED 4/18/89
TN No. 82-11 DATE/EFFECTIVE 2/1/88

- i.e., one who lives with neither family nor in a board and care home, a 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

TRANSMITTAL 91-23
APPROVED 10-24-91
EFFECTIVE 7-1-91
SUPERSEDES 88-25

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.

TRANSMITTED 91-17
APPROVED 6/7/91
EFFECTIVE 4/1/91
SUPERSEDES 88-25

20. Extended Services to Pregnant Women

POSTPARTUM SERVICES

- a.+1 Pregnancy-related and postpartum services are provided through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.

Definition of Service:

Postpartum visits consist of a maximum of two visits to be provided within 28 days following the mother's discharge from the hospital or birthing center. Components of these visits may include but are not limited to:

1. review of the history of the pregnancy and the delivery.
2. medical assessment of the woman's postpartum recovery.
3. evaluation of the infant's status to assess medical problems which may have occurred during or after delivery, feeding habits and general health problems.
4. evaluation of the social and environmental conditions of the home.
5. drawing blood from the infant for a metabolic screen, if needed.
6. health education on infant care, postpartum recovery and family planning.
7. Providers must make referrals for the provisions of EPSDT, WIC, family planning and prenatal and postpartum services, as may be indicated.

Limitations:

Providers of this service are limited to qualified medical professionals; physicians, nurse midwives, physician's assistants, nurse practitioners and registered nurses. Reimbursement is limited to two (2) postpartum home visits per recipient every 280 calendar days.

Provider Qualifications:

Enrollment is open to all providers who can meet the following requirements:

1. Staff performing the service must be physicians, nurse midwives, physician's assistants, nurse practitioners or registered nurses experienced in the provision of maternal and child health care and be fully licensed by the State of Georgia.
2. Staff must possess the clinical skills to complete a medical assessment of the postpartum woman and evaluate the medical status of the infant.
3. Providers must have the capability to perform these services in the recipient's home.

TRANSMITTAL 94-03
APPROVED 2-15-95
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SUPERSEDES 91-19

CHILDBIRTH 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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SUPERSEDES 91-19

State/Territory: GEORGIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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.

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Supersedes 87-6 Approval Date 6/9/92 Effective Date 1/1/92
TN No. 87-6

HCFA ID: 7986E

23. a. TRANSPORTATION

EMERGENCY AMBULANCE

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 institution to 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 (21) 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 the 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 (12) 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.

TRANSMITTA 92-38
APPROVED 12/18/92
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SUPERSEDES 89-51

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.

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No.: 04-009

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TN No.: 10-014
Supersedes
TN No.: 01-027

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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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MD

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 CATEGORICALLY 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) statewide (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, minibus, 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: Georgia

 NON-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

 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 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
MEDICALLY NEEDY GROUP(S): ALL

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

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 covered under the plan.
- Provided: No limitations 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).
- Provided: No limitations With limitations*
3. Other laboratory and x-ray services.
- Provided: No limitations 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.*
- Provided:
- c. Family planning services and supplies for individuals of childbearing age.
- Provided: No limitations With limitations*

* Description provided on attachment 3.1-A, limitations supplement.

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Supersedes
TN No. 92-05

Approval Date

OCT 04 2004

Effective Date

SEP 01 2004

*01-06
dn*

Supersedes
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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

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 X 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

Provided: No limitations With limitations*

b. Optometrists' Services

Provided: No limitations With limitations*

c. Chiropractors' Services

Provided: No limitations With limitations*

d. Other Practitioners' Services

Provided: No limitations 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.

Provided: No limitation With limitations*

b. Home health aide services provided by a home health agency.

Provided: No limitation With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: No limitations With limitations*

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*

*Description provided on attachment.

TN No: 01-06

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

8. Private Duty Nursing Services.

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

c. Prosthetic Devices.

Provided No limitation With limitation*

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.

TN No: 01-06

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

c. Intermediate care facility services

Provided: No limitations With limitations*

Not provided

15. 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.

Provided: No limitations With limitations*

Not provided

16. Inpatient psychiatric facility services for individuals under 21 years of age (Psychiatric Residential Treatment Facilities).

Provided: No limitations With limitations*

Not provided

Services are identical to categorically needy. See attachment 3.1A, pg 7a.1

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 With limitations*

Not provided

Description provided on attachment.

State/Territory: GEORGIA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY'NEEDY GROUP(S) : ALL

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.

