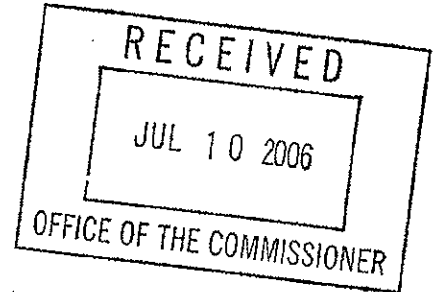


July 6, 2006

Rhonda M. Meadows, M.D.
Commissioner
Georgia Department of Community Health
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159



Subject: Therapeutic Residential Intervention Services (TRIS)

Dear Dr. Meadows:

This letter is to respond to your letter dated March 15, 2006 proposing a resolution of the current and future deferrals for the TRIS program revenues to the State of Georgia. However, due to the complexity of the problems found during our review of the program, we believe several areas must be addressed in more detail. Please see the enclosed Financial Management Review report of the Georgia Department of Community Health's (DCH) program referred to as Therapeutic Intervention Residential Services (TRIS) (CMS FMR #04-FM-2005-GA-006-D).

The State seems to be under the belief that CMS's major objective is to eliminate Georgia's bundled TRIS rate in favor of a system where the behavioral health care services to children are discreetly authorized and billed to Medicaid. This is incorrect. While the bundling of the rate is perhaps the most obvious concern, several underlying issues are equally as important. These issues include questions about provider qualifications, provider type, whether the services are Medicaid covered services, whether the services were provided to ineligible children, and the payment for those services. These issues are discussed below.

Providers:

The CMS believes that the providers in this program must be directly enrolled with the Medicaid Agency, and not as subcontractors of other State agencies who are enrolled with Medicaid. The Georgia Department of Human Resources (DHR) and the Georgia Department of Juvenile Justice (DJJ) are only providing Targeted Case Management services, and therefore should only be paid for these services as Medical Assistance. Any administrative cost incurred by DHR and DJJ associated with care coordination should be billed through an approved cost allocation plan as amended.

In trying to determine if the provider is qualified and whether they meet the provider type requirements under Medicaid rules, the following issues should be considered.

Under Medicaid rules for children, only psychiatric residential treatment facilities (PRTFs) found at § 1905(h) of the Social Security Act and 42 CFR of the Code of Federal Regulations (440.160, 441, Subpart D and 483, Subpart G) would be able to meet the conditions for

participation in Medicaid as institutional care. PRTFs meeting the requirements (Part 441, Subpart D, and Part 483, Subpart G) are the only recognized institutions for mental disease (IMD) facilities where individuals under 21 years of age can receive inpatient psychiatric services and room and board costs can be included. To the extent that any of the current facilities over 16 beds can and wish to qualify as a PRTF, they should be encouraged to apply as a provider once the Medicaid Agency submits a SPA adding PRTFs to their State Plan. If the remaining child caring institutions are not classified as an IMD or an institution that can be converted to a PRTF, it is possible that the child caring institution could bill for outpatient rehabilitative services on a fee for service basis. However, the State must define these discreet services. The services must be billed on a form 1500 and include all required elements of a claim such as who performed the service, date of service, number of units, and whether it is a group or individual setting, etc.

Also, other individual licensed practitioners or practitioners of the healing arts as set forth under §1905(a)(6) & (13) of the Social Security Act and 42 CFR of the Code of Federal Regulations (440.60 and 440.130) may also apply to DCH to be providers. Lesser qualified people such as those with bachelor's degrees and social workers would not qualify to be individual providers.

Medicaid Covered Service:

All services must be Medicaid covered services, meaning they must be medical services and in the State Plan, and must be found in 1905(a). We believe that many of the TRIS services captured by the time study would not qualify under this law. Rather, we believe that most of the TRIS services are more correctly viewed as foster care and not medical treatment, and therefore are the responsibility of the foster care agency. As such, please provide us with a complete list of the rehabilitative services with detailed descriptions that will be included in your program going forward.

Ineligible Children:

It is a longstanding Federal policy that when a juvenile is participating in a program sanctioned under the terms of his/her sentence, whether made voluntarily or involuntarily, FFP is not available (42 CFR 435.1008 and 1009). We believe that the terms of the sentence to the children are still basically involuntary participation mandated by the sentence from DJJ. Medicaid should not be billed for services provided to the children who are the responsibility of the DJJ.

Payment for the Service:

While the State Plan has payment methodology on page 1 of Supplement 2 to Attachment 4.19-B with possible duplication under the rehabilitation option (42 CFR 440.130(d)) "Community Mental Health Rehabilitative Services" as "Psychosocial Rehabilitation Services" and "Residential Rehabilitation Supports", as well as "Child and Adolescent Mental health Services (TRIS), the State Plan is unclear as to what these terms mean or how the payment is developed. However, we believe that when DCH separates the bundled payment as mentioned in your March 15, 2006 letter, the Agency must

Rhonda M. Medows, M.D.

Page 3

ultimately determine what Medicaid service is covered and what the fee for service rate will be for each service supported by actual cost documentation or a comparable benchmark rate from the Medicare fee schedule.

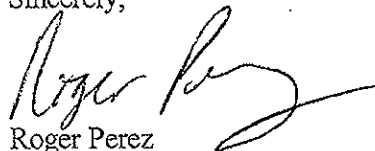
Medicaid Oversight:

The CMS believes the Georgia Medicaid Agency must assume responsibility for oversight of this program. Regulations at 42 CFR 431.10(e) specifies the responsibility that may not be delegated by the Medicaid Agency to any, other than its own employees.

Next Steps:

Since the 12 month transition period started April 28, 2006, we believe that providing an acceptable timeline and action plan to CMS that comports with CMS guidelines is the most urgent step for the Medicaid Agency. The timeline and action plan must include details on how DCH plans to replace the TRIS Program with an allowable medically necessary behavioral health program for the eligible children. Please note that the return of the outstanding deferral amounts is contingent upon CMS receiving the above mentioned timeline and action plan. We would like to meet with DCH to discuss these issues in more depth. Please let us know a convenient time for you.

Sincerely,



Roger Perez
Acting Regional Administrator

Enclosure: CMS FMR #04-FM-2005-GA-006-D