# Georgia Department of Community Health

# FY 2000

## Annual Report

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# Overview

## *Creation of the Department*

On April 19, 1999, Governor Roy Barnes signed Senate Bill 241 into law, creating the Georgia Department of Community Health (DCH). The law consolidates four agencies involved in purchasing, planning, and regulating health care in the state. DCH began operating as an official agency on July 1, 1999.

The Department was created by the General Assembly in response to growing concern about fragmentation of health care delivery at the state level. The legislation outlined several purposes for the Department:

- to serve as the lead planning agency for all health issues in the state;
- to permit the state to maximize its health care purchasing power;
- to minimize duplication and maximize administrative efficiency in the state's health care systems by removing overlapping functions and streamlining uncoordinated programs;
- to allow the state to develop a better health care infrastructure more responsive to the consumers it serves while improving access and coverage; and
- to promote wellness.

## *Responsibilities of the Department*

The Department has several broad responsibilities:

- insuring nearly two million Georgians;
- administering a budget exceeding $5 billion;
- planning for coverage of uninsured Georgians, currently an estimated 1.3 million; and
- coordinating health planning for state agencies.

Among its many challenges, the Department must ensure that quality health care services are provided to teachers, state employees, their dependents and retirees; children of working families eligible for PeachCare; and the aged, low-income, blind, and disabled on Medicaid.

# Overview

## *Responsibilities of the Department*

### The Board of Community Health

The Department is governed by a nine-person board appointed by the Governor and confirmed by the Senate. The Board of Community Health has policy-making authority for the Department. Board meetings are held monthly.

Members of the Board of Community Health as of June 30, 2000 were as follows:

Ms. Joyce Blevins, Chairperson
Thomson, Georgia

Mr. Lloyd Eckberg
Thomasville, Georgia

Gary Edelman, M.D., Vice Chairperson
Tucker, Georgia

Ms. Carol Fullerton
Albany, Georgia

Mr. Richard Holmes
Atlanta, Georgia

Mr. Damon King, Secretary
Macon, Georgia

Stephanie Kong, M.D.
Atlanta, Georgia

Frank Rossiter, M.D.
Savannah, Georgia

Ms. Geri Thomas
Atlanta, Georgia

### Components of the Department

The following entities comprise the Department of Community Health:

*Division of Medical Assistance*
Formerly the Department of Medical Assistance, this division is the largest in Community Health. The division provides Medicaid and PeachCare for Kids health benefits for individuals who are primarily low-income. The agency spends $3.4 billion to provide services to 1.3 million Georgians annually. The Division of Medical Assistance also administers the Indigent Care Trust Fund.

*Division of Health Planning*
The Division of Health Planning performs the functions of the former State Health Planning Agency (SHPA). The division administers the certificate-of-need (CON) program, which approves the expansion of health care facilities and services. It collects and analyzes health care data and works with the Health Strategies Council to develop plans and regulatory criteria for health care services.

*Division of Public Employee Health Benefits*
The functions of the former Health Benefits Services Division of the Georgia Merit System are performed by the Division of Public Employee Health Benefits, which provides health insurance for state employees,

retirees, and teachers. The division contracts with the Board of Regents to coordinate health care coverage for university system employees.

Almost 571,000 State Health Benefit Plan enrollees receive coverage at an annual cost of $1.3 billion. The Board of Regents Health Plan covers 90,000 people each year.

*Office of Women's Health*

This office is responsible for developing a comprehensive state plan to address women's health issues. The Office of Women's Health works to improve women's health and quality of life through education, research, policy development, and coordination of women's health programming. An 11-member advisory council is attached to the office, with first lady Marie Barnes serving as honorary chairperson and former first lady Rosalynn Carter as honorary member.

*Office of Minority Health*

This office develops initiatives to improve the health of minority communities and works to eliminate the disparity in health status between minority and nonminority populations. The office has a 12-member advisory council.

*Office of Rural Health Services*

In September 1999, Governor Roy Barnes issued an executive order placing the Office of Primary Care and the Office of Rural Health in the Department of Community Health. The combined office works to improve access to health services in rural areas.

The following entities are administratively attached to the Department of Community Health. Each of their boards is appointed by the Governor.

*Composite State Board of Medical Examiners*

This 13-member board, composed of 12 physicians and one consumer representative, is responsible for licensing and regulating physicians, physician assistants, respiratory care professionals, acupuncturists, auricular detoxification specialists, paramedics, and cardiac technicians. The board maintains a comprehensive database that offers the public access to information about licensed physicians in the state.

*Georgia Board for Physician Workforce*

This 15-member board develops medical education programs through financial aid to medical schools and residency training programs. The board monitors and evaluates the supply and distribution of physicians by specialty and geographic location to identify underserved areas of the state.

*State Medical Education Board*

This seven-member board administers medical scholarships and loans to promote medical practice in rural areas. Initiatives include the Country Doctor Scholarship and Loan Repayment programs, which encourage physicians to practice in Georgia's underserved areas.

# Overview

## *FY 2000 milestones*

### *State Health Benefit Plan offers PPO*

During FY 2000, the Department developed a preferred provider organization (PPO) option under the State Health Benefit Plan (SHBP) that allows enrollees to choose from a broad network of participating providers throughout the state, including more than 11,000 doctors and 170 hospitals. The provider network is managed by a joint venture between the Medical Resource Network and Georgia 1st.

About 75% of plan members who previously participated in the traditional indemnity options selected the PPO as their coverage option effective July 1, 2000. The standard PPO option was offered at the same monthly premium as the previous Standard Indemnity Plan.

The SHBP also began contracting directly with each acute care hospital in the state, providing for more competitive pricing.

The PPO option, direct contracts and other plan improvements are designed to strengthen the SHBP's financial position. The General Assembly appropriated $263 million to cover current and prior year plan deficits.

### *PeachCare continues rapid growth*

PeachCare for Kids, Georgia's version of the federal Children's Health Insurance Program, began in January 1999 with a two-year enrollment goal of 60,000. At the close of FY 2000, PeachCare had enrolled more than 97,000 children. The program also earned national recognition for its outreach efforts. PeachCare awarded grants to 24 community organizations throughout the state to target hard-to-reach populations. PeachCare targets children whose parents' income exceeds Medicaid limits but who do not have access to affordable private health insurance through their employers.

### *Pharmacy benefit management*

The Department selected a pharmacy benefit manager (PBM) for Medicaid, the SHBP and Board of Regents health plan, which together cover almost two million Georgians. In recent years, pharmacy costs and utilization have risen substantially in all health plans. Between FY 1999 and FY 2000, Georgia's Medicaid pharmacy expenditures increased almost 23% to approximately $539 million, excluding drug rebates. The SHBP expenditures increased 20% annually for the past two years. After a bid process and extensive review, Express Scripts, Inc. was selected as the PBM, which will work to ensure that prescription drugs are used appropriately and cost effectively. The goal is to improve the health of populations served by the Department.

## *FY 2000 milestones*

*Hospitals share additional Indigent Care Trust Fund payment*

Forty-four eligible disproportionate share hospitals (DSH) participating in the Indigent Care Trust Fund shared $164 million in a one-time payment, resulting from five previous years of unspent federal DSH allotment funds. Regular Indigent Care Trust Fund payments to 92 hospitals totaled almost $389 million for the year.

FY 2000 ICTF improvements included the following:

- produced $11 million in savings by canceling contracts not congruent with legislative intent;
- revised the distribution formula (with the cooperation of participating hospitals) to ensure equity of compensation and ensure that rural hospitals receive full compensation for indigent care provided;
- maximized federal reimbursement to the fund by reclassifying payments; and
- expedited the contribution and disbursement approval process.

*Closing disparities in health*

The Department's offices of Rural Health Services, Women's Health and Minority Health worked to lessen health disparities and increase access to care for underserved populations in the state.

- The Office of Rural Health Services focused on building rural health system networks, supporting rural hospitals and identifying ways to make health care available to rural Georgians.

- The Office of Women's Health targeted cardiovascular risks, hosting its first annual Women's Summit for physicians and launching a public education campaign with regional health fairs. The office also published "Georgia Women at a Glance," a profile of the health status and demographics of women in Georgia.

