

## **Table of Contents**

**State/Territory Name: Georgia**

**State Plan Amendment (SPA) #: 20-0009**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages



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**Financial Management Group**

June 15, 2021

Lynnette R. Rhodes, Esq.  
Executive Director, Medical Assistance Plans  
Department of Community Health  
2 Peachtree St., 36<sup>th</sup> Floor  
Atlanta, Georgia 30303-3159

RE: Georgia State Plan Amendment 20-0009

Dear Ms. Rhodes:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number 20-0009. Effective August 14, 2020, this amendment proposes to increase the reimbursement for ventilator dependent nursing facility residents. Specifically, this amendment proposes to increase the nursing facility per diem for a ventilator dependent resident by 3%. The rate will increase from \$540.55 to \$556.77.

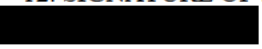
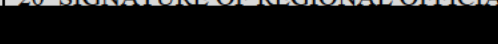
We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of August 14, 2020. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Christie Erickson at (410) 786-8441.

Sincerely,

[Redacted Signature]

For  
Rory Howe  
Acting Director

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>20-0009</b>	2. STATE <b>GEORGIA</b>
		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: <b>August 14, 2020</b>	
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ):			
NEW STATE PLAN <input type="checkbox"/>		AMENDMENT TO BE CONSIDERED AS NEW PLAN <input type="checkbox"/>	
<b>XX</b> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate Transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION:  <b>42 CFR 447.250</b>		7. FEDERAL BUDGET IMPACT:  FFY20: \$96,673  FFY21: \$290,019	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 4.19-D Page 34 and Supplement 1 to Attachment 4.19-D, page 1</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  <b>Attachment 4.19-D Page 34 and Supplement 1 to Attachment 4.19-D, page 1</b>	
10. SUBJECT OF AMENDMENT: <b>The Department is proposing a 3% rate increase for specialized nursing home mechanical ventilator care. The rate will increase from \$540.55 to \$556.77.</b>			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED:	
<input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED		<b>Single State Agency Comments Attached</b>	
<input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:  Department of Community Health Division of Medicaid 2 Peachtree Street, NW, 36th Floor Atlanta, Georgia 30303-3159	
13. TYPED NAME: <b>LYNNETTE R. RHODES, ESQ.</b>			
14. TITLE: EXECUTIVE DIRECTOR, <b>MEDICAL ASSISTANCE PLANS</b>			
15. DATE SUBMITTED: <b>9/30/2020</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: September 30, 2020		18. DATE APPROVED: 6/15/21	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: August 14, 2020		20. SIGNATURE OF REGIONAL OFFICIAL:  For	
21. TYPED NAME: Rory Howe		22. TITLE: Acting Director, Financial Management Group	

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-  
NURSING FACILITY SERVICES

2. Nursing Facility Rate Determination for Ventilator Dependent Residents

- (1) Effective for dates of service on and after July 1, 2019, the nursing facility per diem for a ventilator dependent resident will be \$540.55.

Effective for dates of service on and after August 14, 2020, the nursing facility per diem for a ventilator dependent resident will be \$556.77.

- (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

NURSING FACILITY RATE DETERMINATIONS FOR VENTILATOR DEPENDENT  
RESIDENTS

- (1) Effective for dates of service on and after July 1, 2019, the nursing facility per diem for a ventilator dependent resident will be \$540.55.

Effective for dates of service on and after August 14, 2020, the nursing facility per diem for a ventilator dependent resident will be \$556.77.

- (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.