MEDICAID MODERNIZATION

FOR A

NEW GEORGIA

CONCEPT PAPER: SECTION 1115a WAIVER

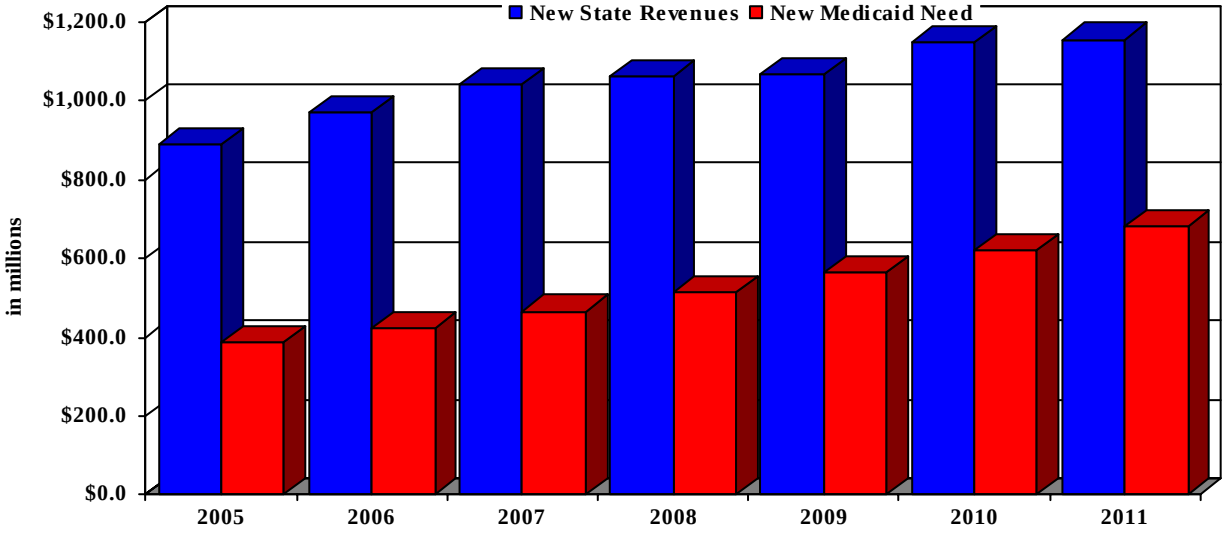
Governor Sonny Perdue
State of Georgia
Draft 5/20/05

I. Statement of Purpose

The Georgia Medicaid program currently faces the prospect of large and deepening annual deficits that will adversely affect Georgia's planning and flexibility to allocate new tax revenues. By fiscal year 2009, the Medicaid program will consume over 50% of all new state revenue.

Figure 1.1 below represents the proportion of all new revenues allocated to non-Medicaid related expenses versus new revenues that will need to be directed toward Medicaid related expenses. It is projected that unabated growth of Medicaid expenditures will consume 60% of all new state revenue by the year 2011.

Figure 1.1 – New State Revenues vs. New Medicaid Need



	FY05	FY06	FY07	FY08	FY09	FY10	FY11
New Revenue (Discretionary)	60%	56%	55%	52%	47%	46%	40%
New Revenue (Medicaid)	40%	44%	45%	48%	53%	54%	60%

Georgia's Medicaid program needs a fundamental, systemic change. The factors driving growth, including restrictive use of resources and growing program complexity, need to be brought under control. Everyone, including beneficiaries and providers, needs to share equitably in the solution.

Georgia is proposing a Medicaid Reform Model that would capitate federal spending for all Medicaid services, initiatives, and administrative costs for 3 to 5 years. Federal funding would be based on a mutually agreed upon base year expenditure and projected growth trends. Federal funds would no longer be based upon the traditional funding formula requiring a state match. The agreed upon model would be calculated as follows:

Base Year Expenditures

*

Per Member Per Year (PMPY) Growth Projection

*

Enrollment Growth Projection

=

Projected New Base

Note: All projections (trends) would be actuarially certified

The PMPY growth rate would be fixed for the contract period while the enrollment growth rate would be variable based on agreed upon macroeconomic indicators. Georgia would be financially at risk for managing within the targeted amount and would benefit from any savings accrued due to program efficiencies that are achieved.

Georgia believes that the innovative strategies described in this document will enable the state to effectively manage public resources while preserving access to health care services. The state is seeking federal authority to reform its program to control overall program expenditures in exchange for a continued, predictable commitment of federal funding. The state believes its strategies will result in program spending below levels that would be experienced absent program reform. The program reformations would also include provisions that would allow Georgia to share in any special arrangements that might be enacted in the future as well as a "*force majeure*" relief clause in the event of a medical catastrophe.

The state will seek federal funding at levels consistent with historical program growth. Figure 1.2 presents historical program funding and caseload for State Fiscal Years 2000 – 2005.