- The Office of Minority Health concentrated on identifying the health issues of African American, Asian and Hispanic/Latino communities and effective ways to reach populations at risk. Initiatives included the radio series, "This is For Real," and other specially designed radio and print messages. The office funded translator services to teams treating 1,300 migrant farm workers in south Georgia and offered training to help community organizations enhance HIV/AIDS services.

*Improving access to health insurance*

Governor Roy Barnes asked the Department to prepare a plan for reducing the number of uninsured Georgians, estimated at 1.3 million. In addition to working with other organizations to conduct research and gather data, the Department sought input from providers, consumers, business leaders, insurers, advocates, and the public. The plan was submitted to the Governor in early FY 2001.

# Overview

## *FY 2000 milestones*

### *Patients' right to independent review*

During its 1999 session, the Georgia General Assembly enacted legislation allowing patients enrolled in a managed care plan to request an independent review of decisions made by managed care organizations to deny treatment. In FY 2000, DCH certified the state's first independent review organization and referred 42 patient requests for review. Twenty-nine requests were approved, requiring that an HMO provide patient services or payment.

### *DCH on the web*

The Department launched its web site during the early months of the agency's operation. Work began to make Medicaid policy and billing manuals, as well as the State Plan and the Department's rules, available on the site. First to be available was the physicians' manual, followed by manuals for other categories of service.

### *Integrating information systems*

During FY 2000, DCH began to standardize its databases, enabling data related to Medicaid, PeachCare for Kids, the State Health Benefit Plan, and the Board of Regents Health Plan to be accessed and utilized for comparative studies and benchmarking. The Department released a Request for Information that discussed plans to move data for all populations served by DCH to a single platform. Sixty vendors participated in a two-day showcase to display new technologies for consideration as part of the Department's new information system. Moving data to a common platform will help identify health needs and trends and aid the Department in improving health outcomes. DCH plans to procure a single platform solution in FY 2001.

In addition, the Department moved most of the DCH divisions and attached offices to one common Local Area Network (LAN) and provided Virtual Private Network (VPN) capabilities to remote offices in Tifton, Swainsboro and Cordele to improve internal communications.

## *FY 2000 DCH Expenditures*

| | | |
|---|---|---|
| **Benefits** | | |
| Medicaid | $3,343,199,902 | |
| PeachCare for Kids | $53,776,658 | |
| Medicaid NET Benefits | $49,146,304 | |
| Medicare Premiums | $116,616,723 | |
| Indigent Care Trust Fund | $652,957,793 | |
| State Health Benefit Plan Payments | $1,249,073,300 | |
| | **$5,464,770,680** | **96.03%** |
| **Services Support (Contracts)** | | |
| Systems (claims, PeachCare eligibility, SHBP support) | $90,414,114 | |
| DHR Interagency Contract - Eligibility (federal funds only) | $40,171,186 | |
| Other (including utilization review, GBHC member services, nurse aide training) | $11,002,513 | |
| | **$141,587,813** | **2.50%** |
| **Medical Education and Licensing** | | |
| Georgia Board for Physician Workforce | $35,965,042 | |
| State Medical Education Board | $1,490,998 | |
| Composite State Board of Medical Examiners | $1,398,335 | |
| | **$38,854,375** | **0.68%** |
| **Health Care Planning and Initiatives** | | |
| Health Planning | $1,721,487 | |
| Rural Health | $2,017,757 | |
| Minority Health | $181,585 | |
| Women's Health | $289,174 | |
| | **$4,210,003** | **0.07%** |
| **Administration** | | |
| Policy and Reimbursement | $16,760,457 | |
| Legal and Regulatory (includes $1.3 million peer review contract) | $6,514,411 | |
| State Health Benefit Plan Administration | $3,774,514 | |
| Audit Contract | $2,740,023 | |
| General Administration* | $11,443,550 | |
| | **$41,232,955** | **0.72%** |
| **TOTALS** | **$5,690,655,826** | **100.00%** |

*Includes rent and utilities, state agency services, telecommunications, accounting and auditing, and other support operations.
Note: Benefits expenditures based on date of service, not date of payment

## FY 2000 milestones

*Y2K preparedness*

The Department's extensive planning and testing for Y2K received high marks for readiness. The federal Health Care Financing Administration (HCFA) awarded a "low risk" ranking for the computer system that pays claims from health care providers who treat Medicaid patients. HCFA also recommended Georgia's contingency plan as a model for other states. The 50-person team from the Division of Medical Assistance put in 36 staff years of work on the 18-month project. None of the Department's functions were disrupted by the Y2K date change.

*Medicaid drug rebates save almost $111 million*

Georgia Medicaid covers the products of all drug manufacturers offering rebates to the state, with certain exceptions allowed by federal law. Georgia Medicaid drug rebates for FY 2000 totaled a projected $110.9 million.

*Better care for recipients*

Georgia Better Health Care (GBHC) matches Medicaid recipients to a primary care physician. Most Medicaid recipients are required to participate in the program, which is designed to improve access to medical care, particularly primary care services; enhance continuity of care; and reduce unnecessary use of medical services. In FY 2000, GBHC began a provider profiling initiative to improve health outcomes by evaluating prevention, access and disease management. More than 4,000 physicians contract with Medicaid to participate in GBHC.

*Community services for more elderly and disabled*

Using tobacco settlement funds, the Department expanded community services for people with physical disabilities or traumatic brain injuries and reduced the waiting list for these services by a third. More than 300 additional people with mental retardation also were able to receive community services. These services help people who qualify for institutional care remain in the community or return to the community from nursing homes or hospitals. Among the services are help with coordinating care; assistance with daily living activities; home health services; emergency response systems and respite care.

## Description of Medicaid

Medicaid is a jointly-funded, federal/state health care assistance program serving primarily low-income individuals: children, pregnant women, the elderly, blind and disabled.

Medicaid reimburses health care providers for services given to eligible individuals. Persons who are eligible for Medicaid receive a card each month to use for health care services from participating providers.

The largest share of Medicaid costs is paid by the federal government. Georgia's Medicaid program receives various levels of federal reimbursement for different services and functions. For example, the federal government pays 90% of the cost of family planning services and almost 60% for most other benefits. Computer costs are 75% federally funded, and most other administrative costs receive 50% federal funding.

# Division of Medical Assistance

## *Description of Medicaid*

Medicaid is often confused with Medicare, a federal program which provides health care reimbursement to everyone in the United States 65 years and older who has worked and paid into the Social Security system. Medicare eligibility, with a few exceptions, is chiefly determined by age. Medicaid eligibility is primarily determined by income and other factors.

## *Statistical Summary*

| | |
|---|---|
| **FY 2000 benefits expenditures** | |
| Medicaid benefits | $3,343,199,902 |
| Medicaid NET benefits | $ 49,146,304 |
| PeachCare for Kids | $ 53,776,658 |
| Indigent Care Trust Fund | $ 652,957,793 |
| Medicare premiums | $ 116,616,723 |
| **Average yearly benefit expenditure per recipient** | $2,782 |
| **Total unduplicated count of Medicaid recipients** | 1,201,669 |
| Categorically Needy (TANF, SSI) | 698,837 |
| Medically Needy | 11,025 |
| Right from the Start Medicaid (pregnant women and infants) | 458,650 |
| Qualified Medicare Beneficiaries | 33,157 |
| **PeachCare for Kids enrollees** | 97,352 |
| **Annual unduplicated count of eligibles** (all persons who received a Medicaid card during FY 2000) | 1,265,859 |
| **Enrolled providers** (as of June 30, 2000) | 44,004 |
| **Providers with paid claims** | 27,572 |
| **Number of Medicaid claims paid** | 27,807,587 |

## *Medicaid coverage*

### Eligibility

To be eligible for Medicaid, a person must be aged (over 65); blind; permanently and totally disabled; a pregnant woman; or a child or a parent/caretaker of a Medicaid-eligible child. Also, the person must meet both the income and resource limits set for the appropriate category and any established non-financial requirements. Non-financial requirements include criteria such as age, U.S. citizenship or lawful alien status, and Georgia residency.

### Major coverage groups

*SSI Recipients* – Aged, blind or disabled individuals who receive Supplemental Security Income (SSI).

*Nursing Home* – Aged, blind or disabled individuals who live in nursing homes and have low income and limited assets.

*Community Care* – Aged, blind or disabled individuals who need nursing home care but can stay at home with special community care services.

