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

February 9, 2015

Mr. Clyde L. Reese III, Esq.
Medical Assistance Plans
Georgia Department of Community Health
2 Peachtree Street, NW, 40th Floor
Atlanta, Georgia 30303

Re: Title XIX State Plan Amendment, GA 13-0028-MM7

Dear Mr. Reese:

Enclosed is an approved copy of Georgia's State Plan Amendment (SPA) 13-0028-MM7, which was originally submitted to the Centers for Medicare & Medicaid Services (CMS) on January 9, 2014. SPA 13-0028-MM7 establishes that one or more qualified hospitals are determining presumptive eligibility, and that the state is providing coverage for individuals determined presumptively eligible, in accordance with the Affordable Care Act. The SPA was approved on February 6, 2015. The effective date of this SPA is January 1, 2014.

We understand that the state is still in the process of finalizing its system to support hospital presumptive eligibility and is estimating an implementation date of February 26, 2015. If any systems or other issues threaten this date, the state should inform CMS as soon as possible.

Enclosed is a copy of the new state plan pages and attachments to be incorporated within a separate section at the back of Georgia's approved state plan.

If you have any questions, please contact Ms. Tandra Hodges of my staff at 404-562-7409.

Sincerely,

Jackie Glaze

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

Enclosure

Medicaid State Plan Eligibility: Summary Page (CMS 179)

- State/Territory name:

  Georgia

- **Transmittal Number:**

  Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

  GA-13-002

- **Proposed Effective Date**

  01/01/2014 (mm/dd/yyyy)

- **Federal Statute/Regulation Citation**

  42 C.F.R. §

- **Federal Budget Impact**

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

- **Subject of Amendment**

Character Count: out of 2000

Hospital Presumptive Eligibility

- **Governor's Office Review**

- ○ Governor's office reported no comment
- ○ Comments of Governor's office received

  Describe:

- ○ No reply received within 45 days of submittal
- ○ Other, as specified

  Describe:

Character Count: out of 2000

Pursuant to 42 C.F.R. § 430.12,

- **Signature of State Agency Official**

- ○ Submitted By:

  Therese Brisco

- ○ Last Revision Date:

  Jan 9, 2014

- ○ Submit Date: Jan 9, 2014

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Presumptive Eligibility by Hospitals — S21

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

(•) Yes ( ) No

☑ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

☑ A qualified hospital is a hospital that:

☑ Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

☑ Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

(•) Yes ( ) No

☑ The eligibility groups or populations for which hospitals determine eligibility presumptively are:

- ☑ Pregnant Women
- ☑ Infants and Children under Age 19
- ☑ Parents and Other Caretaker Relatives
- ☑ Adult Group, if covered by the state
- ☑ Individuals above 133% FPL under Age 65, if covered by the state
- ☑ Individuals Eligible for Family Planning Services, if covered by the state
- ☑ Former Foster Care Children
- ☑ Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state
- ☐ Other Family/Adult groups:
- ☐ Eligibility groups for individuals age 65 and over
- ☐ Eligibility groups for individuals who are blind
- ☐ Eligibility groups for individuals with disabilities
- ☐ Other Medicaid state plan eligibility groups
- ☐ Demonstration populations covered under section 1115

The state establishes standards for qualified hospitals making presumptive eligibility determinations.

Medicaid Eligibility

(•) Yes ( ) No

Select one or both:

☒ The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Description of standards:

Qualified Hospital PE Performance Standards will be established at the end of the first (6) months.
The Department of Community Health (DCH) will review all Qualified Hospital (QH) Presumptive Eligibility (PE) determinations for the first six months before establishing specific performance standards.

This time period will allow DCH to eliminate any potential barriers to providing QH's with the proper tools to determine PE applications correctly and timely.

Base targets on data gathered during the initial implementation:
Georgia will look at the share of PE applicants who file a full application and are found eligible for regular Medicaid at the end of the six month review period, identify the average or median outcome on this measure, and use it to set the target for hospitals in 2015. There is an indicator on our hospital presumptive application so that we can monitor that a full Medicaid application was offered and completed.