Figure 1.2 – Historical Expenditures and Caseload Growth, SFY 2000 – 2005

Aggregate Expeditures	State Fiscal Year						Avg. Annual Trend
	2000	2001	2002	2003	2004	2005	
Federal Funds	$ 2,122,230,811	$ 2,412,931,366	$ 2,764,307,988	$ 3,285,044,235	$ 3,830,015,417	$ 3,999,730,907	14.7%
Matching Funds	$ 1,411,597,197	$ 1,613,376,115	$ 1,874,970,922	$ 2,133,344,832	$ 2,249,214,525	$ 2,581,865,141	13.8%
Total, State and Federal	$ 3,533,828,008	$ 4,026,307,481	$ 4,639,278,910	$ 5,418,389,066	$ 6,079,229,942	$ 6,581,596,048	14.4%
Program Caseload	970,154	1,071,054	1,201,755	1,330,889	1,437,502	1,499,373	9.1%
Average Cost per Enrollee	$ 3,643	$ 3,759	$ 3,860	$ 4,071	$ 4,229	$ 4,390	3.4%

II. Values for Health Care in a New Georgia

In Georgia, health care services provided through Medicaid will be based on the consumer and physician relationship. This consumer and/or physician relationship will be the driving force for decision making for the consumer's care. A "Common Sense" health care delivery approach will be the main focus, in which each consumer will have a "Medical Home" and the consumer and their physician will manage their health care with prevention services, routine care, and acute care with a personalized and well developed discharge plan for both short-term and long-term community-based care.

III. Personal Choice and Responsibility

In Georgia's reformed Medicaid system, consumers will partner with their physicians to determine the care they will receive and how the consumer's health care will be funded using a combination of state funds, Medicaid funds, and consumer cost sharing. Benefits and funding will be tailored to each consumer's individual needs through the use of managed care organizations, transparent pricing and quality measures, flexible health savings accounts, and cost sharing programs.

The reforms listed below are split between mandatory and optional categories of eligibility and services. However, the most important consideration for the state in moving away from an entitlement to a wavier for Medicaid is the amount of flexibility the state will be given to manage mandatory eligibles and services. In Georgia, this is particularly important since 64% of Medicaid expenditures are for mandatory eligibles and 59% of expenditures are for mandatory services.

A. Mandatory Eligibles and Services

1. Beneficiary Cost Sharing
   a) Institute Beneficiary Co-Payments – Currently Medicaid co-payments are virtually non-existent. Where co-payments are allowed, the maximum payment is $3 and is limited to certain services. The broader application of co-payments would be beneficial to the state in terms of controlling service utilization – particularly for over-utilized services such as emergency room care.
   b) Expand Sliding Scale Premiums such as the one instituted in the PeachCare for Children Program. (SCHIP) Sliding scale premiums help target medical benefits to the neediest, meaning the poorest get the highest subsidy and those with higher incomes pay more.

2. Allow flexibility regarding Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Requirements.

   The EPSDT service is a comprehensive and preventive child health program for eligible children and youth under the age of 21. Under this program, the state must provide eligible children with periodic screening, vision, dental, and hearing services. The state is also required to provide any medically necessary health care, even if the service is not available under the State's Medicaid plan. Under the proposed Medicaid wavier, the requirement to provide any medically necessary service could be limited to a prescribed set of services that are shown to promote children's health.

3. Eliminate the Nursing Home Level of Care Standard/Make Nursing Home Services Optional
   Current law requires that for the elderly and disabled to be eligible for community-based services they must first be determined eligible for nursing home level of care. As a result, an individual's need must be more acute and the more expensive nursing home is treated as the preferred care option. By eliminating the nursing home level of care requirement for community services, the state may be able to provide more preventative and less expensive services to the elderly and disabled thus avoiding the more expensive nursing home beds. In addition, converting nursing home services from an entitlement to an optional service would limit backfilling of nursing home beds and promote more affordable options for care in the community. As an optional service, nursing home care would be available only after it is determined that there is no suitable community placement for an individual. (See Appendix IV for the HomeFirst Georgia Program).

B. Optional Eligibles and Services

1. Beneficiary Cost Sharing

   Institute higher co-payments for optional populations and services – particularly pharmacy services. If the member is unable to make the co-payment the prescription is not filled. Georgia could institute a tiered co-payment for drugs according to whether the drug is a generic or brand.

2. Cap or Blockgrant Funding for Optional Services and Populations

   While the largest optional population (PeachCare) already receives capped funding the state could opt to cap funding for other optional populations and services. This would mean the state would receive a waiver on the comparability of services by eligibility group for optional populations. Therefore, the state would be able to provide a more customized set of services for a particular population instead of all members having access to the same scope of services. This might be an easier way to control utilization for optional services such as podiatry, optometry and adult dental.

3. Flexible Health Spending Accounts

   Flexible health spending accounts will be used to encourage and reward consumers for making healthy choices and participating in prevention programs. If consumers choose to participate, a specific amount will be placed in the flexible account. The amounts offered will be an amount for individual coverage and an amount for family coverage. The funds in the flexible account may be used to pay for the costs of sharing obligations or optional benefits.

IV. Marketplace Transparency

As previously mentioned, Medicaid currently creates an obligation to fund mandatory services for a specifically defined set of people. This system hides the cost of the service from the consumer, and treats all health care providers the same regardless of quality of care they provide or health care outcomes they achieve.

In Georgia's Medicaid system, consumers will have the opportunity to select providers and health care services based upon cost and the quality of the service. If consumers choose health care that is cost effective and high quality, they will reduce their obligation for cost sharing. Providers that provide high quality services will have the ability to gain a larger market share. The following scenario is an example of how "Marketplace Transparency" would work.