*Qualified Medicare Beneficiaries (QMB)* – Aged or disabled individuals who have Medicare Part A (hospital) insurance, and have income less than 100 percent of the federal poverty level and limited resources. Medicaid will pay the Medicare premiums (A&B), coinsurance and deductibles only.

*Hospice* – Terminally ill individuals who are not expected to live more than six months may be eligible for coverage. Recipients must agree to receive hospice services through a Medicaid participating hospice care provider.

*Low Income Medicaid (LIM)* – Adults and children who meet the standards of the old AFDC (Aid to Families with Dependent Children) program.

*Right from the Start Medicaid for Pregnant Women (RSM Adults)* – Pregnant women with family income at or below 200 percent of the federal poverty level.

*Right from the Start Medicaid for Children (RSM Children)* – Children under 19 years of age whose family income is at or below the appropriate percentage of the federal poverty level for their age and family size.

*Medically Needy* – Pregnant women, children and aged, blind and disabled individuals who have family income which exceeds the established income limit may be eligible under the Medically Needy program. The program allows persons to use incurred/unpaid medical bills to "spend down" the difference between their income and the income limit to become eligible.

# Division of Medical Assistance

## *Medicaid coverage*

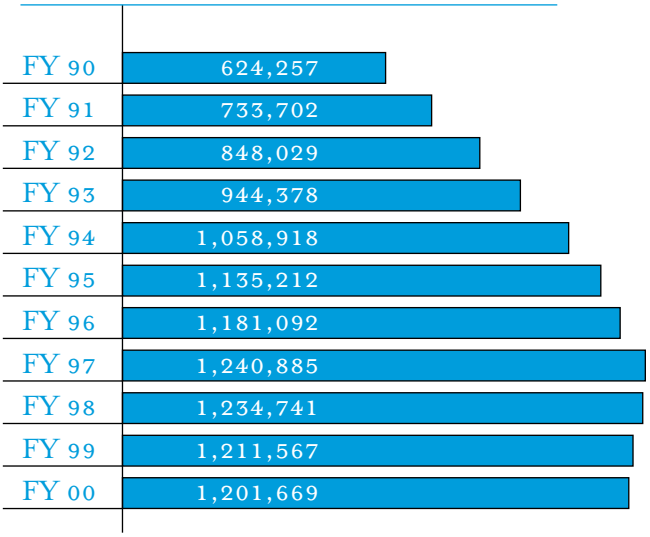
### Covered Services

- Ambulance Services
- Ambulatory Surgical Services
- Certified Registered Nurse Anesthetists
- Childbirth Education Services
- Children's Intervention Services
- Diagnostic, Screening and Preventive Services (Health Departments)
- Dental Services
- Dialysis Services
- Durable Medical Equipment Services
- Family Planning Services
- Georgia Better Health Care
- Health Check (Early and Periodic Screening, Diagnosis and Treatment)
- Health Insurance Premium Purchase Program (HIPP)
- Health Insurance Premiums (Medicare Part A and Part B)
- Home Health Services
- Hospice Services
- Inpatient and Outpatient Hospital Services
- Intermediate Care for the Mentally Retarded Facility Services
- Laboratory and Radiological Services
- Medicare Crossovers
- Mental Health Clinic Services
- Non-Emergency Transportation Services
- Nurse Midwifery Services
- Nurse Practitioner Services
- Nursing Facility Services
- Oral Surgery Services
- Orthotic and Prosthetic Services
- Pharmacy Services
- Physician Services
- Physician's Assistant Services
- Podiatric Services
- Pre-Admission Screening/Annual Resident Review
- Pregnancy-Related Services
- Psychological Services
- Rural Health Clinic/Community Health Center Services
- Swing Bed Services
- Targeted Case Management Services
  - Adults with AIDS
  - Children at Risk of Incarceration
  - Chronically Mentally Ill
  - Early Intervention
  - Perinatal
  - Adult and Child Protective Services
- Therapeutic Residential Intervention
- Vision Care Services
- Waiver Services
  - Community Care
  - Independent Care
  - Mental Retardation
  - Model Waiver for Oxygen or Ventilator-Dependent Children
  - Community Habilitation and Support
  - Traumatic Brain Injury
  - SOURCE (Service Options Using Resources in a Community Environment)

## *Recipients*

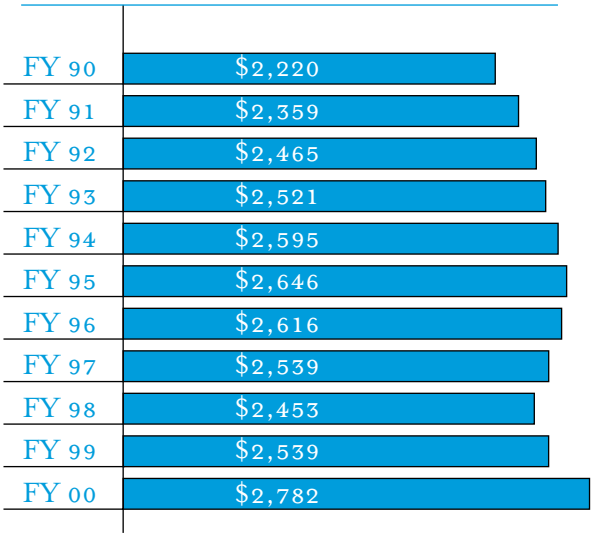
In FY 2000, Medicaid paid for health care services for 1,201,669 individuals. A total of 1,265,859 individuals were approved as eligible for Medicaid, enrolled in the program and received a Medicaid card during the year. Payments for services totaled $3,343,199,902 or approximately $2,782 per recipient. The number of recipients decreased by 0.8% from FY 1999.

### Total Recipients 1990-2000




Since FY 1990, the number of recipients almost doubled, largely due to eligibility expansion, most of which was mandated by the federal government.

### Expenditures per Recipient 1990-2000




Expenditures per recipient have increased just over 25% since FY 1990.

## *Recipients*

### Profile of Recipients

| | Recipients | Payments |
|---|---|---|
| **By Aid Category** | | |
| Aged, Blind or Disabled | 321,649 (27%) | $2,174,637,317 (65%) |
| Low Income Children | 318,270 (26%) | $313,248,007 (9%) |
| RSM Children | 364,777 (30%) | $400,115,673 (12%) |
| Low Income Adults | 103,099 (9%) | $172,661,765 (5%) |
| RSM Adults | 93,874 (8%) | $282,537,140 (9%) |
| **By Age** | | |
| Under 1 year | 165,168 (14%) | $326,516,496 (10%) |
| 1 to 5 years | 218,466 (18%) | $201,877,583 (6%) |
| 6 to 20 years | 392,781 (33%) | $478,429,307 (14%) |
| 21 to 44 years | 209,637 (17%) | $746,450,035 (22%) |
| 45 to 64 years | 90,288 (8%) | $602,930,150 (18%) |
| 65+ years | 125,329 (10%) | $986,996,331 (30%) |
| **By Gender** | | |
| Male | 472,002 (39%) | $1,157,983,489 (35%) |
| Female | 729,667 (61%) | $2,185,216,413 (65%) |
| **By Residence** | | |
| Rural | 487,620 (41%) | $1,484,057,331 (44%) |
| Urban | 714,049 (59%) | $1,859,142,571 (56%) |
| **By Race** | | |
| African-American | 590,400 (49.13%) | $1,317,597,290 (39.41%) |
| White | 396,566 (33.00%) | $1,588,004,228 (47.50%) |
| Hispanic | 18,424 (1.53%) | $41,038,698 (1.23%) |
| Asian/Pacific Islander | 9,406 (0.78%) | $14,410,781 (0.43%) |
| American Indian/Alaskan Native | 599 (0.05%) | $ 1,265,124 (0.04%) |
| Unknown | 186,274 (15.50%) | $380,883,781 (11.39%) |

## *Services*

Making health care available and accessible to medically indigent Georgians is the focus of the state's Medicaid program. A broad array of services addresses the health care needs of those covered by the program.

Below are descriptions of covered services, providers with paid claims, recipients and expenditures by category of service.

