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State/Territory Name: Florida

State Plan Amendment (SPA) #: 18-0004

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services Atlanta Regional Office 61 Forsyth Street, Suite 4T20 Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

August 17, 2018

Beth Kidder Deputy Secretary for Medicaid Agency for Health Care Administration 2727 Mahan Drive, Mailstop #20 Tallahassee, FL 32308

RE: Title XIX State Plan Amendment 18-0004

Dear Ms. Kidder:

We have reviewed the proposed amendment to the Florida State Plan, submitted under transmittal number FL 18-0004. This amendment increases the Personal Needs Allowance for Medicaid residents in institutional settings.

Based on the information provided, this amendment is approved on August 17, 2018. The effective date is July 1, 2018. We are enclosing the approved form HCFA 179 and plan pages. If you have any questions, please contact Cheryl L. Brimage at 404-562-7116 or by email at cheryl.brimage@cms.hhs.gov.

Sincerely,

//s//

Shantrina D. Roberts, MSN Associate Regional Administrator Division of Medicaid & Children's Health Operations

Enclosure

HEALTH CARE FINANCING ADMINISTRATION		ONID NO. 0938-0193
TRANSMITTAL AND NOTICE OF APPROVAL OF	1. TRANSMITTAL NUMBER:	2. STATE
STATE PLAN MATERIAL	2018-004	Florida
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE	
	SOCIAL SECURITY ACT (MEDIC	AID)
TO: REGIONAL ADMINISTRATOR	4. PROPOSED EFFECTIVE DATE	
HEALTH CARE FINANCING ADMINISTRATION	July 01, 2018	
DEPARTMENT OF HEALTH AND HUMAN SERVICES	July 01, 2010	
5. TYPE OF PLAN MATERIAL (Check One):	<u> </u>	
☐ 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: (in	
42 CFR 435.725	FFY 2017-2018 \$2,282	
12 61 11 150 17 20	FFY 2018-2019 \$6,847	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERS	EDED PLAN SECTION
Attachment 2.6-A, pg. 4a	OR ATTACHMENT (If Applicable):	
	Attachment 2.6-A, pg. 4a	
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
10. SUBJECT OF AMENDMENT:		
Personal Needs Allowance (PNA) – Increase in the PNA for Medicaid residents in institutional settings.		
Torsonal receds throwalice (1141) increase in the 1141101 medical residents in institutional settings.		
AL GOVERNADIG DELVERY (GL. 1.0.)		
11. GOVERNOR'S REVIEW (Check One):	M	
GOVERNOR'S OFFICE REPORTED NO COMMENT	☑ OTHER, AS SPECIFIED:	
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED	Reviewed by the Deputy Secretary for Medicaid	
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	who is the Governor's	designee.
12 SIGNATURE OF STATE A CENCY OFFICIAL	16 DETUDN TO	
12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: Ms. Beth Kidder	
	Deputy Secretary for Medicaid	
13. TYPED NAME:	Agency for Health Care Administration	
Ms. Beth Kidder	2727 Mahan Drive, Mail Stop #8	uon
14. TITLE:	Tallahassee, FL 32308	
Deputy Secretary for Medicaid	Tananassee, TL 32300	
15. DATE SUBMITTED: 08/14/18	Attention: Rules Unit	
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED:	18. DATE APPROVED: 08/17/18	
08/14/18 PLAN APPROVED – ONE COPY ATTACHED		
		EICLAL.
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/18	20. SIGNATURE OF REGIONAL OFFICIAL: //s//	
21. TYPED NAME:	22. TITLE: Associate Regional Admin	strator
Shantrina D. Roberts	Division of Medicaid & Children's Health Operations	
23. REMARKS:	Division of Medicald & Children's Hea	utii Operations
2J. KLIVII KKKJ.		

Revision: HCFA-PM-97-2

December 1997

Attachment 2.6-A Page 4a

OMB No. 0938-0673

State: <u>FLORIDA</u>

Citation

1924 of the Act 435.725 435.733 435.832

Condition or Requirement

2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care:

Personal Needs Allowance (PNA) of not less than \$30 For Individuals and \$60 For Couples For All Institutionalized Persons.

a. Aged, blind disabled:

Individuals \$130 Couples \$260

For the following persons with greater need:

Supplement 15 to <u>Attachment 2.6-A</u> describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

b. AFDC related:

Children <u>\$130</u> Adults \$130

For the following persons with greater need:

Supplement 15 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

c. Individual under age 21 covered in the plan as specified in Item B.7. of Attachment 2.2-A. \$130

TN No. 2018-004 Approval Date: <u>08/17/18</u> Effective Date: <u>July 1, 2018</u>

Supersedes TN No. 2014-009