> Would you buy a TV at any store and wait to see what the price was after you received your bank statement? Moreover, a highly recommended store that was in your "network" of preferred electronic stores? Would you think you got the best price or deal, assuming all TVs have similar quality? Probably not.....yet, this is how the average family does business in the US healthcare provider industry.
>
> Now, imagine a young consumer (the healthcare decision makers), whose family is covered by XYZ Insurance company, going to XYZ's website or call center and does a little price comparison shopping for all her vision care needs.

She quickly sees that there are 17 physicians in the XYZ network, in her service area, that all have similar outcomes. She then looks to see where these 17 like to undergo their procedures. Although she has been referred by a friend to Doctor A, she quickly sees that Doctor D has historically performed as well as Doctor A and that the combination of Doctor D and her preferred hospital shows a significant savings over most of the other physician / hospital combinations. She elects to "buy" from Doctor D.

Although this consumer is altruistic and always tries to do the right thing, there was a financial incentive regarding her choice. The savings she received was recognized by XYZ Insurance Company who promptly issued her a consumer savings credit that she can apply to next year's XYZ's insurance premiums. Had she elected to do business with Doctor A, referred to her by her close friend, she would have received the opportunity to realize a slight increase in those same employee contributed health premiums. This is Consumer Choice.

So, what are the barriers as to why the general public has little to no knowledge of what our healthcare costs? Is it lack of data, pricing and quality, and what they are capable of providing or proving? Partly. If we can get to these quality and pricing indicators, will there be resistance? Probably. But why?

For consumer driven healthcare to really work, we need to know costs, prices and quality. That is how we buy just about all we buy, except for healthcare. It is time we tried to shine a light here and start the dialogue with the health industry. We simply can't consume in ignorance and just pay the price.

Prescription Drugs

Marketplace Transparency will be used in the pharmacy benefit plan as a tool to place downward pressure on the cost of prescription drugs. Using a web based system consumers would have access to information about drug cost and dispensing fees for all drug categories. The state would set a specific cost and dispensing fee it would pay in each drug category. Consumers choosing to purchase drugs at the cost and dispensing fee set by the state would not share in the cost the drug. However, consumers choosing drugs above the state set cost and dispensing fee would pay the difference between the state rates and the actual charge of the drug from the pharmacy. The state would ensure that at least on drug in every category was available at no charge and that consumers would have access to that drug from a pharmacy within a reasonable distance from the consumer.

For Marketplace Transparency to work, Georgia's Medicaid system will use technology to pull together the right information, at the right time and place to ensure the right medical decision is made in the most cost efficient manner. Consumers and physicians will have easy access to consumer service histories, provider costs and quality assessments on a web accessible health care information system. Types of information included in the health care information system will be:

- Consumer demographics
- Eligibility status
- Covered services
- Cost sharing information (premiums or co-pays)
- Allergies
- Immunization records
- Prescription medication, including quantity and date dispensed
- Diagnoses
- Service history
- Lab history
- Provider contact information

V. Quality Health Care Outcomes

The Georgia Medicaid system will embark upon a process to develop a clearly defined, commonly held vision for improving Georgians' health. This vision will result in multi-level alignment and support; definition of the state's health policy priorities; and expanded public/private partnerships to facilitate and inform health policy.

The process will entail**:**

1. Listening directly to the needs of Georgians; gathering and translating national and State-specific health and process information;
2. Convening government, business, provider, philanthropic, community, consumer, insurer, researcher, and other stakeholders to define and implement the change needed to reach our vision;
3. Brokering resources to maximize our potential;
4. Strengthening the power of local communities; and
5. Evaluating what is done to inform further research and improve policies and programs.

Momentum is building throughout the state to better understand and improve the health of Georgians. In the past few months, a growing number of people, programs, and projects that seek to connect with a broader picture of Georgia's current and future health have emerged. The following agencies are an integral part of creating a Georgia's Medicaid reforms.

The Provider Council, an organization representative of physician, nurse, hospital, and other providers, seeks to generate consensus about health policy among key stakeholder groups, including representatives from business, consumer, provider, philanthropic, and government sectors.

Georgia Health Decisions, a non-profit with nearly 15 years of experience in structured listening to gather Georgians' input and opinions about health issues, is developing a process to improve health status by improving the behavioral, biological, and environmental conditions that put people at risk for poorer health.

The Georgia Department of Community Affairs is working to make the connection between healthcare and economic development. At the same time, the Georgia Department of Community Health's Office of Rural Health Services has commissioned a statewide rural health plan.

In addition, Governor Perdue's Commission for a New Georgia, a non-profit corporation chartered to identify ways state government can better manage its assets and services and map its strategic future, recently established a taskforce to focus on mental health. These examples offer a snapshot of the people, programs, and projects in action and the momentum in support of better health in Georgia. Although specific priorities and outcomes will emerge from our planning process, possible outcomes could include:

Providing comprehensive, prevention-oriented care:

1. Appropriate service utilization trends in emergency room and child-well visits.
2. Appropriate service utilization trends for specific sub-populations, such as PeachCare kids, pregnant women, or minorities.

Building on the strengths of Georgia's current healthcare delivery system**:**

1. Adequate provider networks.
2. Adequate provider rates (compared to fee-for-service).

Quality of care:

1. Quality of care audits that demonstrate improvements in system performance and clinical view, such as utilization review, immunization performance standards and Diabetes performance standards.
2. Timeliness of claims processing for providers.