### Physician services

- Pays for services provided by licensed physicians.
- About 71% of all recipients visited physicians last year.
- Physician services accounted for almost 12% of benefits expenditures in FY 2000.
- Reimbursement: Medicare's Resource-Based Relative Value Scale (RBRVS) is used to set the statewide maximum allowable fee.

| Category of service | Providers with paid claims | FY 2000 recipients | Expenditures per recipient | FY 2000 expenditures |
|---|---|---|---|---|
| **Physician services** | 16,546 | 850,386 | $455 | **$386,925,219** |

### Pharmacy services

- Covers drugs requiring a prescription, insulin, diabetic supplies and certain nonprescription drugs; a few require prior approval.
- Accounted for 16% of benefits expenditures in FY 2000; 67% of recipients used pharmacy services during the year.
- DCH contracts with First Health Services to review and process prior approval requests.
- Rebate agreements with pharmaceutical manufacturers saved the state $110.9 million in FY 2000.

| Category of service | Providers with paid claims | FY 2000 recipients | Expenditures per recipient | FY 2000 expenditures |
|---|---|---|---|---|
| **Pharmacy Services** | 1,930 | 809,481 | $666 | **$538,978,630*** |

*Excludes drug rebates.

## *Services*

### Hospital services

- Inpatient services are covered when services cannot be provided on an outpatient basis.
- Most inpatient hospital stays and outpatient procedures must be certified prior to admission.
- Outpatient services may include emergency room care, outpatient surgery and clinic services.
- Hospital services accounted for 30% of benefits expenditures in FY 2000.
- Reimbursement: For inpatient services, DRG-based (Diagnosis Related Groups) system similar to the one used by Medicare; based on diagnosis, with payments increasing with the severity of a patient's condition. For outpatient services, reimbursement is based on a percentage of cost.

| Category of service | Providers with paid claims | FY 2000 recipients | Expenditures per recipient | FY 2000 expenditures |
|---|---|---|---|---|
| **Hospital Services** | | | | |
| Hospital, Inpatient | 366 | 192,473 | $3,551 | $ 683,527,983 |
| Hospital, Outpatient | 540 | 541,973 | $ 600 | $ 325,041,240 |
| **Total Hospital Services** | | | | **$1,008,569,223** |

### Nursing facility services

- Covers institutional care for recipients who are unable to remain at home or in the community.
- The quality of nursing home care is regulated by the Office of Regulatory Services, a part of the Georgia Department of Human Resources.
- Accounted for 24% of benefits expenditures in FY 2000.
- Reimbursement: Per diem rates are calculated from standardized cost reports. Allowable costs are determined using Department policy, federal principles of reimbursement and audits of cost reports. The June 30, 1998, cost reports and an overall growth allowance of 6.2% were used to set reimbursement rates for FY 2000.

| Category of service | Providers with paid claims | FY 2000 recipients | Expenditures per recipient | FY 2000 expenditures |
|---|---|---|---|---|
| **Nursing Facilities** | | | | |
| Nursing Home Intermediate Care-MR | 10 | 1,420 | $77,336 | $109,816,562 |
| Nursing Home Services | 356 | 50,004 | $13,975 | $698,825,248 |
| Swing Bed Services | 16 | 95 | $ 2,447 | $ 232,432 |
| **Total Nursing Facilities** | | | | **$808,874,242** |

## Maternal and child health services

- Covers prenatal and perinatal care and family planning, pays for children's preventive health care through the HealthCheck program, helps children with physical and developmental problems, and assists children at risk through the Family Connection.
- The category represented 2% of all benefits expenditures for FY 2000.

| Category of service | Providers with paid claims | FY 2000 recipients | Expenditures per recipient | FY 2000 expenditures |
|---|---|---|---|---|
| **Maternal and Child Health** | | | | |
| Childbirth Education Program | 15 | 369 | $ 30 | $ 11,161 |
| Children at Risk Case Management | 17 | 3,949 | $ 468 | $ 1,847,308 |
| Children's Intervention Services | 1,186 | 20,578 | $1,311 | $26,984,837 |
| Early Intervention Case Management | 92 | 3,456 | $ 678 | $ 2,344,637 |
| Family Planning | 92 | 22,353 | $ 70 | $ 1,568,118 |
| HealthCheck (EPSDT) | 1,509 | 271,703 | $ 98 | $26,655,246 |
| Perinatal Case Management | 105 | 52,228 | $ 101 | $ 5,276,192 |
| Pregnancy-Related Services | 75 | 16,587 | $ 87 | $ 1,441,911 |
| **Total Maternal and Child Health Services** | | | | **$66,129,410** |

## Other practitioner services

- Covers preventive and routine dental services for adults and children. Dental services were the most widely used services in this category in FY 2000. About 17% of all recipients visited a dentist last year.
- Increased reimbursement rates by approximately 70% on the 50 most frequent dental procedures. Also streamlined claim processing by adopting the standard American Dental Association procedure codes and claim form.
- Also includes optometric services, podiatry and psychology services, the care provided by nurse midwives, nurse practitioners, physician's assistants and certified registered nurse anesthetists and reimbursements to county health departments for diagnostic, screening and preventive services.
- Health departments and private providers are reimbursed through the diagnostic, screening and preventive services program for pregnancy and postpartum care, adult immunizations, and screening and treatment of hypertension, tuberculosis, and sexually transmitted diseases.
- Reimbursement for most other services in this category is the lower of the submitted charge or Medicare's Resource-Based Relative Value Scale rate for the procedure.
- Services in this category accounted for just over 2% of benefits expenditures during the year.

## *Services*

| Category of service | Providers with paid claims | FY 2000 recipients | Expenditures per recipient | FY 2000 expenditures |
|---|---|---|---|---|
| **Other Practitioner Services** | | | | |
| Certified RNA | 790 | 32,758 | $158 | $ 5,182,272 |
| Dental, Adult | 591 | 33,092 | $140 | $ 4,625,078 |
| Dental, Child | 812 | 171,661 | $184 | $31,641,573 |
| Dental Oral Surgery | 33 | 321 | $149 | $ 47,928 |
| Diagnostic, Screening and Preventive Services | 33 | 70,547 | $ 30 | $ 2,093,463 |
| Nurse Midwife | 145 | 13,467 | $554 | $ 7,462,034 |
| Nurse Practitioner | 401 | 37,397 | $ 73 | $ 2,718,318 |
| Optometry | 584 | 82,075 | $ 48 | $ 3,945,696 |
| Physician's Assistant | 437 | 28,165 | $ 92 | $ 2,605,214 |
| Podiatry | 234 | 32,466 | $ 78 | $ 2,530,606 |
| Psychology | 578 | 22,766 | $545 | $12,418,341 |
| **Total Other Practitioner Services** | | | | **$75,270,523** |

### Mental health services

- Covers a comprehensive range of services provided by outpatient mental health clinics.
- Individuals with chronic mental illness, mental retardation or substance abuse may receive case management services in the community which help them live more independently and are less expensive than institutional services.
- DMA worked with the state Department of Audits to complete thorough reviews of selected community service boards, the providers of clinic services.
- Mental health clinic and case management services accounted for almost 2% of benefits expenditures in FY 2000.

| Category of service | Providers with paid claims | FY 2000 recipients | Expenditures per recipient | FY 2000 expenditures |
|---|---|---|---|---|
| **Mental Health Services** | | | | |
| Mental Health Clinic | 51 | 49,710 | $1,219 | $60,572,329 |
| Mental Health Case Management | 27 | 3,938 | $ 845 | $ 3,329,176 |
| **Total Mental Health Services** | | | | **$63,901,505** |

## Waiver services for home and community-based care

- Five home and community-based programs and two demonstration projects for which the federal government has waived certain provisions of Medicaid law. Allows the state to pay for home and community-based services as an alternative to institutional care. Each waiver program offers several "core" services, including service coordination, personal support, home health services, emergency response systems, and respite care. Additional services are available under each program. Home and community-based alternatives accounted for 5% of benefits expenditures in FY 2000. Per-recipient costs averaged $10,659 for the year. Programs include:
  - Community Care services help people who are elderly and/or functionally impaired or disabled remain in the community or return to the community from nursing homes.
  - The Mental Retardation Waiver program and Community Habilitation and Support Services help people who have mental retardation or a developmental disability.
  - The Model Waiver program covers private duty nursing and medical day care for individuals under age 21 who are respirator or oxygen dependent.
  - The Independent Care waiver program helps adult Medicaid recipients with disabilities live in their own homes or in the community instead of hospital settings. Also includes services for adult Medicaid recipients with traumatic brain injuries.
- Two demonstration projects:
  - SOURCE (Service Options Using Resources in a Community Environment) links primary care with an array of long-term health services in a person's home or community to avoid preventable hospital and nursing home care for frail elderly and disabled individuals. Available in the Atlanta, Savannah, Hinesville and Augusta areas.
  - ShepherdCare provides primary care through an outreach program managed by advanced practice nurses who coordinate medical care for severely disabled clients at the Shepherd Spinal Center in Atlanta.

