

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
61 Forsyth Street S.W. Suite 4T20  
Atlanta, Georgia 30303-8909



## **Atlanta Regional Operations Group**

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October 18, 2018

Lynnette Rhodes, Esq.  
Executive Director, Medical Assistance Plans  
Department of Community Health  
2 Peachtree Street, NW, Suite 36-450  
Atlanta, Georgia 30303

Dear Ms. Rhodes:

We have reviewed the proposed amendment to the Georgia Medicaid State Plan (SPA) GA 19-0010 (Personal Needs Allowance Increase for Nursing Home Residents) that was submitted on September 30, 2019. This state plan amendment was submitted in order to increase Social Security Income (SSI) nursing home resident's monthly supplement to \$70 per month.

Based on the information provided, the Medicaid State Plan Amendment GA 19-0010 was approved on October 18, 2019. The effective date of this amendment is July 1, 2019. We are enclosing the approved HCFA 179 and the plan page.

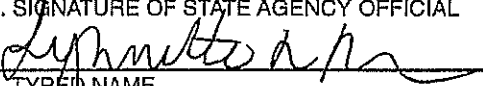
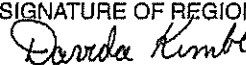
Should you have questions or need further assistance, please contact Etta Hawkins at (404) 562-7429, or [etta.hawkins@cms.hhs.gov](mailto:etta.hawkins@cms.hhs.gov).

Sincerely,

Digitally signed  
Davida R.  
Kimble -S  
Date: 2019.10.18  
11:27:43 -0400

Davida R. Kimble  
Acting Deputy Director  
Division of Medicaid Field Operations South

Enclosure

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	1. TRANSMITTAL NUMBER ___ 19 — 0010 ___	2. STATE GEORGIA
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE JULY 1, 2019	
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ) <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate transmittal for each amendment</i> )		
6. FEDERAL STATUTE/REGULATION CITATION 42 C.F.R. 447.205; 42 C.F.R. 440.40	7. FEDERAL BUDGET IMPACT a. FFY 2020 \$ 829,390 b. FFY _____ \$ _____	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 2.6-A, Page 4a	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ) Attachment 2.6-A, Page 4a	
10. SUBJECT OF AMENDMENT Nursing Home Personal Needs Allowance (PNA) Rate Increase.		
11. GOVERNOR'S REVIEW ( <i>Check One</i> ) <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		
12. SIGNATURE OF STATE AGENCY OFFICIAL 	16. RETURN TO Georgia Department of Community Health Division of Medical Assistance Plans 2 Peachtree St., 36th Floor Atlanta, Georgia 30303	
13. TYPED NAME LYNNETTE R. RHODES, ESQ.		
14. TITLE EXECUTIVE DIRECTOR, MEDICAL ASSISTANCE PLANS		
15. DATE SUBMITTED 9/27/19		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED 09/27/19	18. DATE APPROVED 10/18/19	
PLAN APPROVED - ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL 07/01/19	20. SIGNATURE OF REGIONAL OFFICIAL 	
21. TYPED NAME Davida R. Kimble	22. TITLE Acting Deputy Director Division of Medicaid Field Operations South	
23. REMARKS		

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Citation	Condition or Requirement
1924 of the Act 435.725 435.733 435.832	<p data-bbox="477 436 1105 554">2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care:</p> <p data-bbox="526 590 1101 674">Personal Needs Allowance (PNA) of not less than \$30 For Individuals and \$60 For Couples For All Institutionalized Persons.</p> <p data-bbox="526 709 792 800">a. Aged, blind, disabled: Individuals \$ 70.00 Couples \$ 140.00</p> <p data-bbox="574 863 1040 892">For the following persons with greater need:</p> <p data-bbox="574 955 1203 1136">Supplement 12 to <u>Attachment 2.6-A</u> describes the greater need describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.</p> <p data-bbox="526 1171 760 1262">b. AFDC related: Children \$ 70.00 Adults \$ 70.00</p> <p data-bbox="574 1293 1040 1323">For the following persons with greater need:</p> <p data-bbox="574 1356 1138 1537">Supplement 12 to <u>Attachment 2.6-A</u> describes the greater need describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.</p> <p data-bbox="526 1570 1057 1623">c. Individual under age 21 covered in the plan as specified in Item B. 7. of <u>Attachment 2.2 -A</u>.</p>