Achieving value and budget predictability for state dollars:

1. Provide a stable financial platform for payers and providers.
2. Reasonableness of administrative costs in relation to the program and compared to other states.

Georgia is requesting that CMS evaluate the success of its Medicaid reforms by the improvement in its health care indicators, rather than traditional means of measurement.

VI. Implementation Outline

The State of Georgia proposes to start an implementation of Medicaid reform with a review of eligible populations. The implementation plan will be rolled out by regions until the entire the state is completed. Upon evaluation of the reform effort, the state will develop an implementation plan by commencing to add other population groups. The implementation timeline will be determined by January 1, 2006.

Appendix I

Transformation of Entitlements under the Proposed Medicaid Contract

As an entitlement or mandatory program, Medicaid creates a government obligation to finance health services for a specified set of people, with no aggregate limit on funding. As a result, government funding for Medicaid becomes difficult to predict and even more difficult to control. The Medicaid entitlement is prescribed by both federal and state law but at a minimum is driven by federal law requiring certain mandatory categories of eligibility and health services. States must conform to these mandatory requirements in order to receive federal matching funds. In addition, health services under Medicaid are available at no cost or minimal co-pay (up to $3) for all members. Finally, contingent upon federal approval, states do have the option to expand the categories of eligibility and medical services to best meet the needs of their populations. These optional eligibles and medical services must have federal approval and must be detailed in the state's Medicaid plan.

Existing Categories of Mandatory Medicaid Coverage – Eligibility

Table 1 below lists the categories of mandatory coverage and the calendar year 2003 expenditures and number of eligibles. Note – additional charts on eligibility are included within Appendices II and Appendices III.

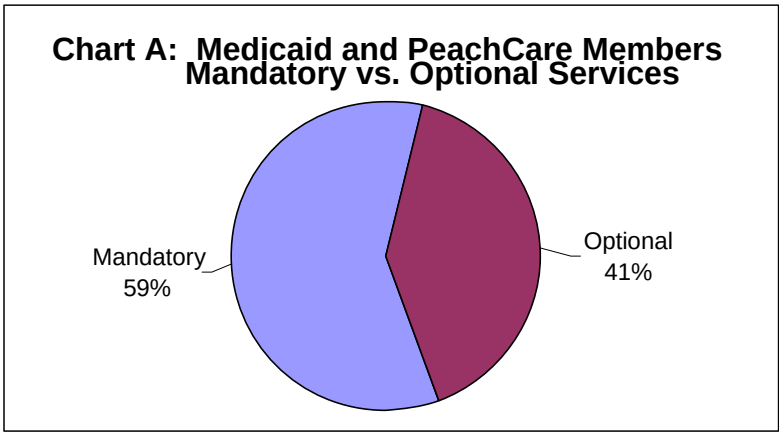
Table 1 The Mandatory Eligible Population	CY 2003 Expenditures	Eligibles
a. Low Income Medicaid (LIM) for Parents and Children - Standard of Need $6,088	$ 701,500,000	309,000
b. Pregnant Women and children under age 1 at or less than 185% FPL ($28,376)	$ 703,500,000	122,600
c. Children under age 6 at or less than 133% FPL ($20,301)	$ 207,600,000	167,000
d. Children ages 6 to 19 at or less than 100% FPL ($15,264)	$ 305,200,000	232,400
e. SSI Recipients and Elderly and Disabled Nursing Home Eligible	$ 1,889,000,000	231,000
f. Qualified Medicare Beneficiaries (QMB)	$ 30,800,000	44,900
g. Transitional Medicaid for Parents and Children	$ 102,800,000	58,200
h. Emergency Medical – Aliens	$ 83,400,000	3,380
TOTAL	$ 4,023,800,000	1,168,480

Existing Categories of Optional Coverage – Eligibility

Table 2 below lists the categories of optional coverage as detailed in Georgia's State Plan for Medicaid and the State Children's Health Insurance Program. This population is typically referred to as the categorically needy. The largest optional population is for the State Children's Health Insurance Program (PeachCare). Note – additional charts on eligibility are included within Appendices II and Appendices III.

Table 2 The Optional Population - Eligibility	CY 2003 Expenditures	Eligibles
a. Medically Needy Pregnant Women and Children - Over 200% FPL	$4,900,000	6,600
b. Pregnant Women - Right From the Start Medicaid	$59,000,000	8,000
c. PeachCare Children up to 235% FPL and Medicaid Infants up to 200% FPL	$275,400,000	201,200
d. Breast and Cervical Cancer State Plan Option	$27,000,000	1,700
e. Medically Needy - Elderly and Disabled - 100% SSI	$82,700,000	6,200
f. Medically Needy Nursing Home Level of Care - Over 300% SSI	$38,300,000	1,700
g. Nursing Home Level of Care - under 300% SSI	$102,800,000	58,200
h. Community Care Services Program Waiver - Elderly and Functionally Impaired - under 300% SSI	$80,700,000	6,100
i. Independent Care Waiver Program - Severely Physically Disabled 21 - 64 years old and under 300% SSI	$13,600,000	280
j. Mental Retardation Waiver Program/Community Habilitation and Social Services Program - under 300% SSI	$35,200,000	1,200
k. Medically Fragile Under 21 years old - under 300% SSI	$31,500,000	400
l. Katie Beckett Deeming Waiver - under 100% SSI	$33,000,000	5,900
m. Terminally Ill/Hospice - under 300% SSI	$10,200,000	570
TOTAL	$794,300,000	298,050

Georgia's mandatory eligible population constitutes the majority of the members enrolled in Medicaid. Chart A includes the State Health Insurance Program known as PeachCare, which is classified as an optional population.