TN No: 01-06

Approval Date OCT 15 2001 Effective Date 7/1/2001

Supersedes
TN No:92-03

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

ATTACHMENT 3.1-B
Page 8
OMB No. 0938-0193

State/Territory: GEORGIA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY'NEEDY GROUP(S): ALL

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 sanitoria.

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.

TN No: 01-06

Approval Date OCT 15 2001 Effective Date 7/1/2001

Supersedes
TN No: 87-6

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);

TN No.: 06-010

Supersedes

TN No.: New

Approved: 09/26/06

Effective Date: 07/01/06

(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.

TN No.: 06-010

Supersedes

TN No.: New

Approved: 09/26/06

Effective Date: 07/01/06

Supersedes
TN No: 86-27
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March 1987

HCFA ID: 1042P/0016P
ATTACHMENT 3.1-B
Page 9

State/Territory: GEORGIA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY'NEEDY GROUP(S): ALL

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

TN No: 01-06

Approval Date **OCT 15 2001** Effective Date 7/1/2001

Supersedes
TN No: 93-003
Supersedes
TN No: New

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 Ill 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.

TN No. 04-001

Supersedes

TN No. 84-19

Approval Date 05/27/2004 Effective Date 01/01/2004

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.

TN No. 04-001

Supersedes

TN No. ~~84-19~~ *NEW*

dn

Approval Date 05/27/2004 Effective Date 01/01/2004

STATE: Georgia

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.

TN No.: 06-010

Supersedes

TN No.: 98-001Approval Date: 09/26/06Effective Date: 07/01/06

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

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.

TRANSMITTAL 90-36
APPROVED 3-31-92
EFFECTIVE 7-1-90
SUPERSEDES 87-6

Citation

Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

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). This authority may *not* 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)

B. General Description of the Program and Public Process.

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

Georgia Better Health Care (GBHC) is a PCCM program for the State of Georgia. This program matches Medicaid aged, blind and disabled beneficiaries to a primary care provider (PCP). The PCP is responsible for coordinating health care services, including necessary referrals, and maintaining a 24-hour availability for beneficiaries. This SPA will incorporate a disease management component to GBHC, as an enhancement to the basic PCCM program. Through this enhanced PCCM program it is expected that health outcomes of the population will improve, while medical costs will decrease. The disease management program will include the following components:

- Patient and provider adherence to evidence-based clinical guidelines;
- Twenty -four hour call nurse;
- Provider education to improve adherence to clinical guidelines and total enrollee care;

- Enrollee education to improve self-management of their diseases/conditions

Citation

Condition or Requirement

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

- Claims analysis, including enrollee and provider profiling; and
- Clinical outcome measurements reporting and feedback to providers and enrollees on a scheduled basis.

2. The payment method to the contracting entity will be:

- i. fee for service;
- ii. capitation;
- iii. a case management fee;
- iv. a bonus/incentive payment;
- v. a supplemental payment, or
- vi. other. (Please provide a description below).

Primary Care Providers participating in GBHC will be paid fee for service (FFS) for medical services provided. In addition, PCPs will be paid a monthly case management fee for performing the case management functions expected of the PCP.

As part of the enhanced PCCM program, the disease management entity will be paid a monthly fee for case management services for face-to-face and ancillary contact. This rate will be triggered by a submitted monthly claim, ie, upon member receipt of services the disease management entity will submit a claim for the monthly all-inclusive rate. The rate will not be paid unless and until services are rendered, unlike prepaid capitation payments, which are paid monthly regardless of whether any services are rendered. The disease management entity will not be "at-risk" for the provision of medical services. The rate will be based on all case management services to be performed by the disease management entity on a monthly basis. Services other than case management services will be rendered by Medicaid providers and paid according to the State's fee schedule.

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.

Citation

Condition or Requirement

If applicable to this state plan, place a check mark to affirm the state has met *all* 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)).

- 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.
- ii. Incentives will be based upon specific activities and targets.
- iii. Incentives will be based upon a fixed period of time.
- iv. Incentives will not be renewed automatically.
- v. Incentives will be made available to both public and private PCCMs.
- vi. Incentives will not be conditioned on intergovernmental transfer agreements.
- vii. Not applicable to this 1932 state plan amendment.

CFR 438.50(b)(4)

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. *(Example: public meeting, advisory groups.)*

Georgia Better Health Care (GBHC) began on a limited basis in 1993. Throughout the design, initial implementation, and statewide expansion, the State has obtained and considered public comment from providers and recipients. As a PCCM program, GBHC operates concurrent with the CMO program Georgia Cares (GCS). An extensive public notice process, including numerous stakeholder meetings, was held in conjunction with the design of GCS and the resulting changes to the GBHC program, including the addition of a disease management component. The ongoing public input process established under GBHC will continue, including the Advisory Committee, staff liaisons and member surveys.