Increasing benchmarks over time:
Georgia will start with a modest target accuracy but then increase it by five percentage points (or more) in future years.

Percent of PE determinations conducted accurately:
Georgia will require that 90 percent of a hospital's PE determinations be done correctly based on the information that an applicant has provided. If an applicant provides misinformation, his or her circumstances change, or his or her information cannot be verified, it would not affect a hospital's performance on the accuracy measure.

Percent of applicants checked for existing Medicaid enrollment:
Hospitals would be required to ensure that 100 percent of potential applicants are checked for existing enrollment in Medicaid before a PE determination is conducted. A screening function is built into the web portal.

Percent of applicants checked for prior PE enrollment:
Hospitals would be required to ensure that 95 to 100 percent of potential applicants are checked for recent PE determinations (e.g., with the exception of pregnant women, not enrolled in PE within prior 2 calendar years) before a new PE determination is conducted on their behalf. Hospitals would be trained to identity PE eligibility.

Qualified Hospitals may be disqualified from conducting PE determinations for failure to adhere to the above standards or the state's policies and procedures.

☐ The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

■ The presumptive period begins on the date the determination is made.

■ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

■ Periods of presumptive eligibility are limited as follows:

○ No more than one period within a calendar year.

○ No more than one period within two calendar years.

○ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

◉ Other reasonable limitation:

	Name of limitation	Description	
+	Pregnant Women/because a woman can potentially have a miscarriage and conceive again before the end of 12 months.	Pregnant women may receive presumptive eligibility, once per pregnancy.	X
+	Infants and Children under age 19, Parents and Other Caretaker Relatives, Former Foster Care Children, and Women's Health (BCC)	Infants and Children under age 19, Parents and Other Caretaker Relatives, Former Foster Care Children, and Women's Health (BCC) may receive presumptive eligibility no more than one period within two calendar years.	X

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

◉ Yes ○ No

○ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

◉ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

■ The presumptive eligibility determination is based on the following factors:

■ The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

■ Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status

☑ The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

Medicaid Eligibility

	An attachment is submitted.	

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

EFFECTIVE FOR SERVICES BEGINNING _____
MONTH DAY YEAR

HP PROVIDER CONTACT CENTER
P.O. BOX 105200
TUCKER, GA 30085-5200

PHONE: 1-800-766-4456
FAX: 1-866-483-1044

_____
MEDICAID IDENTIFICATION NUMBER

QUALIFIED HOSPITAL PRESUMPTIVE ELIGIBILITY DETERMINATION

APPLICANT'S NAME: _____ MAIDEN NAME: _____

APPLICANT'S ADDRESS: _____ TELEPHONE NUMBER: _____

APARTMENT/LOT NUMBER: _____ SOCIAL SECURITY NUMBER: _____ (OPTIONAL)

CITY: _____ STATE: _____ ZIP CODE: _____ COUNTY OF RESIDENCE: _____

HEALTH INSURANCE: ☐ YES ☐ NO

FORMER FOSTER CARE:

FORMER FOSTER CARE? ☐ YES ☐ N/A

WHAT AGE DID YOU LEAVE FOSTER CARE? _____

IN WHAT STATE DID YOU RECEIVE FOSTER CARE?

_____

	TAX FILER HOUSEHOLD ■ YES ■ NO NON TAX FILER HOUSEHOLD ■ YES ■ NO FIRST NAME MI LAST NAME SUFFIX	DATE OF BIRTH MM/DD/YYYY	* RACE	GENDER	RELATION TO APPLICANT	MONTHLY GROSS TAXABLE INCOME				MONTHLY DEDUCTIONS		MONTHLY NET TAXABLE INCOME
						TYPE	AMOUNT	FREQ	MONTHLY AMOUNT	PRE-TAX DEDUCTION	1040 DEDUCTION	
01					SELF							
02	UNBORN CHILD ☐ N/A ☐1 ☐2 ☐3 ☐4 ☐5 ☐6				APPLICANT'S STATEMENT/NAME OF PREGNANT WOMAN:							
03												
04												
05												

SWORN STATEMENT OF APPLICANT:

I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILIY FOR MEDICAID AND THAT THE RIGHT FROM THE START MEDICAID (RSM) PROJECT OR COUNTY DIVISION OF FAMILY AND CHILDREN SERVICES (DFCS) WILL DETERMINE MY CONTINUING ELIGIBILITY WHEN I SUBMIT A HEALTCARE COVERAGE APPLICATION.

