

## Holly, Mary V. (CMS/CMCHO)

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**From:** Dubois, Anna M. (CMS/CMCHO)  
**Sent:** Thursday, February 23, 2017 8:29 AM  
**To:** Holly, Mary V. (CMS/CMCHO)  
**Subject:** FW: Approved Georgia 16-0015 OSN.pdf, Georgia 16-0015 SPA.pdf  
**Attachments:** Georgia 16-0015 OSN.pdf; Georgia 16-0015 SPA.pdf

FYI

-----Original Message-----

**From:** Winkler, Ella B. (CMS/CMCS)  
**Sent:** Wednesday, February 22, 2017 3:11 PM  
**To:** Yablochnikov, Daniil (CMS/CMCS) <Daniil.Yablochnikov@cms.hhs.gov>; Dubois, Anna M. (CMS/CMCHO) <Anna.Dubois@cms.hhs.gov>  
**Subject:** Approved Georgia 16-0015 OSN.pdf, Georgia 16-0015 SPA.pdf

Approved Georgia 16-0015 SPA



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**Financial Management Group**

FEB 22 2017

Ms. Linda Wiant  
Directory of Medicaid Assistance Plans  
Medicaid Division  
Georgia Department of Community Health  
9 Peachtree Street, NW, Suite 36-450  
Atlanta, GA 30303-3159

RE: Georgia State Plan Amendment 16-0015

Dear Ms. Wiant:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number 16-0015. Effective October 1, 2016, this amendment proposes to increase the reimbursement rate for the newborn screening test to include screening newborn children for severe combined immunodeficiency.

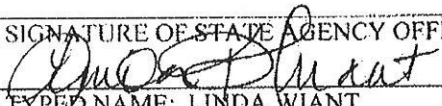

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed reimbursement methodology complies with applicable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

If you have any questions, please call Anna Dubois at (850) 878-0916.

Sincerely,

A handwritten signature in blue ink, which appears to read "Kristin Fan". The signature is written in a cursive, flowing style.

Kristin Fan  
Director

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: 16-015	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 <del>August 12, 2016</del> <b>October 1, 2016</b>	
5. TYPE OF PLAN MATERIAL (Check One):			
<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 (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 C.F.R. § 447.205		7. FEDERAL BUDGET IMPACT: FFY 2016 \$622,896 <b>FFY 2017 \$1,038,188</b>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 4.19-A, page 14a		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  Attachment 4.19-A, page 14a	
10. SUBJECT OF AMENDMENT: The Georgia General Assembly has appropriated funds for an increase in the Newborn Screening Test Laboratory Fee. The fee will increase from \$50 to \$63 per newborn, to include a test for SCID.			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <b>Single State Agency Comments Attached</b>	
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:	
13. TYPED NAME: LINDA WIANT		Department of Community Health Division of Medicaid 2 Peachtree Street, NW, 36 <sup>th</sup> Floor Atlanta, Georgia 30303-3159	
14. TITLE: CHIEF, DIVISION OF MEDICAID			
15. DATE SUBMITTED: <b>11.22.16</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: <b>FEB 22 2017</b>	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>OCT 01 2016</b>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <b>Kristin Fan</b>		22. TITLE: <b>Director, FMG</b>	
23. REMARKS: <b>The state has authorized pen and ink charges to blocks 4 and 7.</b> <b>Block 4 - Effective Date : October 1, 2016</b> <b>Block 7 - FFY 2017 : \$1,038,188</b>			

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METHODS AND STANDARDS FOR REESTABLISHING PAYMENT RATES  
INPATIENT SERVICES

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The maximum allowable payment to enrolled Georgia and non-Georgia hospitals for Medicare inpatient deductibles and coinsurance (crossover claims) will be the hospital-specific Medicaid per case rate. The maximum allowable payment to non-Georgia hospitals not enrolled the Georgia Medicaid program for Medicare inpatient crossover claims will be the average hospital-specific inpatient per case rate for enrolled non- Georgia hospitals.

J. Payment In Full

1. Participating in-state providers must accept the amount paid in accordance with the Georgia Title XIX Inpatient Hospital Reimbursement Plan as payment in full for covered services.

K. Expanded Newborn Screening Program

Effective for services provided on and after October 1, 2016, an additional payment of \$63 per newborn admission will be made to fund costs associated with the expansion of the newborn screening program administered by the Georgia Department of Public Health.

TN No.: 16-015  
Supersedes  
TN No.:15-005

Approval Date: FEB 22 2017

Effective Date: October 1, 2016