Holly, Mary V. (CMS/CMCHO)

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

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

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

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,

Kristin Fan
Director

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	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 ~~August 12, 2016~~ October 1, 2016	

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

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ 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 $622,896 FFY 2017 $1,038,188
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, page 14a	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)*:
☐ 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:	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: 11.22.16	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: FEB 22 2017
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 01 2016	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMG

23. REMARKS:
The state has authorized pen and ink changes to blocks 4 and 7.

Block 4 – Effective Date: October 1, 2016
Block 7 – FFY 2017: $1,038,188

METHODS AND STANDARDS FOR RESTABLISHING PAYMENT RATES
INPATIENT SERVICES

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.