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State/Territory Name: Georgia

State Plan Amendment (SPA) #:13-0028-MM7

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
- 4) Additional Attachments that are part of the state plan

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

February 9, 2015

Mr. Clyde L. Reese III, Esq.
Medical Assistance Plans
Georgia Department of Community Health
2 Peachtree Street, NW, 40th Floor
Atlanta, Georgia 30303

Re: Title XIX State Plan Amendment, GA 13-0028-MM7

Dear Mr. Reese:

Enclosed is an approved copy of Georgia's State Plan Amendment (SPA) 13-0028-MM7, which was originally submitted to the Centers for Medicare & Medicaid Services (CMS) on January 9, 2014. SPA 13-0028-MM7 establishes that one or more qualified hospitals are determining presumptive eligibility, and that the state is providing coverage for individuals determined presumptively eligible, in accordance with the Affordable Care Act. The SPA was approved on February 6, 2015. The effective date of this SPA is January 1, 2014.

We understand that the state is still in the process of finalizing its system to support hospital presumptive eligibility and is estimating an implementation date of February 26, 2015. If any systems or other issues threaten this date, the state should inform CMS as soon as possible.

Enclosed is a copy of the new state plan pages and attachments to be incorporated within a separate section at the back of Georgia's approved state plan.

If you have any questions, please contact Ms. Tandra Hodges of my staff at 404-562-7409.

Sincerely,

//s//

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

Medicaid State Plan Eligibility: Summary Page (CMS 179)

- State/Territory name:

Georgia

- **Transmittal Number:**

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

GA-13-002

- **Proposed Effective Date**

01/01/2014
(mm/dd/yyyy)

- **Federal Statute/Regulation Citation**

42 C.F.R. §

- **Federal Budget Impact**

	Federal Fiscal Year	Amount
First Year	2014	\$ 0.00
Second Year	2015	\$ 0.00

- **Subject of Amendment**

Character Count: out of 2000

Hospital Presumptive Eligibility

- **Governor's Office Review**

- Governor's office reported no comment
- Comments of Governor's office received

Describe:

- No reply received within 45 days of submittal
- Other, as specified

Describe:

Character Count: out of 2000

Pursuant to 42 C.F.R. § 430.12,

- **Signature of State Agency Official**

- Submitted By:

Therese Brisco

- Last Revision Date:

Jan 9, 2014

- Submit Date: Jan 9, 2014



Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Presumptive Eligibility by Hospitals

S21

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

Yes No

The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

A qualified hospital is a hospital that:

Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of
 its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance
 with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

Yes No

The eligibility groups or populations for which hospitals determine eligibility presumptively are:

Pregnant Women

Infants and Children under Age 19

Parents and Other Caretaker Relatives

Adult Group, if covered by the state

Individuals above 133% FPL under Age 65, if covered by the state

Individuals Eligible for Family Planning Services, if covered by the state

Former Foster Care Children

Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

Other Family/Adult groups:

Eligibility groups for individuals age 65 and over

Eligibility groups for individuals who are blind

Eligibility groups for individuals with disabilities

Other Medicaid state plan eligibility groups

Demonstration populations covered under section 1115

The state establishes standards for qualified hospitals making presumptive eligibility determinations.

TN No: 13-0028-MM7
Georgia

Approval Date: 02/06/15

Effective Date: 01/01/14

S21-1



Medicaid Eligibility

Yes No

Select one or both:

- The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Description of standards:

Qualified Hospital PE Performance Standards will be established at the end of the first (6) months.

The Department of Community Health (DCH) will review all Qualified Hospital (QH) Presumptive Eligibility (PE) determinations for the first six months before establishing specific performance standards.

This time period will allow DCH to eliminate any potential barriers to providing QH's with the proper tools to determine PE applications correctly and timely.

Base targets on data gathered during the initial implementation:

Georgia will look at the share of PE applicants who file a full application and are found eligible for regular Medicaid at the end of the six month review period, identify the average or median outcome on this measure, and use it to set the target for hospitals in 2015. There is an indicator on our hospital presumptive application so that we can monitor that a full Medicaid application was offered and completed.

Increasing benchmarks over time:

Georgia will start with a modest target accuracy but then increase it by five percentage points (or more) in future years.

Percent of PE determinations conducted accurately:

Georgia will require that 90 percent of a hospital's PE determinations be done correctly based on the information that an applicant has provided. If an applicant provides misinformation, his or her circumstances change, or his or her information cannot be verified, it would not affect a hospital's performance on the accuracy measure.