1932(a)(1)(A)

5. The state plan program will /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):

Citation	Condition or Requirement
	i. county/counties (mandatory) _____
	ii. county/counties (voluntary) _____
	iii. area/areas (mandatory) _____
	iv. area/areas (voluntary) _____

C. State Assurances and Compliance with the Statute and Regulations.

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. <u>N/A</u> The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met. |
| 1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A) | 2. <u>x</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>N/A</u> The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met. |

Citation	Condition or Requirement
1932(a)(1)(A) 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 for payments under any nonrisk contracts will be met. This section applies to nonrisk prepaid capitation plans. Under this contract the disease management entity will be paid on a FFS basis.
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. <ul style="list-style-type: none">• <u>SSI RECIPIENTS</u> - Aged, blind or disabled adults age 19 and above who receive Supplemental Security Insurance (SSI) benefits. This excludes residents of nursing homes, personal care homes, or mental health hospitals or other domiciliary facilities. <i>Previous eligibility groups listed for participation in GBHC PCCM will now be enrolled in Georgia Cares (GCS), according to the phased-in implementation schedule for GCS.</i> <i>For the enhanced PCCM disease management component, enrollment will be voluntary.</i>
	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> </u> Recipients who are also eligible for Medicare. 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. <u> </u> 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

Citation	Condition or Requirement
	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. <input checked="" type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> 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.*
- 1932(a)(2)
42 CFR 438.50(d)
2. Place a check mark to affirm if the state's definition of title V children is determined by:
- i. program participation,
 ii. special health care needs, or
 iii. both
- 1932(a)(2)
42 CFR 438.50(d)
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.

Citation

Condition or Requirement

1932(a)(2)
CFR 438.50 (d)

- i. yes
 ii. no

4. Describe how the state identifies the following groups of children who are exempt 42 from mandatory enrollment: (*Examples: eligibility database, self- identification*)

i. Children under 19 years of age who are eligible for SSI under title XVI;

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 the PCCM program, 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.

ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

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 the PCCM program, 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.

iii. Children under 19 years of age who are in foster care or other out-of-home placement;

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 the PCCM program, 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.

iv. Children under 19 years of age who are receiving foster care or adoption assistance.

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 the PCCM program, 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.

Citation	Condition or Requirement
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 the PCCM program, 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 the PCCM program, notification by the enrollee, provider or other state agency of the exempt status will be processed by the State.</i></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><i>There are no federally recognized Indian Tribes in Georgia.</i></p>
42 CFR 438.50	<p>F. <u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u></p> <p><i>Children enrolled in the Georgia Pediatric Program (GAPP) who are eligible under another aid category in addition to section 1902(e)(3) will be exempted from enrollment. In addition, children with severe emotional disturbance who need mental health treatment in residential settings are exempted from enrollment into the PCCM program. Their care is coordinated under the Multi-Agency Team for Children (MATCH) program. For both of these groups of children, eligibility files will be matched, as will category of service files, to exempt these children from mandatory enrollment. In the case of inadvertent enrollment into the PCCM, the enrollee, provider or another state agency may request disenrollment</i></p>

Citation	Condition or Requirement
	<i>based upon the enrollee's participation in GAPP or MATCH and the child will be disenrolled.</i>
42 CFR 438.50	G. <u>List all other eligible groups who will be permitted to enroll on a voluntary basis</u> <i>Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.</i>
	H. <u>Enrollment process.</u>
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 records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient. ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. Describe how the state's default enrollment process will preserve: i. the existing provider-recipient relationship (as defined in H.1.i). <i>The State assures that default enrollment will be based on maintaining existing, as well as historical, provider/enrollee relationships to the extent possible. Enrollees are auto-assigned to a PCP provider based on enrollee and family history, as well as sex, age and geographic proximity. If no enrollee 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, enrollees are assigned to PCPs using an algorithm based on age, sex, geographic proximity, and in a manner that equitably distributes enrollees among qualified PCCMs available. Enrollees are notified of the auto-assignment and provided with a list of providers within the enrollee's service area. If unhappy with an auto-assigned provider, an enrollee may contact Member Services within the first 90-day period to request a change.</i> ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

Citation

Condition or Requirement

PCP providers in the GBHC PCCM are those providers that have traditionally served the Medicaid population. Enrollees participating in the enhanced PCCM disease management component will continue to receive services from their PCP.