| Category of service | Providers with paid claims | FY 2000 recipients | Expenditures per recipient | FY 2000 expenditures |
|---|---|---|---|---|
| **Waiver Services and Demonstration Projects** | | | | |
| Community Care | 317 | 12,274 | $ 5,137 | $ 63,047,498 |
| Mental Retardation Waiver | 192 | 2,803 | $26,381 | $ 73,945,355 |
| Model Waiver | 13 | 122 | $22,845 | $ 2,787,058 |
| Independent Care | 73 | 416 | $37,006 | $ 15,394,543 |
| Community Habilitation and Support | 46 | 701 | $34,727 | $ 24,343,323 |
| SOURCE Project | 43 | 926 | $ 4,923 | $ 4,558,474 |
| ShepherdCare | 2 | 41 | $ 3,699 | $ 151,669* |
| **Total Waiver Services** | | | | **$184,227,920** |

*Does not represent all services; includes only case management and some equipment.

## *Services*

### Transportation

- Covers both emergency and non-emergency transportation services to assist recipients who need medical care and have no other means of transportation.
- As a more cost-effective means of covering non-emergency transportation, Georgia Medicaid uses a broker system in which the agency contracted with three brokers covering the five regions of the state.
- Brokers are responsible for contracting with sufficient numbers and types of transportation providers to deliver services to eligible Medicaid recipients.
- Each broker is reimbursed a set rate per month for each Medicaid recipient residing within the region.
- The three NET brokers' contracts totaling $49,146,304 are accounted for separately and are not shown below.
- The Georgia Department of Audits and Accounts evaluates the brokers' performance.
- Emergency transportation costs accounted for 0.5% of benefits expenditures in FY 2000.

| Category of service | Providers with paid claims | FY 2000 recipients | Expenditures per recipient | FY 2000 expenditures |
|---|---|---|---|---|
| **Emergency Transportation Services** | 207 | 66,259 | $231 | **$15,308,576** |

### Equipment and devices

- Covers the rental or purchase of medical equipment including hospital beds, wheelchairs, oxygen equipment and walkers, and devices such as artificial limbs, braces, glasses and artificial eyes.
- Services in this category accounted for just over 1% of benefits expenditures for FY 2000.

| Category of service | Providers with paid claims | FY 2000 recipients | Expenditures per recipient | FY 2000 expenditures |
|---|---|---|---|---|
| **Equipment and Devices** | | | | |
| Durable Medical Equipment | 1,632 | 94,704 | $348 | $32,999,262 |
| Eyeglasses | 1 | 44,393 | $ 18 | $ 787,747 |
| Orthotics/Prosthetics | 84 | 8,588 | $617 | $ 5,296,669 |
| **Total Equipment and Devices** | | | | **$39,083,678** |

## All others

- Covers the services of ambulatory surgical centers and rural health clinics as well as laboratory, x-ray, dialysis, home health, protective services, hospice, therapy and specialized services for specific populations such as adults with AIDS and children at risk of incarceration.
- Georgia Better Health Care (GBHC) matches Medicaid recipients and primary care providers to improve access to care, enhance continuity of care, and reduce unnecessary use of services. More than three-fourths of all recipients participated in GBHC.
- GBHC began a physician advisory committee to assist with a physician profiling initiative to improve health outcomes.

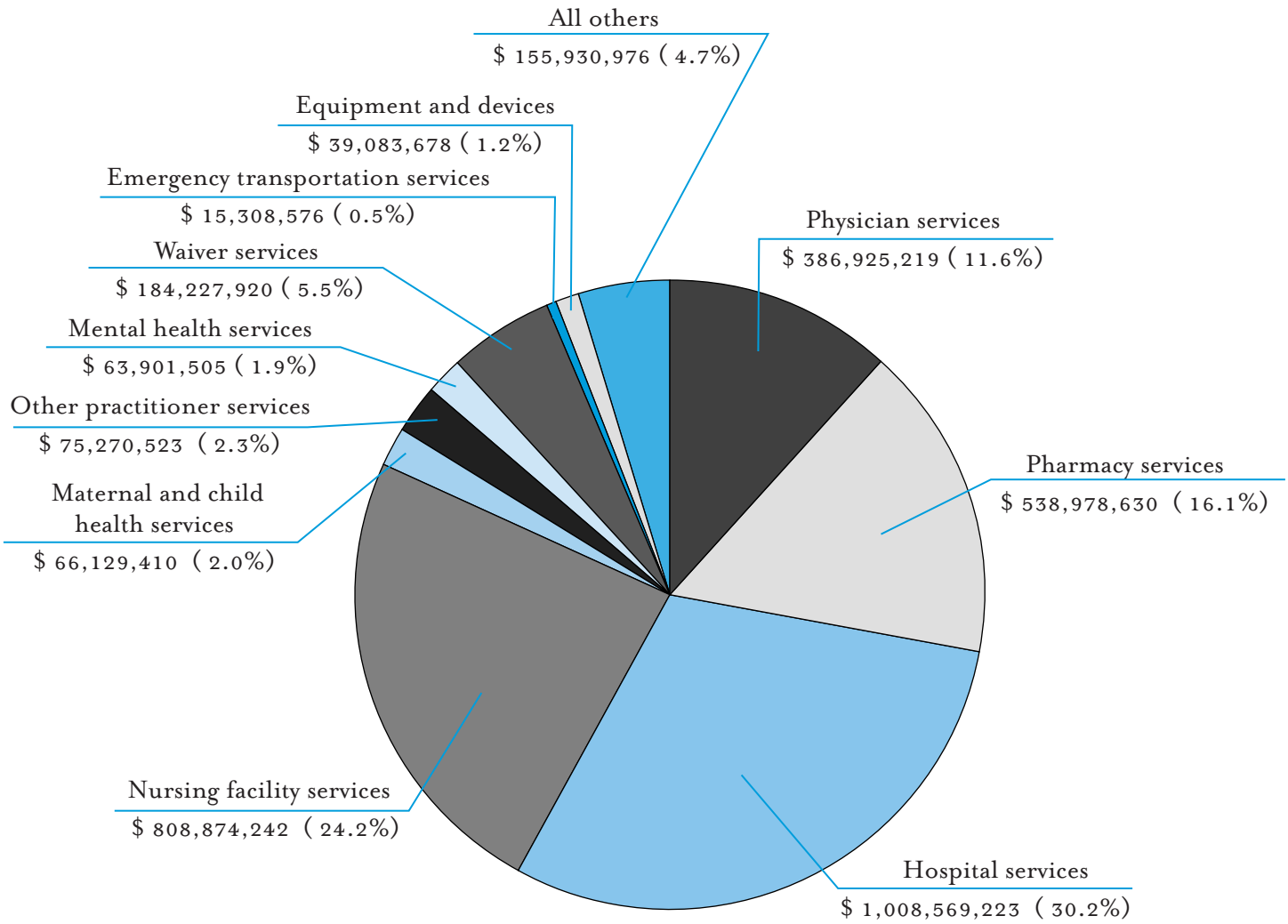
| Category of service | Providers with paid claims | FY 2000 recipients | Expenditures per recipient | FY 2000 expenditures |
|---|---|---|---|---|
| **All Others** | | | | |
| Adults with AIDS | 22 | 1,230 | $ 259 | $ 319,049 |
| Ambulatory Surgical | 65 | 5,443 | $ 338 | $ 1,842,403 |
| At Risk of Incarceration | 1 | 1,412 | $ 368 | $ 519,170 |
| Dialysis | 220 | 726 | $14,556 | $10,567,756 |
| Federally Qualified Health Centers | 29 | 27,882 | $ 210 | $ 5,861,429 |
| Georgia Better Health Care | 2,415 | 906,079 | $ 25 | $22,390,700 |
| HMO* | 1 | 25,563 | $ 579 | $14,813,724 |
| Home Health | 91 | 6,998 | $ 1,413 | $ 9,889,639 |
| Hospice | 65 | 2,757 | $ 6,525 | $ 17,989,253 |
| Laboratory/Radiology | 51 | 162,425 | $ 96 | $ 15,532,543 |
| PASARR | 1 | 2,824 | $ 1,339 | $ 3,780,197 |
| Protective Services, Adult | 1 | 2,765 | $ 1,546 | $ 4,275,570 |
| Protective Services, Child | 1 | 20,984 | $ 919 | $ 19,283,880 |
| QMB | 8 | 18 | $ 251 | $ 4,519 |
| Rural Health Clinic | 28 | 16,128 | $ 186 | $ 2,994,743 |
| Therapeutic Residential Intervention | 17 | 803 | $32,089 | $ 25,767,276 |
| Therapy Services (Physical, Occupational, Speech) | 163 | 1,362 | $ 73 | $ 99,125 |
| **Total All Others** | | | | **$155,930,976** |

*Medicaid recipients in HMOs were shifted to Georgia Better Health Care in December 1999.