I DECLARE UNDER PENALTY OF PERJURY THAT I AM A U.S. CITIZEN OR LAWFULLY PRESENT IMMIGRANT IN THE UNITED STATES. I CERTIFY UNDER PENALTY OF PERJURY I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ABOUT MYSELF, MY FAMILY, PREGNANCY, RESIDENCY, TAX STATUS, PRET-TAX DEDUCTIONS, 1040 DEDUCTIONS, FOSTER CARE STATUS AND INCOME.

I AGREE TO ASSIGN TO THE STATE ALL RIGHTS TO MEDICAL SUPPORT AND THIRD PARTY SUPPORT PAYMENTS (HOSPITAL AND MEDICAL BENEFITS).
I UNDERSTAND THAT MY ELIGIBILITY FOR THIS TEMPORARY ELIGIBILITY ENDS THE MONTH IN WHICH THE RSM OR DFCS OFFICE MAKES THE DECISION ABOUT MY CONTINUING ELIGIBILITY, OR NO LATER THAN THE LAST DAY OF THE FOLLOWING MONTH.

I WILL REPORT ALL CHANGES IN MY HOUSEHOLD WITHIN 10 DAYS THROUGH WWW.COMPASS.GA.GOV OR CALL 1-877-423-4746 (TDD/TTY 1-800-255-0135); FAX 1-888-740-9355.

_____ _____
DATE OF APPLICATION **APPLICANT'S SIGNATURE**

*By providing Race information, you will assist us in administering our programs in a non-discriminatory manner. You are not required to give us this information and it will not affect your eligibility or benefit level.

TOTAL GROSS TAXABLE INCOME = SUBTOTAL NET INCOME =

NUMBER IN BUDGET GROUP = 5 % FPL DEDUCTION =

POVERTY INCOME LEVEL = TOTAL NET INCOME =

APPLICANT IS ☐ **ELIGIBLE** OR ☐ **INELIGIBLE** FOR RESUMPTIVE ELIGIBLITY MEDICAID

THE WOMAN FOR WHOM THIS PRESUMPTIVE DETERMINATION OF ELIGIBILITY HAS BEEN MADE IS APPROXIMATELY _____ WEEKS PREGNANT WITH _____ FETUS(ES). HER EXPECTED DELIVERY DATE IS _____. ☐ N/A

I HAVE OBTAINED A HEALTHCARE COVERAGE APPLICATION FROM THE APPLICANT AND HAVE FAXED IT TO DCH AT **770-302-8169**: ☐ YES (Included in PE Packet) ☐ NO _____ APPLICANT'S INITIALS

_____ _____ _____
DATE OF COMPLETION **COMPLETED BY (PLEASE PRINT)** **TITLE**

_____ _____
QH DIRECT PHONE NUMBER **SIGNATURE OF QUALIFIED HOSPITAL PERSONNEL**

_____ _____
QUALIFIED HOSPITAL NAME AND ADDRESS **QH PROVIDER ID**

REIMBURSEMENT FOR MEDICAID SERVICES THROUGH THE PREGNANGY PRESUMPTIVE ELIGIBILITY PERIOD DOES NOT INCLUDE INPATIENT HOSPITAL SERVICES OR DELIVERY

