

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 52-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations (CMSO)

Dr. Jerry Dubberly, PharmD.
Chief, Medicaid Division
Georgia Department of Community Health
2 Peachtree Street, NW
Atlanta, GA 30303-3159

MAR 12 2010

RE: State Plan Amendment 09-011

Dear Dr. Dubberly:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number 09-011. Effective November 13, 2009, this amendment modifies the State's reimbursement methodology for setting payment rates for nursing facility services. Specifically, this amendment will implement a reimbursement rate for ventilator-dependent services.

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 changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of November 13, 2009. 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 or Venesa Day at 410-786-8281.

Sincerely

//s//

Cindy Mann
Director, CMSO

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| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL | | 1. TRANSMITTAL NUMBER: 09-011 | 2. STATE GEORGIA |
| FOR: HEALTH CARE FINANCING ADMINISTRATION | | 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 November 13, 2009 | |
| 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 CFR 447.250 | | 7. FEDERAL BUDGET IMPACT: | |
| | | a. FFY 2010 (\$1700,220) | |
| | | FFY 2011 (\$7,097,032) | |
| "8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D, pp. 34- | | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-D, pp 34- | |
| 10. SUBJECT OF AMENDMENT: REIMBURSEMENT FOR NURSING FACILITY VENTILATOR DEPENDENT RESIDENTS | | | |
| 11. GOVERNOR'S REVIEW (Check One): | | | |
| <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: | | | |
| <input checked="" type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED | | | |
| <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL | | | |

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|--|---|
| 12. SIGNATURE OF STATE AGENCY OFFICIAL: //s// | 16. RETURN TO: Department of Community Health Division of Medicaid 2 Peachtree Street, NW, 36 th Floor Atlanta, Georgia 30303-3159 |
| 13. TYPED NAME: Jerry Dubberly | |
| 14. TITLE: Chief, Division of Medicaid | |
| 15. DATE SUBMITTED: 12-23-09 | |

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| FOR REGIONAL OFFICE USE ONLY | |
| 17. DATE RECEIVED: 12-23-09 | 18. DATE APPROVED: 03-12-10 |
| PLAN APPROVED - ONE COPY ATTACHED | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: 11-13-09 | 20. SIGNATURE OF REGIONAL OFFICIAL: //s// |
| 21. TYPED NAME: Cindy Mann | 22. TITLE: Director, CMSO |

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| 23. REMARKS: |
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
NURSING FACILITY SERVICES

2. Nursing Facility Rate Determination for Ventilator Dependent Residents

- (1) 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. Through June 30, 2012, the per diem will increase annually on January 1 by an annual inflation factor. The Department will use the Skilled Nursing Facility Total Market Basket (with capital) inflation factors from Global Insight and use the first quarter of the current year and compare it to the first quarter of the prior year to determine the annual inflation amount to be applied.
- (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.