- 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.)

GBHC 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. In rural areas, if only one PCCM group exists within the enrollee service area, enrollees will be given a choice between two providers within the PCCM group. The auto-assignment process includes mechanisms for monitoring PCP enrollment and enrollees are distributed equitably among PCCM groups and PCPs.

For the disease management component of the program enrollees will be auto-assigned to disease management entity operating in the geographic region in which the enrollee resides. Because participation in the disease management component is voluntary, enrollees may disenroll from the enhanced PCCM disease management program at any time.

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:
- i. The state will x /will not use a lock-in for enrollment into the PCCM.
- ii. The State will /will not x use a lock-in for enrollment into the enhanced PCCM disease management component.
- iii. The time frame for recipients to choose a PCCM before being auto-assigned will be 15 days .
- iv. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

Once eligibility is determined, beneficiaries are mailed informational materials regarding GBHC. In addition to information on the auto-assignment process, the

Citation

Condition or Requirement

materials include information on: eligibility requirements and exclusions, provider and member rights and responsibilities, grievance, fair hearing and appeal procedures and timeframes, covered services and those services that are not covered by Georgia Better Health Care, Primary Care Case Managers available, 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. Also included is a list of 2 or more primary care providers located geographically convenient to the recipient. Additionally, enrollees will receive information about the enhanced PCCM disease management program.

If the beneficiary does not choose a PCP, assignment is completed through the auto-assignment process and enrollees are notified by mail of the auto-assignment. Enrollees 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 enrollee satisfaction including travel time to the primary care provider office and wait times for scheduled appointments.

For assignment to a specific nurse case manager within a disease management entity, the process will be developed by the disease management entity.

- v. 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. (Examples: state generated correspondence, HMO enrollment packets etc.)

The information packet described above includes member rights, including disenrollment rights. Enrollees have the opportunity to change their PCP within the first 90 days of enrollment or reenrollment and every six months thereafter. Enrollees may change PCP at any time with cause. Enrollees 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 enrollee satisfaction including travel time to the primary care provider office and wait times for scheduled appointments.

Enrollees assigned to a nurse case manager in the enhanced PCCM disease management program may disenroll at any time.

- vi. Describe the default assignment algorithm used for auto-assignment.

Citation

Condition or Requirement

(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)

Enrollees are auto-assigned to the provider using an algorithm that ensures historical usage, family history, sex, age and geographic proximity. If the claims history shows the enrollee has prior history with a PCP, the enrollee 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, enrollees are assigned to PCPs using an algorithm based on age, sex, geographic proximity, and in a manner that equitably distributes enrollees among qualified PCCMs available.

- vii. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

The State monitors changes in the rate of PCP default assignment through reports generated from the MMIS.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. x 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.
2. x 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).

For the enhanced PCCM disease management program the State will contract with one entity per region. Enrollment in the enhanced PCCM disease management program is voluntary, and enrollees will have a choice of nurse case managers.

3. x The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

TN No.: 05-001
Supersedes
TN No.: New

Approval Date: 09/28/05

Effective Date: 07/01/05

Citation	Condition or Requirement
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This provision is not applicable to this 1932 State Plan Amendment.

4. 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.)

This provision is not applicable to this 1932 State Plan Amendment.

5. 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.

This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will /will not use lock-in for PCP enrollment.
2. The lock-in will apply for 12 months (up to 12 months).
3. Place a check mark to affirm state compliance.

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).

GBHC enrollees are permitted to disenroll with a PCP at any time with cause. (Cause may be, but is not limited to: enrollees 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.) Enrollees will be allowed to request a change in PCP during the first 90 days of enrollment and at least every six months thereafter without cause.

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)

The state assures that its state plan program is in compliance with 42 CFR

TN No.: 05-001
Supersedes
TN No.: New

Approval Date: 09/28/05

Effective Date: 07/01/05

Citation	Condition or Requirement
42 CFR 438.50 42 CFR 438.10	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)(D) 1905(t)	L. <u>List all services that are excluded for each model (MCO & PCCM)</u> <i>Enrollees obtain referrals from their PCP for all ambulatory and facility services, with the exception of behavioral health services.</i>
1932 (a)(1)(A)(ii)	M. <u>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. <ol style="list-style-type: none">1. The state will <u>X</u> /will not _____ intentionally limit the number of entities it contracts under a 1932 state plan option.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.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>) <i>The State will limit the number Enhanced PCCM vendors to one per Region; however, there will be no limited contracting of qualified Primary Care Providers. Additionally, the Enhanced PCCM vendor will have multiple nurse case managers for members to freely choose from.</i>4. _____ The selective contracting provision in not applicable to this state plan.

