DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

SEP 01 2016

Ms. Linda Wiant, PharmD
Chief, Medicaid Assistance Plans
Medicaid Division
Georgia Department of Community Health
9 Peachtree Street, NW, Suite 36-450
Atlanta, GA 30303-315

RE: Georgia 16-004

Dear Ms. Wiant:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 16-004. Effective July 1, 2016 this amendment proposes to revise the payment methodology for specialized nursing home ventilator services. Specifically, this amendment will increase the payment rates by three (3%) percent.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of July 1, 2016. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Stanley Fields at (502) 223-5332.

Sincerely,

Kristin Fan
Director

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 16-004	2. STATE GEORGIA
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2016	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 C.F.R. § 447.205	FFY 2016 $49,806.34 FFY 2017 $200,445.23
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19D page 1 and page 34	Attachment 4.19D page 1 and page 34

10. SUBJECT OF AMENDMENT:
Effective July 1, 2016, the Department of Community Health proposes to increase reimbursement for specialized nursing home ventilator care by 3%.

11. GOVERNOR'S REVIEW *(Check One)*:
- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
- ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- ☒ OTHER, AS SPECIFIED: **Single State Agency Comments Attached**

12. SIGNATURE OF STATE AGENCY OFFICIAL: Linda Wiant	16. RETURN TO:
13. TYPED NAME: LINDA WIANT	Department of Community Health Division of Medicaid 2 Peachtree Street, NW, 36th Floor Atlanta, Georgia 30303-3159
14. TITLE: CHIEF, DIVISION OF MEDICAID	
15. DATE SUBMITTED: 6/21/16	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: SEP 01 2016
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2016	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMG

23. REMARKS:

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
NURSING FACILITY SERVICES

2. Nursing Facility Rate Determination for Ventilator Dependent Residents

(I) The nursing facility per diem for a ventilator dependent resident will be $463.87 effective for dates of service on and after November 13, 2009. Effective for dates of service on and after July 1, 2016, the nursing facility per diem for a ventilator dependent resident will be $494.68.

(2) The per diem costs of providing services to the ventilator dependent residents shall be maintained separately (as a distinct part) of each facility's annual cost report beginning November 13, 2009.

(3) Ventilator dependent per diem rates will cover all skilled nursing care services and will be all-inclusive.

(4) No additional amount above the current nursing facility daily rate shall be allowed until the service is prior authorized by the Department's Medical Management Contractor.

(5) The resident's clinical condition shall be reviewed every 90 days to determine if the resident's medical condition continues to warrant services at the ventilator dependent nursing facility rate. Prior authorization through the Department's Medical Management Contractor spans a 90-day maximum time period. The nursing facility is required to resubmit requests for continued stay prior to expiration of the current PA. If a resident no longer requires the use of a ventilator, the provider shall not receive additional reimbursement beyond the Georgia Medicaid nursing home per diem rate determined for the facility.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-NURSING FACILITY SERVICES

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