Percent of applicants checked for existing Medicaid enrollment:

Hospitals would be required to ensure that 100 percent of potential applicants are checked for existing enrollment in Medicaid before a PE determination is conducted. A screening function is built into the web portal.

Percent of applicants checked for prior PE enrollment:

Hospitals would be required to ensure that 95 to 100 percent of potential applicants are checked for recent PE determinations (e.g., with the exception of pregnant women, not enrolled in PE within prior 2 calendar years) before a new PE determination is conducted on their behalf. Hospitals would be trained to identify PE eligibility.

Qualified Hospitals may be disqualified from conducting PE determinations for failure to adhere to the above standards or the state's policies and procedures.

- The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.
- The presumptive period begins on the date the determination is made.
- The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

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Approval Date: 02/06/15

Effective Date: 01/01/14

Georgia

S21-2

Medicaid Eligibility

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

Periods of presumptive eligibility are limited as follows:

- No more than one period within a calendar year.
- No more than one period within two calendar years.
- No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.
- Other reasonable limitation:

	Name of limitation	Description	
+	Pregnant Women/because a woman can potentially have a miscarriage and conceive again before the end of 12 months.	Pregnant women may receive presumptive eligibility, once per pregnancy.	X
+	Infants and Children under age 19, Parents and Other Caretaker Relatives, Former Foster Care Children, and Women's Health (BCC)	Infants and Children under age 19, Parents and Other Caretaker Relatives, Former Foster Care Children, and Women's Health (BCC) may receive presumptive eligibility no more than one period within two calendar years.	X

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

- Yes No
- The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.
- The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

The presumptive eligibility determination is based on the following factors:

- The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)
- Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.
- State residency
- Citizenship, status as a national, or satisfactory immigration status

The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.



Medicaid Eligibility

	An attachment is submitted.	
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PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Date		<u>Date Updated</u>
Qualified Hospital Provider Name		
QH Provider ID Number:		
Address		
City, State, Zip Code		
County		
Phone		
FAX		
PE Coordinator		
Direct Phone Number		
Email Address		
PE Certification:	<u>Date Requested</u>	<u>Date Completed</u>
Parent/Caretaker with Child(ren)		
Children Under 19 Years of Age		
Pregnant Women		
Former FosterCare		
Women's Health ***		
*** Requires Certification from Department of Public Health for BCCP		
Page 1 of 3	Authorized User List Page 2	Corrective Action Plan Page 3

EFFECTIVE FOR SERVICES
 BEGINNING MONTH DAY YEAR

HP PROVIDER CONTACT CENTER
 P.O. BOX 105200
 TUCKER, GA 30085-5200

PHONE: 1-800-766-4456
 FAX: 1-866-483-1044



MEDICAID IDENTIFICATION NUMBER

PRESUMPTIVE ELIGIBILITY DETERMINATION FOR WOMEN'S HEALTH MEDICAID

VALID FOR LISTED MONTH ONLY

APPLICANT'S NAME: _____ MAIDEN NAME: _____
 APPLICANT'S ADDRESS: _____ TELEPHONE NUMBER: _____
 APARTMENT/LOT NUMBER: _____ SOCIAL SECURITY NUMBER: _____
 CITY: _____ STATE: _____ ZIP CODE: _____ COUNTY OF RESIDENCE: _____
 DATE OF INTERVIEW: _____

	FAMILY MEMBERS			DATE OF BIRTH MM/DD/YYYY	* RACE	GENDER	RELATION TO APPLICANT	MONTHLY GROSS INCOME			MONTHLY DISREGARDS		MONTHLY NET INCOME		
	FIRST NAME MI	LAST NAME	SUFFIX					TYPE	AMOUNT	FREQ	MONTHLY AMOUNT	STANDARD WORK DISREGARD		DEPENDENT CARE DISREGARD	
01							SELF								
02															
03															
04															
05															
06															

SWORN STATEMENT OF APPLICANT:

I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILITY FOR MEDICAID AND THAT THE ARROWHEAD RIGHT FROM THE START MEDICAID (ARSM) PROJECT WILL DETERMINE MY CONTINUING ELIGIBILITY.
 I DECLARE UNDER PENALTY OF PERJURY THAT I AM A U.S. CITIZEN OR LAWFULLY PRESENT IN THE UNITED STATES AND I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ABOUT MY FAMILY AND INCOME.
 I AGREE TO ASSIGN TO THE STATE ALL RIGHTS TO MEDICAL SUPPORT AND THIRD PARTY SUPPORT PAYMENTS (HOSPITAL AND MEDICAL BENEFITS).
 I UNDERSTAND THAT MY ELIGIBILITY FOR THIS TEMPORARY ELIGIBILITY ENDS THE MONTH IN WHICH ARSM MAKES THE DECISION ABOUT MY CONTINUING ELIGIBILITY.
 I WILL REPORT ALL CHANGES IN MY HOUSEHOLD WITHIN 10 DAYS.