State: Georgia

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 <u>Georgia</u> 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). 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>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>
1932(a)(1)(B)(i) 1932(a)(1)(B)(ii) 42 CFR 438.50(b)(1)	<p>1. The State will contract with an</p> <ul style="list-style-type: none"><input checked="" type="checkbox"/> i. MCO (Care Management Organizations – CMOs)<input type="checkbox"/> ii. PCCM (including capitated PCCMs that qualify as PAHPs)<input type="checkbox"/> iii. Both
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	<p>2. The payment method to the contracting entity will be:</p> <ul style="list-style-type: none"><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).
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>

State:: Georgia

Citation

Condition or Requirement

If applicable to this state plan, place a check mark to affirm the state has met **all** 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)).

- 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.
- ii. Incentives will be based upon specific activities and targets.
- iii. Incentives will be based upon a fixed period of time.
- iv. Incentives will not be renewed automatically.
- v. Incentives will be made available to both public and private PCCMs.
- vi. Incentives will not be conditioned on intergovernmental transfer agreements.
- vii. Not applicable to this 1932 state plan amendment.

CFR 438.50(b)(4)

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. (*Example: public meeting, advisory groups.*)

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.

In October 2003, a diverse team of stakeholders, including senior executives from healthcare providers 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.

In August 2004, the State announced that it would implement a mandatory managed care program using Care Management Organizations. From

State:: Georgia

Citation	Condition or Requirement
	<p><i>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 groups affected by the new mandatory managed care program.</i></p> <p><i>Upon implementation of the program, the State will continue to utilize providers from the various medical advisory committees, recipients involved in NET advisory committees, staff liaisons to advocacy groups that include both providers and recipients, and member satisfaction survey.</i></p>
1932(a)(1)(A)	<p>5. The state plan program will <u>x</u> /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 style="list-style-type: none">i. county/counties (mandatory) _____ii. county/counties (voluntary) _____iii. area/areas (mandatory) _____iv. area/areas (voluntary) _____
	<p>C. <u>State Assurances and Compliance with the Statute and Regulations.</u></p>
	<p>If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.</p>
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	<p>1. <u>x</u> The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.</p>
1932(a)(1)(A)(i)(I) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	<p>2. <u>N/A</u> The state assures that all the applicable requirements of section 1905(t) 1905(t) of the Act for PCCMs and PCCM contracts will be met.</p>
1932(a)(1)(A)	<p>3. <u>x</u> The state assures that all the applicable requirements of section 1932</p>

State:: Georgia

Citation	Condition or Requirement
42 CFR 438.50(c)(3)	(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 income limit, pursuant to section 1925.
 - ***Pregnant Women (Right from the Start Medicaid - RSM)*** - 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(l)(1)(A) and 1902(e)(5).
 - ***Children (Right from the Start Medicaid - RSM)*** - Children under age nineteen (19) whose family income is at or below the appropriate percentage of the federal

State:: Georgia

Citation	Condition or Requirement
	<p><i>poverty level for their age and family, pursuant to section 1902(l)(1)(B) and 1902(l)(1)(C) and 1902(l)(1)(D).</i></p> <ul style="list-style-type: none">• <u>Children (newborn)</u> – Pursuant to section 1902(e)(4), a child born to a woman who is eligible for Medicaid on the day the child is born.• <u>Breast and Cervical Cancer</u> – 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.• <u>Refugees</u> – 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>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)	<p>i. <input type="checkbox"/> Recipients who are also eligible for Medicare.</p> <p>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.)</p> <p><i>N/A – there is no voluntary enrollment</i></p>
1932(a)(2)(C) 42 CFR 438(d)(2)	<p>ii. <input type="checkbox"/> 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>
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	<p>iii. <input type="checkbox"/> Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.</p>
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	<p>iv. <input type="checkbox"/> Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.</p>
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	<p>v. <input type="checkbox"/> Children under the age of 19 years who are in foster care or other out-of-the-home placement.</p>

