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State/Territory Name: Georgia

State Plan Amendment (SPA) #: 19-0010

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
61 Forsyth Street S.W. Suite 4T20
Atlanta, Georgia 30303-8909

Atlanta Regional Operations Group

October 18, 2018

Lynette Rhodes, Esq.
Executive Director, Medical Assistance Plans
Department of Community Health
2 Peachtree Street, NW, Suite 36-450
Atlanta, Georgia 30303

Dear Ms. Rhodes:

We have reviewed the proposed amendment to the Georgia Medicaid State Plan (SPA) GA 19-0010 (Personal Needs Allowance Increase for Nursing Home Residents) that was submitted on September 30, 2019. This state plan amendment was submitted in order to increase Social Security Income (SSI) nursing home resident's monthly supplement to $70 per month.

Based on the information provided, the Medicaid State Plan Amendment GA 19-0010 was approved on October 18, 2019. The effective date of this amendment is July 1, 2019. We are enclosing the approved HCFA 179 and the plan page.

Should you have questions or need further assistance, please contact Etta Hawkins at (404) 562-7429, or etta.hawkins@cms.hhs.gov.

Sincerely,

/s/

Davida R. Kimble
Acting Deputy Director
Division of Medicaid Field Operations South

Enclosure

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 19-0010

2. STATE: GEORGIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2019

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

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN x☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 C.F.R. 447.205; 42 C.F.R. 440.40

7. FEDERAL BUDGET IMPACT:
a. FFY 2020 $829,390

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 2.6-A, Page 4a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 2.6-A, Page 4a

10. SUBJECT OF AMENDMENT:
This State Plan Amendment is for Nursing Home Personal Needs Allowance (PNA) Rate Increase.

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
x☐ OTHER, AS SPECIFIED:
Single State Agency Comments Attached

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//s//

13. TYPED NAME:
LYNNETTE R. RHODES, ESQ.

14. TITLE: Executive Director, Medical Assistance Plan

15. DATE SUBMITTED: 09/27/19

16. RETURN TO:
Department of Community Health
Division of Medicaid
2 Peachtree Street, NW, 36th Floor
Atlanta, Ga 30303-3159

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09/27/19

18. DATE APPROVED: 10/18/19

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
07/01/19

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME:
Davida R. Kimble

22. TITLE: Acting Deputy Director
Division of Medicaid Field Operation South

23. REMARKS:

Citation	Condition or Requirement
1924 of the Act 435.725 435.733 435.832	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 $ 70.00
Couples $ 140.00

For the following persons with greater need:

Supplement 12 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.

b. AFDC related:
Children $ 70.00
Adults $ 70.00

For the following persons with greater need:

Supplement 12 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.