DATE OF APPLICATION _____ APPLICANT'S SIGNATURE _____
 * By providing Race information, you will assist us in administering our programs in a non-discriminatory manner. You are not required to give us this information and it will not affect your eligibility or benefit level.

TOTAL GROSS INCOME = _____ CHILD SUPPORT DISREGARD = _____
 NUMBER IN FAMILY = _____ TOTAL FAMILY NET INCOME = _____
 POVERTY INCOME LEVEL = _____
 Applicant is ELIGIBLE or INELIGIBLE for PE WHM.
PROVIDER CERTIFICATION:
 I CERTIFY THAT THE WOMAN FOR WHOM THIS PRESUMPTIVE DETERMINATION OF ELIGIBILITY HAS BEEN DETERMINED WAS SCREENED IN ACCORDANCE WITH THE REQUIREMENTS OF PUBLIC LAW 106-354 ON _____
 HER DIAGNOSIS MET THE BCC PROGRAM IN GEORGIA. I HAVE OBTAINED A SIGNED HEALTHCARE COVERAGE APPLICATION FROM THE APPLICANT AND HAVE FAXED IT TO THE ARROWHEAD (ARSM) PROJECT AT 770-359-1813.

DATE OF COMPLETION _____ COMPLETED BY (PLEASE PRINT) _____ TITLE _____
 DIRECT PHONE NUMBER _____ SIGNATURE OF INDIVIDUAL COMPLETING FORM _____
 QUALIFIED PROVIDER NAME _____ QUALIFIED PROVIDER ID NUMBER _____



Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

GEORGIA QUALIFIED HOSPITAL PROVIDER AGREEMENT FOR PRESUMPTIVE ELIGIBILITY MEDICAID DETERMINATIONS

Qualified Hospital (QH) Name: _____

Qualified Hospital Provider agrees:

- 1. To participate as a qualified hospital provider in the Georgia Medicaid program with the Department of Community Health (DCH);
2. To complete full Presumptive Eligibility (PE) Medicaid training;
3. To maintain PE Medicaid knowledge with PE Manual usage, and PE Medicaid meetings;
4. To complete monthly internal reviews of PE Medicaid cases for both approved and denied PE Medicaid applications, act upon findings when required;
5. To conduct periodic PE Medicaid refresher training for veteran staff and full PE Medicaid training for new workers. Submit completed training list to DCH monthly (DCH/QH worksheet provided);
6. To correctly determine Presumptive Eligibility (PE) in accordance with Medicaid regulations and guidelines as promulgated by the Department of Community Health; all procedures and regulations are outlined in each PE Medicaid manual;
7. To participate in quality assurance reviews which will be conducted by the Department of Community Health;
8. To timely act upon corrective action required by the Department of Community Health.

Failure to continue to meet any of the above conditions shall be cause for termination of this qualified hospital provider agreement.

The qualified hospital provider also agrees that either the qualified hospital provider, or the Department of Community Health, may terminate this agreement by giving the other party thirty (30) days written notice.

Date

Signature of Authorized QH Provider

QH Provider ID Number

Title



Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

ACA Presumptive Eligibility (PE) for Medicaid Training Statement of Completion of Required PE Training

Employee's Name (Please Print)

Qualified Hospital Provider ID Number

All Qualified Hospital Providers must complete PE policies & procedures training prior to rendering PE services. After review of all of the PE training documents and requirements listed below, please initial and enter date next to each policy, sign at the bottom of the page, and return the originals to your PE Coordinator, fax a copy to DCH at 1-770-302-8169 or email to pecorrections@dch.ga.gov within five (5) business days of completion of training.

Table with 4 columns: Initials, Date, Document/Form, Title. Rows include ACA PE Manual, DMA-632H, DMA-Form 216, DMA-634H, Medicaid Application Order Forms, PE Document, PE Document, and P4HB.

By my initials and signing, I acknowledge that I am aware of and accountable for compliance of ACA Presumptive Eligibility for Medicaid program policies and procedures.

Employee's Signature: _____ Date: _____

By my signature below, I acknowledge my responsibility to ensure that this employee is aware of PE Medicaid policies and procedures and DCH compliance requirements.

PE Coordinator's Name (Please Print): _____

PE Coordinator's Signature: _____ Date: _____