# Division of Medical Assistance

## *Services*

### Expenditures by Category of Service




**TOTAL: $3,343,199,902 (100.0%)**

## *PeachCare for Kids*

PeachCare for Kids is Georgia's version of the federal Children's Health Insurance Program that provides medical and dental coverage for children whose parents' income is too high to qualify for Medicaid but who do not have access to private health insurance. In FY 2000, uninsured children could be eligible for PeachCare if their families' incomes were up to 200% of the federal poverty limit but above Medicaid income guidelines. For a family of four in 1999, 200% of the federal poverty limit was $33,408. The Georgia General Assembly approved raising the income limit to 235% for FY 2001.

During FY 2000, Peachcare for Kids implemented several program improvements:

- revised the referral process for Medicaid eligible children who apply for PeachCare, drastically reducing the amount of time needed to enroll them in Medicaid.
- reached children in Georgia public schools, working with the Georgia Department of Education to add a question about health insurance coverage to applications for free and reduced lunches.
- streamlined eligibility verification for providers, giving them 24-hour access.

The federal/state match for PeachCare funds is approximately 72% federal to 28% state dollars, a larger federal share than allowed in the Medicaid program.

### *Outreach*

More than 300,000 Georgia children are uninsured, and most of these children live in working families whose employers do not provide affordable insurance. An estimated 143,000 children up to age 19 who don't have insurance are eligible for PeachCare.

Special efforts are being made to reach minority and underserved communities. In addition to traditional marketing efforts, PeachCare uses grassroots strategies to heighten awareness and accessibility through the nationally-recognized Right from the Start Medicaid outreach program and through other community-based organizations.

In FY 2000, PeachCare awarded 24 minigrants to organizations in 45 counties for outreach. The organizations developed and implemented targeted methods to bring PeachCare to hard-to-reach populations. Efforts resulted in significant increases in new applications.

### *Enrollees*

The program began in January 1999 with a two-year enrollment goal of 60,000. Just 18 months later, at the close of the fiscal year, 97,352 children were enrolled.

## *PeachCare for Kids*

### Profile of PeachCare for Kids Enrollees

| | Enrollees | Payments |
|---|---|---|
| **By Age** | | |
| Under 1 year | 1,681 (2%) | $588,130 (1%) |
| 1 to 5 years | 29,751 (31%) | $16,627,537 (31%) |
| 6 to 13 years | 50,048 (51%) | $26,076,996 (48%) |
| 14 to 21 years | 15,872 (16%) | $10,483,995 (19%) |
| **By Gender** | | |
| Male | 49,909 (51%) | $28,985,607 (54%) |
| Female | 47,443 (49%) | $24,791,051 (46%) |
| **By Residence** | | |
| Rural | 37,230 (38%) | $23,134,486 (43%) |
| Urban | 60,122 (62%) | $30,642,172 (57%) |
| **By Race *** | | |
| African-American | 31,322 (32.17%) | $17,302,102 (32.17%) |
| White | 52,399 (53.82%) | $28,944,211 (53.82%) |
| Hispanic | 4,161 (4.27%) | $2,298,952 (4.27%) |
| Asian/Pacific Islander | 1,330 (1.37%) | $734,589 (1.37%) |
| American Indian/Alaskan Native | 19 (0.02%) | $10,755 (0.02%) |
| Unknown | 8,121 (8.34%) | $4,486,049 (8.34%) |

*Recipient values by race were adjusted based on information provided by DHACS.

## *PeachCare for Kids*

*Premium and Services*

Families with children 6 years old or older pay a $7.50 monthly premium for one child; $15 for two or more children. The plan requires no premium for children age 5 or younger.

The plan pays for preventive services and acute medical care as well as prescribed drugs and vision and dental care. PeachCare covers most of the same services as Medicaid with a few exceptions, such as non-emergency transportation, targeted case management, nursing facilities and community waiver programs.

### PeachCare for Kids Expenditures by Type of Service FY 2000

| | |
|---|---|
| Physician Services | $11,264,258 (20.9%) |
| Pharmacy Services | $10,543,039 (19.6%) |
| Hospital Services | $15,427,987 (28.7%) |
| Maternal & Child Health Services | $2,199,127 (4.1%) |
| Other Practitioner Services | $9,670,530 (18.0%) |
| Mental Health Services | $1,332,650 (2.5%) |
| Emergency Transportation Services | $140,392 (0.3%) |
| Equipment & Devices | $352,948 (0.6%) |
| All Other Services | $2,845,727 (5.3%) |
| **TOTAL** | **$53,776,658** |

## *Indigent Care Trust Fund*

The Indigent Care Trust Fund (ICTF), which funds and supports programs and facilities serving medically indigent Georgians, completed its tenth year of operation in FY 2000. Contributions from participating disproportionate share hospitals (DSH) and other funding sources totaled $261,900,318. The Department used these funds to attract $391,057,475 in additional federal Medicaid matching dollars for a total trust fund amount of $652,957,793. No money from the state's general fund is used.

Trust fund payments to 92 participating hospitals totaled $388,990,056. In addition, 44 eligible hospitals shared a one-time payment of $164 million, resulting from a settlement for five previous years of unspent federal DSH allotment funds.

Each hospital must submit a plan for using at least 15% of its trust fund receipts to provide and expand primary care in the community. No more than 5% may be used for capital costs. Through the program, even uninsured people who do not qualify for Medicaid may receive health care from participating providers.

The ICTF advisory committee assists in making decisions about administering the trust fund program. The panel includes representatives from hospitals, medical schools, public health, consumer advocacy groups, and government agencies.

## ICTF PARTICIPATING HOSPITALS
### Regular Payments FY 2000*

| Hospital | County | ICTF Payment | Primary Care | Hospital Contribution |
|---|---|---|---|---|
| Appling General | Appling | $1,214,697 | $182,205 | $607,349 |
| Athens Regional | Clarke | $8,350,778 | $1,252,617 | $4,175,389 |
| Atlanta Medical Center | Fulton | $3,840,293 | $576,044 | |
| Bacon County | Bacon | $596,271 | $89,441 | $298,136 |
| Banks-Jackson-Commerce | Jackson | $484,847 | $72,727 | $242,424 |
| Baptist Hospital Worth County | Worth | $554,245 | $83,137 | |
| Barrow Medical Center | Barrow | $459,398 | $68,910 | |
| Berrien County | Berrien | $58,801 | $8,820 | |
| Bleckley Memorial | Bleckley | $81,948 | $12,292 | $40,974 |
| Brooks County | Brooks | $336,516 | $50,477 | $168,258 |
| Bulloch Memorial | Bulloch | $46,904 | $7,036 | |
| Burke County | Burke | $536,425 | $80,464 | $268,213 |
| Calhoun Memorial | Calhoun | $441,230 | $66,185 | $220,615 |
| Camden Medical Center | Camden | $950,776 | $142,616 | |
| Charlton Memorial | Charlton | $1,422,332 | $213,350 | $711,166 |
| Cobb Memorial | Franklin | $1,398,374 | $209,756 | |
| Coffee Regional | Coffee | $4,721,344 | $708,202 | $2,360,672 |
| Colquitt Regional | Colquitt | $1,813,337 | $272,001 | $906,669 |
| Crawford Long | Fulton | $2,643,830 | $396,575 | |
| Crisp Regional | Crisp | $2,325,561 | $348,834 | $1,162,781 |
| Dodge County | Dodge | $895,447 | $134,317 | $447,724 |
| Dooly Medical Center | Dooly | $539,799 | $80,970 | $269,900 |
| Dorminy Medical Center | Ben Hill | $1,243,447 | $186,517 | $621,724 |
| Early Memorial | Early | $812,949 | $121,942 | $406,475 |
| Egleston Children's | DeKalb | $8,837,013 | $1,325,552 | |
| Elbert Memorial | Elbert | $774,080 | $116,112 | $387,040 |
| Emanuel County | Emanuel | $692,853 | $103,928 | $346,427 |
| Evans Memorial | Evans | $415,669 | $62,350 | $207,835 |
| Fairview Park | Laurens | $488,243 | $73,236 | |
| Floyd Medical Center | Floyd | $7,095,636 | $1,064,345 | $3,547,818 |
| Grady General | Grady | $698,514 | $104,777 | $349,257 |
| Grady Memorial | Fulton | $128,870,407 | $19,330,561 | $64,435,204 |
| Habersham County | Habersham | $692,974 | $103,946 | $346,487 |