OMB No.:0938-

Citation	Condition or Requirement
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. <u>Identification of Mandatory Exempt Groups</u>
1932(a)(2) 42 CFR 438.50(d)	<p>1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. (<i>Examples: children receiving services at a specific clinic or enrolled in a particular program.</i>)</p> <p><i>1. 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:</i></p> <ul style="list-style-type: none"> <i>• burns</i> <i>• cardiac conditions</i> <i>• cystic fibrosis</i> <i>• hearing disorders</i> <i>• spina bifida</i> <i>• cerebral palsy</i> <i>• diabetes mellitus</i> <i>• vision disorders</i> <i>• craniofacial anomalies (including cleft lip/palate)</i> <i>• gastrointestinal disorders</i> <i>• neurological and neurosurgical conditions including epilepsy and hydrocephalus</i> <i>• orthopedic and/or neuromuscular disorders (scoliosis)</i> <i>• congenital or traumatic amputations of limbs</i>
1932(a)(2) 42 CFR 438.50(d)	<p>2. Place a check mark to affirm if the state's definition of title V children is determined by:</p> <p>____ i. program participation,</p>

TN No. 10-011

Supersedes

TN No. 09-009Approval Date: 08-25-10Effective Date 07-01-10

State:: Georgia

Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	<p><input type="checkbox"/> ii. special health care needs, or <input checked="" type="checkbox"/> iii. both</p> <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>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>iii.</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 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>

State:: Georgia

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1932(a)(2) 42 CFR 438.50(d)	<p>v. 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> <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 enrollments 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 exempt status will be processed by the State.</i></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>

State:: Georgia

Citation	Condition or Requirement
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There are no federally recognized Indian Tribes in Georgia.

42 CFR 438.50 F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

1. Children enrolled in the Georgia Pediatric Program (GAPP) who are eligible under another aid category in addition to section 1902(e)(3) will be exempted from enrollment. In the case of inadvertent enrollment into managed care, the enrollee, provider or another state agency may request disenrollment based upon the enrollee's participation in GAPP.

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

3. Individuals enrolled in a Hospice category of aid.

4. Individuals enrolled in a Nursing Home category of aid

42 CFR 438.50 G. List all other eligible groups who will be permitted to enroll on a voluntary basis

N/A

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 records of previous managed care enrollment or fee-for-service experience or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid Recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

State:: Georgia

Citation

Condition or Requirement

- i. the existing provider-recipient relationship (as defined in H.1.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.

- ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

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 traditional Medicaid 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 is 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.

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

- i. The state will x /will not use a lock-in for managed care managed care.

State:: Georgia

Citation	Condition or Requirement
ii.	The time frame for recipients to choose a health plan before being auto-assigned will be <u>30 days</u> .
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"><i>• the name of the enrollee automatically assigned;</i><i>• the name of the CMO to which the enrollee was assigned;</i><i>• an explanation of why the auto-assignment was performed i.e. failure to select a CMO within the required time;</i><i>• the CMO member services telephone number;</i><i>• the effective date of enrollment in the CMO; and</i><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 enrollees' service region</i>
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 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>
v.	<p>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>)</p> <p><i>If a CMO selection is not made, the enrollee is auto assigned to the CMO as follows:</i></p>

Citation	Condition or Requirement
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2. 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).
3. The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

This provision will be applicable only if the State is not successful in procuring more than one CMO plan in rural areas. 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.

This provision is not applicable to this 1932 State Plan Amendment.

4. 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.)

This provision is not applicable to this 1932 State Plan Amendment.

5. 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.

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.

This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will /will not use lock-in for managed care.
2. The lock-in will apply for 12 months (up to 12 months).
3. Place a check mark to affirm state compliance.

The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

State: Georgia

Citation	Condition or Requirement
	<p><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).</p> <p>4. Describe any additional circumstances of “cause” for disenrollment (if any).</p> <ul style="list-style-type: none">• <i>Enrollee requests to be assigned to the same CMO as other family members.</i>
	<p>K. <u>Information requirements for beneficiaries</u></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 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.)</p>
1932(a)(5)(D) 1905(t)	<p>L. <u>List all services that are excluded for each model (MCO & PCCM)</u></p> <ul style="list-style-type: none">• <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>• <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>
1932 (a)(1)(A)(ii)	<p>M. <u>Selective contracting under a 1932 state plan option</u></p> <p>To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.</p> <p>1. The state will <u> x </u> /will not _____ intentionally limit the number of entities it contracts under a 1932 state plan option.</p> <p><i>The State will limit the number of entities to four (4) plans in the Atlanta region and two (2) entities in other regions.</i></p> <p>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.</p>

State:: Georgia

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.

4. ____ The selective contracting provision in not applicable to this state plan.