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

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

July 3, 2013

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

Re: Georgia Title XIX State Plan Amendment, Transmittal #13-008

Dear Mr. Dubberly:

This letter is being sent as a companion to our approval of GA 13-008 which was filed to allow the Department of Community Health to provide both curative and hospice services in accordance with section 1905 of the Affordable Care Act. During our corresponding page review of GA 13-008, we noted that Georgia's State Plan financial page for hospice services does not meet comprehensiveness requirements. Based on that review, it was determined that attachment 4.19B, Page 6a is not consistent with the following Medicaid statutory and regulatory requirements. Therefore, we would like to offer our continuing assistance with your efforts.

Statutory and Regulatory Requirements

Section 1902(a) of the Act requires that States have a State plan for medical assistance that meets certain federal requirements that set out a framework for the State program. Implementing regulations at 42 CFR 430.10 require that the State plan be a comprehensive written statement containing all information necessary for CMS to determine whether the plan can be approved as a basis for federal financial participation (FFP) in the State program. In addition, section 1902(a)(30)(A) of the Act requires that States have methods and procedures in place to assure that payments to providers are consistent with efficiency, economy, and quality of care. To be comprehensive, payment methodologies should be understandable, clear, and unambiguous.

In addition, because the plan is the basis for FFP, it is important that the plan language provide an auditable basis for determining whether payment is appropriate.

Comprehensiveness of the State Plan

The current approved State plan advises that GA uses an undisclosed rate to pay for hospice services however further advises that additional per diem amounts are provided for routine home care and room and board. This language is not transparent and does not identify how providers and auditors can locate the applicable fee schedule and the period for which the fee schedule is in effect. The language also does not comply with the revised revisions to the hospice wage index published in final in the Federal Register on August 8, 2008.

1) Attachment 4.19B, Page 6a - Please refer to section four of the State Medicaid Manual which addresses Hospice (section 4306). Please see section 4603.3 for the discussion on the payment rates (these rates are revised annually and published). The current state plan approved methodology has not been revised since its effective date of October 1, 1990 and therefore does not comply with the final published guidance in the Federal Register on August 8, 2008. GA currently references Medicaid reimbursement with per diem amounts and daily rates. Any rate being used should be listed and published in the State Plan. Also, the American Recovery and Reinvestment Act (ARRA) required revisions to the hospice wage index previously published in final in the Federal Register on August 8, 2008. The hospice wage index has been revised to eliminate a reduction for the budget neutrality adjustment factor (BNAF), which had begun to be phased-out over 3 years, beginning in FY 2009. The revised wage index has been published on the CMS website, at the following link:

   http://www.cms.hhs.gov/Hospice/downloads/FY2009HospiceWI_ARRA.pdf.

   The wage index is applied to both Medicare and Medicaid hospice rates. While the Medicaid rates published by CMS in a September 10, 2008 memorandum have not changed as a result of the revised wage index, the new wage index should be applied to the portion of each Medicaid hospice rate category subject to the wage index. This will require State Medicaid Agencies to recalculate their hospice rates. The revised wage index is retroactive to October 1, 2008. States' Medicaid hospice rates should be recalculated accordingly.

2) When updating the reimbursement methodology for hospice services please include the following:

   1. Stipulate specifically the covered services included their per diem rate reimbursement.

   2. Differentiate the difference between the over 21 and under 21 participants as related to curative covered services:

   Example:
   The reimbursement rate for hospice services for participants age 21 and over includes all covered services related to the treatment of the terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice. The reimbursement for hospice services for participants under age 21 is the same with the exclusion of reimbursement of curative covered services.

3) Please amend your hospice service methodology to include reimbursement of nursing home room and board for participants.

Example:
Nursing home room and Board for Medicaid- eligible individuals residing in Medicaid-certified nursing facilities who meet the hospice eligibility criteria may elect Medicaid hospice care services. In addition to the routine home care or continuous home care per-diem rates, an amount may be paid to the hospice to cover the nursing home room and board costs which will be determined in accordance with rates established under 1905 of the Social Security Act.

4) 4.19B, Page 6a, Paragraph 1 – This section references a reimbursement methodology for physician services. Please include the physician services reimbursement methodology page reference on this plan page. Also, please confirm on the plan page that the reimbursement methodology for physicians participating in hospice services is in compliance with 42 CFR 440.50

Example:
Physician services will be reimbursed in accordance with Medicaid reimbursement policy for physician services based on 42 CFR 440.50

5) Also, please confirm on the plan pages that a nursing facility may not bill Medicaid for the individual's care that duplicates hospice services.

Within 90 days of the date of this letter, the State is required to submit a State plan amendment that resolves the issues, or a corrective action plan to resolve the issues, whichever is appropriate. During the 90-day period, we are happy to provide any technical assistance that the State requires necessary. State plans that are not in compliance with requirements referenced above are grounds for initiating a formal compliance process.

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

Sincerely,

Jackie Glaze

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