## *Indigent Care Trust Fund*

| Hospital | County | ICTF Payment | Primary Care | Hospital Contribution |
|---|---|---|---|---|
| Hamilton Medical Center | Whitfield | $2,862,212 | $429,332 | |
| Hancock Memorial | Hancock | $35,030 | $5,255 | $17,515 |
| Henry Medical Center, Inc. | Henry | $2,676,254 | $401,438 | $1,338,127 |
| Higgins General | Haralson | $501,740 | $75,261 | $250,870 |
| Hughes Spalding Children's | Fulton | $6,014,262 | $902,139 | $3,007,131 |
| Hutcheson Medical Center | Catoosa | $4,971,699 | $745,755 | $2,485,850 |
| Irwin County | Irwin | $849,985 | $127,498 | $424,993 |
| Jasper Memorial | Jasper | $245,721 | $36,858 | $122,861 |
| Jeff Davis | Jeff Davis | $1,063,646 | $159,547 | $531,823 |
| Jefferson | Jefferson | $697,809 | $104,671 | $348,905 |
| John D. Archbold Memorial | Thomas | $2,024,380 | $303,657 | |
| Liberty Regional | Liberty | $1,485,344 | $222,802 | $742,672 |
| Louis Smith Memorial | Lanier | $414,195 | $62,129 | |
| Meadows Regional Med. Ctr. | Toombs | $1,265,077 | $189,762 | $632,539 |
| Medical Center Central Georgia | Bibb | $22,208,513 | $3,331,277 | $11,104,257 |
| Medical Center Columbus | Muscogee | $12,265,441 | $1,839,816 | $6,132,721 |
| Medical College of Georgia | Richmond | $48,910,016 | $7,336,502 | $24,455,008 |
| Medical/Surgical Center | Baldwin | $5,954,370 | $893,156 | $2,977,185 |
| Memorial Adel | Cook | $297,411 | $44,612 | |
| Memorial Bainbridge | Decatur | $1,472,050 | $220,808 | $736,025 |
| Memorial Medical Center | Chatham | $18,434,467 | $2,765,170 | $9,217,234 |
| Miller County | Miller | $535,168 | $80,275 | $260,000 |
| Minnie G. Boswell | Greene | $739,497 | $110,925 | $369,749 |
| Mitchell County | Mitchell | $918,337 | $137,751 | $459,169 |
| Monroe County | Monroe | $461,010 | $69,152 | $230,505 |
| Murray Medical Center | Murray | $198,787 | $29,818 | $99,394 |
| Northeast Georgia Med. Ctr. | Hall | $10,017,574 | $1,502,636 | $5,008,787 |
| Oconee Regional Medical Center | Baldwin | $3,622,305 | $543,346 | $1,811,153 |
| Parkway Medical Center | Douglas | $894,399 | $134,160 | |
| Perry | Houston | $921,835 | $138,275 | $460,918 |
| Phoebe Putney | Dougherty | $3,179,360 | $476,904 | $1,589,680 |
| Polk General | Polk | $836,028 | $125,404 | $418,014 |
| Putnam General | Putnam | $387,082 | $58,062 | $193,541 |
| Rabun County | Rabun | $310,350 | $46,553 | $155,175 |

## *Indigent Care Trust Fund*

| Hospital | County | ICTF Payment | Primary Care | Hospital Contribution |
|---|---|---|---|---|
| Roosevelt Warm Springs | Meriwether | $1,848,509 | $277,276 | $948,274 |
| Satilla Regional | Ware | $2,482,624 | $372,394 | $1,241,312 |
| Scottish Rite | Fulton | $1,538,069 | $230,710 | |
| Screven County | Screven | $328,893 | $49,334 | $164,447 |
| Shepherd Center, Inc. | Fulton | $305,717 | $45,858 | |
| Smith | Lowndes | $803,012 | $120,452 | |
| South Fulton | Fulton | $2,716,839 | $407,526 | |
| South Georgia Medical Center | Lowndes | $4,561,351 | $684,203 | $2,280,676 |
| Southeast Georgia Med. Ctr. | Glynn | $5,947,211 | $892,082 | $2,973,606 |
| Southwest Hospital & Med. Ctr. | Fulton | $1,250,738 | $187,611 | |
| Stephens County | Stephens | $959,796 | $143,969 | $479,898 |
| Stewart Webster | Stewart | $142,801 | $21,420 | |
| Sumter Regional | Sumter | $1,867,084 | $280,063 | $933,542 |
| Sylvan Grove | Butts | $694,649 | $104,197 | $347,325 |
| Tanner Medical/Villa Rica | Carroll | $974,273 | $146,141 | $487,137 |
| Taylor Regional | Pulaski | $315,873 | $47,381 | |
| Tift General | Tift | $2,302,058 | $345,309 | $1,151,029 |
| Union General | Union | $60,282 | $9,042 | $30,141 |
| University | Richmond | $11,204,148 | $1,680,622 | $5,602,075 |
| Upson Regional Medical Center | Upson | $1,909,573 | $286,436 | $954,787 |
| Washington County Regional Medical Center | Washington | $439,219 | $65,883 | $219,610 |
| Wayne Memorial | Wayne | $1,715,955 | $257,393 | $857,978 |
| West Georgia Medical Center | Troup | $1,503,668 | $225,550 | $751,834 |
| Wheeler County | Wheeler | $335,358 | $50,304 | |
| Wills Memorial | Wilkes | $776,064 | $116,410 | $388,032 |
| **TOTALS** | | **$388,990,056** | **$58,348,514** | **$177,922,041** |

*Does not include one-time payment of $164 million.

## *Fraud and Abuse Prevention and Detection*

Georgia Medicaid is committed to preventing fraud, waste and abuse within the program. Staff work to identify and correct problems in Medicaid policies and procedures; detect and stop potential fraudulent and abusive activity; and develop and implement proactive and reactive techniques for detecting and preventing provider fraud and abuse.

The program integrity section is composed of three units: program assessment, utilization review, and investigations and compliance. In addition, the provider enrollment unit helps to ensure that providers applying to participate in Medicaid are eligible and are enrolled properly. The South Georgia office, located in Tifton, enables staff to cover the entire state more effectively.

*Program assessment*

Staff conduct reviews of Medicaid claim submissions, monitoring weekly billing and statistical reports of providers in each of the Medicaid program's categories of service. When aberrations are noted, staff conduct an audit or review and may meet with the provider to determine whether there is fraudulent or abusive claims submission activity. Staff perform civil recoupments as well as make referrals for potential criminal investigation. In FY 2000, staff audited and reviewed all dentists providing services using mobile vans. These reviews resulted in policy revisions, recoupments and referrals for further investigation. In FY 2000, savings from all proactive reviews totaled $7,191,795.

Staff also monitor reports generated by the Auto-Audit system, which denies inappropriate claims and identifies patterns which may indicate provider fraud or quality of care problems. In FY 2000, the Auto-Audit system saved $3,333,886.

In FY 2000, the Program Assessment Unit completed reviews of hospital billing for inpatient admissions of less than 24 hours. Beginning in 1997, hospitals have participated in a self-disclosure program utilizing InterQual criteria to identify improperly billed claims for inpatient admissions. The project saved a total of $10,790,815 with $4,842,389 savings in FY 2000 alone.