Date		Date Updated
Qualified Hospital Provider Name		
QH Provider ID Number:		
Address		
City, State, Zip Code		
County		
Phone		
FAX		
PE Coordinator		
Direct Phone Number		
Email Address		
PE Certification:	**Date Requested**	**Date Completed**
Parent/Caretaker with Child(ren)		
Children Under 19 Years of Age		
Pregnant Women		
Former FosterCare		
Women's Health ***		
*** Requires Certification from Department of Public Health for BCCP		
	Authorized User List Page 2	
Page 1 of 3	**Corrective Action Plan Page 3**	

EFFECTIVE FOR SERVICES BEGINNING _____
MONTH DAY YEAR

HP PROVIDER CONTACT CENTER
P.O. BOX 105200
TUCKER, GA 30085-5200

PHONE: 1-800-766-4456
FAX: 1-866-483-1044

_____
MEDICAID IDENTIFICATION NUMBER

PRESUMPTIVE ELIGIBILITY DETERMINATION FOR WOMEN'S HEALTH MEDICAID

_____
VALID FOR LISTED MONTH ONLY

APPLICANT'S NAME: _____ MAIDEN NAME: _____ HEALTH INSURANCE: ☐ YES ☐ NO

APPLICANT'S ADDRESS: _____ TELEPHONE NUMBER: _____

APARTMENT/LOT NUMBER: _____ SOCIAL SECURITY NUMBER: _____ (Optional) APPLICANT'S RECORD: _____

CITY: _____ STATE: _____ ZIP CODE: _____ COUNTY OF RESIDENCE: _____ DATE OF INTERVIEW: _____

	FAMILY MEMBERS	DATE OF BIRTH	*		RELATION	MONTHLY GROSS INCOME				MONTHLY DISREGARDS		MONTHLY
	FIRST NAME MI LAST NAME SUFFIX	MM/DD/YYYY	RACE	GENDER	TO APPLICANT	TYPE	AMOUNT	FREQ	MONTHLY AMOUNT	STANDARD WORK DISREGARD	DEPENDENT CARE DISREGARD	NET INCOME
01					**SELF**							
02												
03												
04												
05												
06												

SWORN STATEMENT OF APPLICANT:

I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILIY FOR MEDICAID AND THAT THE ARROWHEAD RIGHT FROM THE START MEDICAID (ARSM) PROJECT WILL DETERMINE MY CONTINUING ELIGIBILITY.
I DECLARE UNDER PENALTY OF PERJURY THAT I AM A U.S. CITIZEN OR LAWFULLY PRESENT IN THE UNITED STATES AND I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ABOUT MY FAMILY AND INCOME.
I AGREE TO ASSIGN TO THE STATE ALL RIGHTS TO MEDICAL SUPPORT AND THIRD PARTY SUPPORT PAYMENTS (HOSPITAL AND MEDICAL BENEFITS).
I UNDERSTAND THAT MY ELIGIBILITY FOR THIS TEMPORARY ELIGIBILITY ENDS THE MONTH IN WHICH ARSM MAKES THE DECISION ABOUT MY CONTINUING ELIGIBILITY.
I WILL REPORT ALL CHANGES IN MY HOUSEHOLD WITHIN 10 DAYS.

_____ _____
DATE OF APPLICATION APPLICANT'S SIGNATURE

*By providing Race information, you will assist us in administering our programs in a non-discriminatory manner. You are not required to give us this information and it will not affect your eligibility or benefit level.

TOTAL GROSS INCOME = _____ CHILD SUPPORT DISREGARD= _____

NUMBER IN FAMILY = _____

POVERTY INCOME LEVEL = _____ TOTAL FAMILY NET INCOME = _____

Applicant is ☐ ELIGIBLE or ☐ INELIGIBLE for PE WHM.

PROVIDER CERTIFICATION:

I CERTIFY THAT THE WOMAN FOR WHOM THIS PRESUMPTIVE DETERMINATION OF ELIGIBILITY HAS BEEN DETERMINED WAS SCREENED IN ACCORDANCE WITH THE REQUIREMENTS OF PULIC LAW 106-354 ON _____

HER DIAGNOSIS MET THE BCC PROGRAM IN GEORGIA. I HAVE OBTAINED A SIGNED HEALTHCARE COVERAGE APPLICATION FROM THE APPLICANT AND HAVE FAXED IT TO THE ARROWHEAD (ARSM) PROJECT AT 770-359-1813.