While mandatory services comprise the majority of Medicaid and PeachCare expenditures, optional services comprise a significant 41% of expenditures with the single largest optional service being the pharmacy category at nearly $1.1 billion or 51% of optional service expenditures. It is important to note that $321 million or 15% of the optional services in FY 2004 were associated with home and community-based waiver in which the state offers an alternative health care package for individuals who would otherwise be institutionalized under Medicaid. States are not limited in the scope of services they provide under these waivers so long as they are cost effective.

Mandatory Services

Federal law (42 USC 1396 d(e)) requires states to provide certain health services to all Medicaid enrollees in order to receive federal matching funds. Table 3 lists these mandatory services and the estimated expenditures by service for state fiscal year 2004. It is important to note that under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, any additional medical services identified as medically necessary for eligible children must be provided by Medicaid, even if those services are not specified as part of covered services in the state's Medicaid Plan.

Table 3: Mandatory Services – Medicaid and PeachCare

Service	FY 2004 Est. Spread*
Inpatient Hospital Care	$1,157,882,253
Skilled Nursing Facilities (SNF)	$743,482,412
Physician Services	$660,232,862
Outpatient Hospital Care	$641,490,777
Intermediate Care Facilities (ICF)	$158,761,120
Early Periodic Screening, Diagnosis and Treatment (EPSDT)**	$48,010,685
Durable Medical Equipment	$38,039,766
Independent Laboratory	$26,534,068
Nurse Practitioner	$17,985,760
Nurse Mid Wife	$14,038,755
Home Health	$11,825,343
Federally Qualified Health Centers	$9,699,995
Physician Assistant Services	$8,521,674
Intermediate Care for the Mentally Retarded (ICFMR)	$6,142,626
Hospital Based Rural Health Centers	$4,541,895
Free Standing Rural Health Centers	$4,310,831
Nursing Facility-based Mental Health services (PASARR)	$3,018,287
Family Planning	$2,733,681
Unknown Category of Service	$396,834
Oral Surgery	$171,069
Chiropractic (Medicare only)	$39,706
Rehabilitative Therapy (Medicare only)	$25,750
Physical Therapy (Medicare only)	$22,747
Licensed Clinical Social Work	$16,656
Speech Therapy (Medicare only)	$689
Subtotal – Mandatory Benefits	**$3,557,926,242**
Service State-Owned Facilities	**FY 2004 Expenditures**
State-owned ICFMR (DHR)	$102,849,336
State-owned SNF (DHR)	$26,316,579
State-owned ICF (DHR)	$2,034,665
Subtotal – Mandatory Benefits State-Owned Facilities	**$131,200,580**
Total - All Mandatory Benefits	**$3,689,126,821**

***FY 2004 actual expenditures by category of service will be available in June 2005 from DCH.**
****Under EPSDT, the state must provide all medically necessary services. This includes optional services. If an optional service is only available through the EPSDT program it does not appear on this chart.**

Optional Services

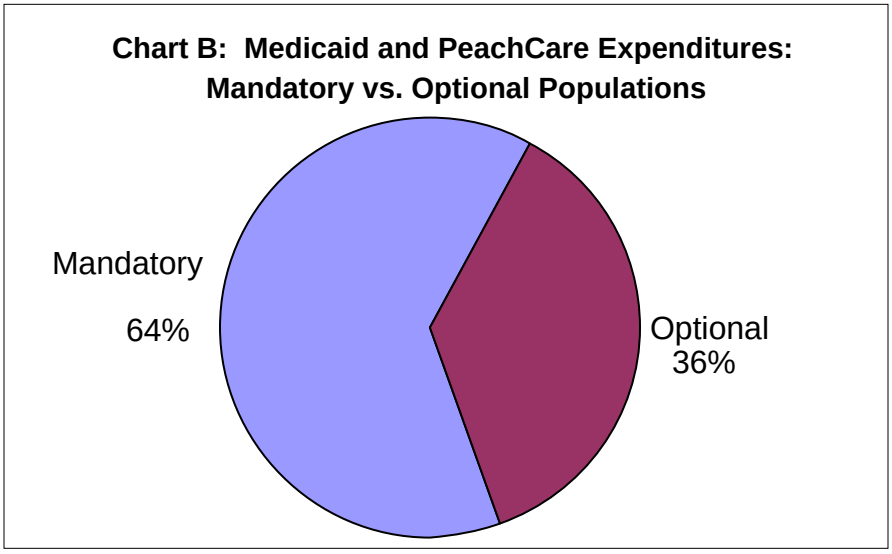
States can also receive federal funding if they opt to provide certain medical services. The optional services and expenditures provided in Georgia are detailed in Table 4.