_____ _____
QUALIFIED PROVIDER SIGNATURE TITLE

_____ _____ _____
DATE OF COMPLETION COMPLETED BY (PLEASE PRINT) TITLE

_____ _____
QUALIFIED PROVIDER NAME QUALIFIED PROVIDER ID NUMBER

_____ _____
DIRECT PHONE NUMBER SIGNATURE OF INDIVIDUAL COMPLETING FORM

QUALIFIED PROVIDER ADDRESS: _____

_____

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Nathan Deal, Governor **Clyde L. Reese III, Esq., Commissioner**

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

GEORGIA QUALIFIED HOSPITAL PROVIDER AGREEMENT FOR PRESUMPTIVE ELIGIBILITY MEDICAID DETERMINATIONS

Qualified Hospital (QH) Name:_____

Qualified Hospital Provider agrees:

1. To participate as a qualified hospital provider in the Georgia Medicaid program with the Department of Community Health (DCH);
2. To complete full Presumptive Eligibility (PE) Medicaid training;
3. To maintain PE Medicaid knowledge with PE Manual usage, and PE Medicaid meetings;
4. To complete monthly internal reviews of PE Medicaid cases for both approved and denied PE Medicaid applications, act upon findings when required;
5. To conduct periodic PE Medicaid refresher training for veteran staff and full PE Medicaid training for new workers. Submit completed training list to DCH monthly (DCH/QH worksheet provided);
6. To correctly determine Presumptive Eligibility (PE) in accordance with Medicaid regulations and guidelines as promulgated by the Department of Community Health; all procedures and regulations are outlined in each PE Medicaid manual;
7. To participate in quality assurance reviews which will be conducted by the Department of Community Health;
8. To timely act upon corrective action required by the Department of Community Health.

Failure to continue to meet any of the above conditions shall be cause for termination of this qualified hospital provider agreement.

The qualified hospital provider also agrees that either the qualified hospital provider, or the Department of Community Health, may terminate this agreement by giving the other party thirty (30) days written notice.

_____ _____
Date Signature of Authorized QH Provider

_____ _____
QH Provider ID Number Title

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Nathan Deal, Governor **Clyde L. Reese III, Esq., Commissioner**

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

ACA Presumptive Eligibility (PE) for Medicaid Training
Statement of Completion of Required PE Training

Employee's Name (Please Print) _____ Qualified Hospital Provider ID Number _____

All Qualified Hospital Providers must complete PE policies & procedures training prior to rendering PE services. After review of all of the PE training documents and requirements listed below, please initial and enter date next to each policy, sign at the bottom of the page, and return the originals to your PE Coordinator, fax a copy to DCH at 1-770-302-8169 or email to pecorrections@dch.ga.gov within five (5) business days of completion of training.

Initials	Date	Document/Form	Title
		ACA PE Manual	ACA Presumptive Eligibility for Medicaid
		DMA-632H	Presumptive Eligibility Application (* required exercise-must compute a PE budget using Form 632H and Federal Poverty Levels)
		DMA-Form 216	Citizenship Affidavit/Qualified Immigrant Status
		DMA-634H	Notice of Action
		Medicaid Application Order Forms	Single Streamed Lined Application form and how to order PE Forms
		PE Document	Quick Guide on Medicaid
		PE Document	Procedures for processing On-line, Manual & Denied Applications
		P4HB	Planning for Healthy Babies

By my initials and signing, I acknowledge that I am aware of and accountable for compliance of ACA Presumptive Eligibility for Medicaid program policies and procedures.

Employee's Signature: _____ Date: _____

By my signature below, I acknowledge my responsibility to ensure that this employee is aware of PE Medicaid policies and procedures and DCH compliance requirements.

PE Coordinator's Name (Please Print): _____

PE Coordinator's Signature: _____ Date: _____