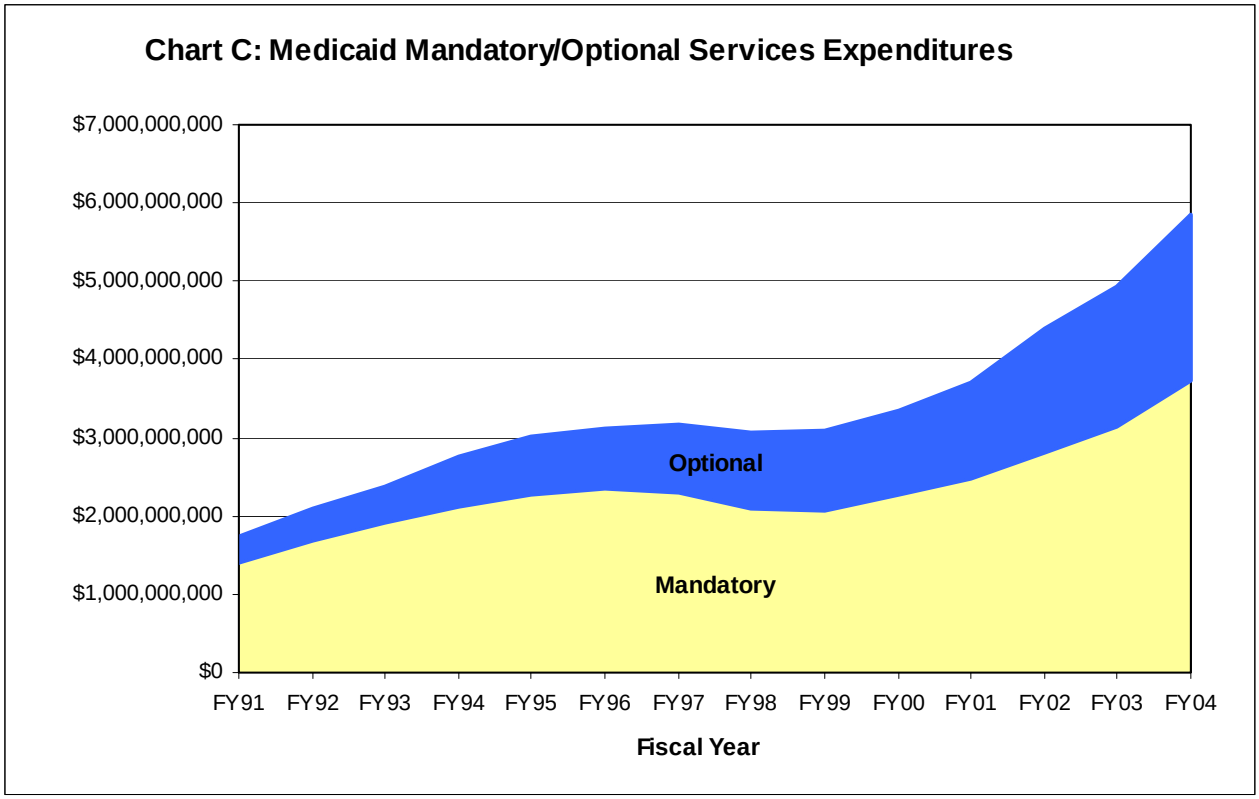
Table 4: Optional Services – Medicaid and PeachCare

Service	FY 2004 Total Expenditures	FY 2004 Expenditures for Children	FY 2004 All Other Expenditures
Pharmacy	$1,084,347,750.14	$269,547,545.96	$814,800,204.18
Children's Dental	$183,257,814	$128,408,836.65	$54,848,977.32
Children Intervention Services	$52,985,797	$49,037,658.61	$3,948,138.74
Dialysis Services - Technical	$31,084,678	$299,517.50	$30,785,160.54
Hospice	$30,573,795	$692,764.52	$29,881,030.15
Independent Care Waiver Program	$26,659,103	$511,597.46	$26,147,505.58
Psychology	$24,734,547	$20,361,932.82	$4,372,614.14
SOURCE Case Management	$24,489,479	$402,228.89	$24,087,250.28
Emergency Ambulance	$22,635,798	$6,036,513.40	$16,599,284.64
Georgia Better Health Care	$21,044,873	$12,676,241.17	$8,368,631.69
Adult Dental	$18,118,450	$49,631.37	$18,068,818.67
Optometric	$11,914,980	$7,057,241.42	$4,857,738.21
Pharmacy DME Supplier	$11,101,818	$2,694,478.39	$8,407,339.83
Orthotics and Prosthetics	$9,992,485	$5,267,879.68	$4,724,605.32
Ambulatory Surgical Centers	$8,378,714	$3,796,182.58	$4,582,531.19
GAPP In-Home Private Duty Nursing	$8,141,562	$8,100,830.24	$40,731.98
Model Waiver Program	$7,400,733	$7,400,733.47	$0.00
Dedicated Case Management Services	$6,361,626	$491,289.42	$5,870,336.98
Early Intervention Program	$4,642,845	$4,599,423.85	$43,421.50
Perinatal Case Management	$4,639,762	$204,139.59	$4,435,622.60
Podiatry	$4,097,700	$682,762.34	$3,414,937.35
Emergency Air Ambulance	$1,392,989	$1,147,866.60	$245,122.54
Dialysis Services – Professional	$1,279,641	$21,312.66	$1,258,328.27
Pregnancy Related Services	$1,065,188	$130,422.10	$934,765.96
Hospital Beds used for SNF services	$464,545	$425.30	$464,120.15
Adults with AIDS Case Management	$259,720	$1,926.40	$257,793.91
GAAP Medically Fragile Daycare	$55,728	$55,728.35	$0.00
Childbirth Education	$15,651	$1,323.81	$14,327.01
Mental Retardation Waiver Program (DHR)	$128,792,734	$6,246,230.58	$122,546,503.34
Community Mental Health Services (DHR)	$97,012,775	$38,293,617.56	$58,719,157.39
Therapeutic Residential Intervention Services (DHR)	$93,733,625	$93,549,130.61	$184,494.54
Community Care Services Program (DHR)	$90,787,076	$1,239,301.49	$89,547,774.14
Community Habilitation and Support Services (DHR)	$50,345,241	$4,518,400.11	$45,826,841.35
Child Protective Services Case Management (DHR)	$38,097,982	$38,050,254.08	$47,727.88
School-based Children's Intervention Services (DOE)	$13,305,336	$11,715,925.77	$1,589,410.64
At Risk of Incarceration Case Management (DJJ)	$7,669,920	$7,566,368.60	$103,550.95
Diagnostic, Screening, and Prevention Services (DHR)	$5,134,067	$2,927,763.61	$2,206,302.92
Adult Protective Services Case Management (DHR)	$3,597,763	$103,972.13	$3,493,790.55
Children at Risk Targeted Case Management (DHR)	$2,687,556	$2,652,423.26	$35,132.95
Total – All Optional Benefits	$2,132,301,848	$736,541,822	$1,395,760,025

Chart B below shows the ratio of optional populations to mandatory populations.

Chart C shows trends in optional and mandatory services spending since FY 1991.





Appendix II

Medicaid and PeachCare Eligibility by Income:

<table>
<tr><th>Annual Income (family size = 3)</th><th>% of Federal Poverty Level</th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th></tr>
<tr><td></td><td>over 235%</td><td></td><td colspan="2" rowspan="2">Spend Down for Non-Categorical Pregnant Women/Children[6]</td><td rowspan="2"></td><td rowspan="2"></td><td rowspan="2"></td><td></td><td></td><td rowspan="2"></td></tr>
<tr><td>$36,008</td><td>235% FPL</td><td rowspan="2">Presumptive Eligibility[3]</td><td rowspan="2">PeachCare for Kids[2]</td><td rowspan="2">PeachCare for Kids</td><td rowspan="2">PeachCare for Kids</td><td></td><td></td></tr>
<tr><td>$30,681</td><td>200% FPL</td><td>RSM[7]</td><td>Medicaid</td><td></td><td></td><td rowspan="4">Transitional Medical Assistance (TMA)[4]</td><td rowspan="4">Breast and Cervical Cancer Medicaid State Plan Option[5]</td></tr>
<tr><td>$28,376</td><td>185% FPL</td><td rowspan="3">RSM[7]</td><td rowspan="3">Newborn[9]</td><td rowspan="3">Newborn[9]</td><td>PeachCare for Kids</td><td rowspan="2">PeachCare for Kids</td><td></td></tr>
<tr><td>$20,301</td><td>133% FPL</td><td rowspan="2">RSM[7]</td><td></td></tr>
<tr><td>$15,264</td><td>100% FPL</td><td>RSM[7]</td><td></td></tr>
<tr><td>$6,088</td><td>Standard of Need</td><td colspan="3">Low Income Medicaid (LIM)[8]</td></tr>
<tr><td></td><td></td><td>Pregnant Women</td><td>Pregnant Women[1]</td><td>Infants up to Age 1</td><td>Infants up to Age 1[2]</td><td>Children 1-5</td><td>Children 6 - 18</td><td>Parents</td><td>Parents & Children-Transitional Medicaid</td><td>Breast and Cervical Cancer</td></tr>
</table>

[1] Coverage for pregnant women limited to time of pregnancy and 60 days postpartum

[2] For infants born to pregnant women not eligible for Medicaid coverage at the time of birth

[3] Services restricted - no inpatient hospital or delivery

[4] Covers children & parents who lose LIM due to earnings (limited to one year)

[5] Must meet breast/cervical cancer screening requirement, be uninsured, and under 65 years old

[6] Spend down to medically needy level income limit of $507/month for a family of 3

[7] Right From The Start Medicaid, coverage for pregnant women also covers newborn child

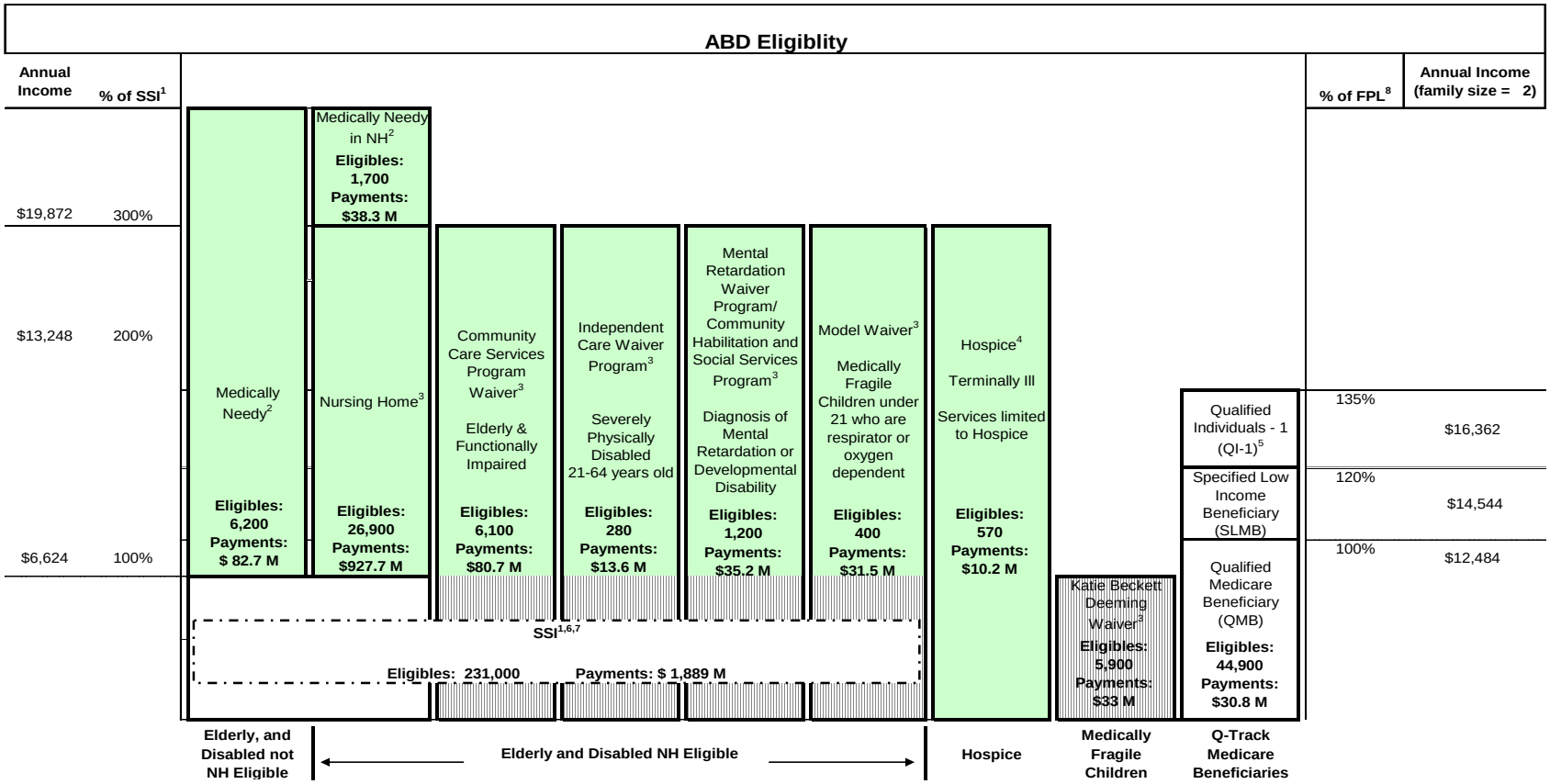
[8] Includes adoption supplement and foster care children

Legend

Mandatory

Optional

Appendix III



[1] SSI - Supplemental Security Income
[2] Spenddown required to medically needy level
[3] Nursing Home level of care required
[4] Services waiver only, this population becomes eligible via other eligibility groups or waivers
[5] Mandatory but limited to state allotment
[6] Includes former SSI recipients who remain eligible under Public Laws and Nursing Home SSIs
[7] Former SSI Children
[8] Federal Poverty Level (FPL) - the FPL only applies to the Q-track members

Legend
- Mandatory
- Optional
- Optional, but would transition to nursing home w/o the waivered services

Appendix IV

HomeFirst Georgia:
Transforming Long Term Care

Accountability and administrative efficiencies will be realized by consolidating in one agency the responsibility and authority to fully integrate all long-term care social and medical services including the Medicaid nursing home program. The integration of finances and services through organizational consolidation, capitated funding and consumer-directed care would increase efficiencies and target services for a fast growing population. With over thirty years of achievement and growth, the Georgia Department of Human Resources, Division of Aging Services, with its statewide network of Area Agencies on Aging and service providers, stands ready to expand capacity to provide a full range of consumer-oriented home- and community-based long-term care services.

Long-term care benefits will be designed to provide access to a full array of health and supportive services to meet the needs of citizens. The model is a "continuing care community without walls". Community services are organized around the consumer's needs and preferences. Quality assurance and continuous quality improvements are built in to ensure that the right services are provided to the right people for the right amount of time, and at the right cost.

HomeFirst Georgia will promote community integration of those individuals clinically able and willing to live in the community. Barriers that increase the likelihood of institutional placement are removed. Housing, work force shortage, provider capacity, supports and transportation are addressed through multi-agency, multi-discipline groups.

Services are integrated and coordinated through single-entry access points. Simplified eligibility processes are in place to assure that services are delivered to those at or below poverty. For those with incomes above poverty, a sliding-fee scale allows individuals and families the opportunity to pay for services. All citizens seeking long-term support or care services will receive an initial assessment and counseling about available options. A focus on educating all citizens about Long Life Planning (beginning 7-01-05) is an essential element of any strategy to rebalance long-term care systems and lessen the reliance on publicly funded long-term care.

Services to protect vulnerable adults, such as the Long Term Care Ombudsman Program, Adult Protective Services, Elderly Legal Assistance Program, Elder Abuse Prevention, Consumer Protection and insurance counseling, prescription drug assistance, and public guardianship programs are vital to the commitment to serve and protect Georgians most at risk and in need of social and medical supports.

Until we consider improving long-term care qualitatively and not "piece meal", we will continue to have a loosely organized and fragmented process of gaining access to care, and the bias toward more expensive institutional care will only increase.