**FY 2000 savings:** **$15,368,070**

## *Fraud and Abuse Prevention and Detection*

*Utilization review*

Georgia Medicaid conducts reviews of providers and recipients of Medicaid services. The utilization review unit identifies and corrects issues involving misutilization of services; incorrect coding of submitted claims; inappropriate unbundling or bundling of services; documentation that does not support submitted claims; fraudulent or abusive practices; poor quality services that affect recipient health; and policy noncompliance. Department staff conduct provider reviews, and recipient reviews are performed by a contractor. Providers and recipients may be reviewed if their Medicaid billing or utilization patterns appear aberrant in comparison to their peers.

During the year, the unit also reviewed providers referred by state agencies or the community and conducted several site visits as a result. In FY 2000, the unit expanded hospital reviews to include DRG coding practices. The unit also worked with hospitals to identify DRG billing problems and to provide correct DRG coding information.

| | |
|---|---|
| **FY 2000 initial recoupment identified:** | **$1,102,479** |

*Investigations and Compliance*

Investigators identify potential fraud through computer programs, telephone complaints and calls to the hot line, correspondence, referrals from DCH units and other state and federal agencies. When provider fraud is determined, the case is referred to the State Health Care Fraud Control Unit (SHCFCU). DCH staff work with SHCFCU to develop the case. Staff also work with federal law enforcement agencies and local prosecutors.

During the fiscal year, 10 cases initiated by Program Integrity staff were successfully prosecuted. Eighty other cases were in progress.

| | |
|---|---|
| **FY 2000 collections:** | **$8,528,630** |
| **FY 2000 court-ordered restitution (not collected):** | **$1,679,000** |
| **Total savings, recoupment, collections, and restitution:** | **$26,678,179** |

## *Medicaid Recipients and Expenditures by County FY 2000*

| County | Benefits Paid | Estimated 2000 Population | Unduplicated Recipients | % Population Receiving Medicaid | % Total State Recipients | Expenditures per Recipient |
|---|---|---|---|---|---|---|
| Appling | $12,383,423 | 16,493 | 4,283 | 25.97% | 0.36% | $2,891.30 |
| Atkinson | $4,855,123 | 7,138 | 2,085 | 29.21% | 0.17% | $2,328.60 |
| Bacon | $9,337,299 | 10,375 | 2,612 | 25.18% | 0.22% | $3,574.77 |
| Baker | $2,642,287 | 3,673 | 1,228 | 33.43% | 0.10% | $2,151.70 |
| Baldwin | $67,913,489 | 41,968 | 7,702 | 18.35% | 0.64% | $8,817.64 |
| Banks | $3,481,766 | 12,798 | 1,827 | 14.28% | 0.15% | $1,905.73 |
| Barrow | $16,089,482 | 40,344 | 5,905 | 14.64% | 0.49% | $2,724.72 |
| Bartow | $25,294,312 | 71,929 | 9,497 | 13.20% | 0.79% | $2,663.40 |
| Ben Hill | $14,304,762 | 17,496 | 4,773 | 27.28% | 0.40% | $2,997.02 |
| Berrien | $11,131,755 | 16,353 | 3,898 | 23.84% | 0.32% | $2,855.76 |
| Bibb | $106,649,261 | 156,086 | 36,988 | 23.70% | 3.08% | $2,883.35 |
| Bleckley | $6,657,349 | 11,185 | 2,365 | 21.14% | 0.20% | $2,814.95 |
| Brantley | $8,320,476 | 13,571 | 3,344 | 24.64% | 0.28% | $2,488.18 |
| Brooks | $12,640,208 | 16,000 | 4,443 | 27.77% | 0.37% | $2,844.97 |
| Bryan | $8,445,737 | 23,482 | 3,049 | 12.98% | 0.25% | $2,770.00 |
| Bulloch | $29,427,984 | 50,614 | 11,078 | 21.89% | 0.92% | $2,656.43 |
| Burke | $16,264,485 | 22,854 | 6,539 | 28.61% | 0.54% | $2,487.30 |
| Butts | $10,099,186 | 17,837 | 3,073 | 17.23% | 0.26% | $3,286.43 |
| Calhoun | $5,030,040 | 5,053 | 1,743 | 34.49% | 0.15% | $2,885.85 |
| Camden | $10,703,271 | 47,443 | 5,749 | 12.12% | 0.48% | $1,861.76 |
| Candler | $11,261,001 | 9,078 | 2,661 | 29.31% | 0.22% | $4,231.87 |
| Carroll | $38,782,893 | 83,021 | 15,294 | 18.42% | 1.27% | $2,535.82 |
| Catoosa | $15,080,477 | 50,547 | 5,619 | 11.12% | 0.47% | $2,683.84 |
| Charlton | $5,215,509 | 9,442 | 2,139 | 22.65% | 0.18% | $2,438.29 |
| Chatham | $111,226,920 | 225,543 | 41,447 | 18.38% | 3.45% | $2,683.59 |
| Chattahoochee | $1,377,440 | 16,679 | 938 | 5.62% | 0.08% | $1,468.49 |
| Chattooga | $12,800,509 | 22,813 | 3,685 | 16.15% | 0.31% | $3,473.68 |
| Cherokee | $23,103,634 | 134,498 | 7,377 | 5.48% | 0.61% | $3,131.85 |
| Clarke | $39,309,355 | 90,630 | 15,001 | 16.55% | 1.25% | $2,620.45 |
| Clay | $3,266,396 | 3,453 | 1,288 | 37.30% | 0.11% | $2,536.02 |
| Clayton | $74,675,063 | 208,999 | 41,701 | 19.95% | 3.47% | $1,790.73 |
| Clinch | $6,558,135 | 6,660 | 2,173 | 32.63% | 0.18% | $3,018.01 |
| Cobb | $106,568,956 | 566,203 | 39,116 | 6.91% | 3.26% | $2,724.43 |

## *Medicaid Recipients and Expenditures by County FY 2000*

| County | Benefits Paid | Estimated 2000 Population | Unduplicated Recipients | % Population Receiving Medicaid | % Total State Recipients | Expenditures per Recipient |
|---|---|---|---|---|---|---|
| Coffee | $22,155,224 | 34,298 | 8,244 | 24.04% | 0.69% | $2,687.44 |
| Colquitt | $28,173,208 | 40,156 | 11,703 | 29.14% | 0.97% | $2,407.35 |
| Columbia | $17,233,420 | 91,118 | 6,842 | 7.51% | 0.57% | $2,518.77 |
| Cook | $11,609,075 | 15,011 | 4,178 | 27.83% | 0.35% | $2,778.62 |
| Coweta | $22,731,301 | 85,028 | 8,863 | 10.42% | 0.74% | $2,564.74 |
| Crawford | $5,073,106 | 10,667 | 1,980 | 18.56% | 0.16% | $2,562.17 |
| Crisp | $20,675,089 | 20,725 | 6,770 | 32.67% | 0.56% | $3,053.93 |
| Dade | $5,156,470 | 15,058 | 1,921 | 12.76% | 0.16% | $2,684.26 |
| Dawson | $3,352,992 | 14,851 | 1,794 | 12.08% | 0.15% | $1,869.00 |
| Decatur | $28,465,844 | 27,035 | 7,590 | 28.07% | 0.63% | $3,750.44 |
| DeKalb | $209,171,878 | 593,850 | 94,216 | 15.87% | 7.84% | $2,220.13 |
| Dodge | $14,093,045 | 18,108 | 4,076 | 22.51% | 0.34% | $3,457.57 |
| Dooly | $9,500,106 | 10,388 | 3,110 | 29.94% | 0.26% | $3,054.70 |
| Dougherty | $61,654,751 | 95,309 | 27,013 | 28.34% | 2.25% | $2,282.41 |
| Douglas | $23,931,842 | 89,843 | 9,842 | 10.95% | 0.82% | $2,431.60 |
| Early | $9,583,399 | 12,197 | 4,122 | 33.80% | 0.34% | $2,324.94 |
| Echols | $1,284,720 | 2,401 | 721 | 30.03% | 0.06% | $1,781.86 |
| Effingham | $11,569,842 | 36,483 | 4,545 | 12.46% | 0.38% | $2,545.62 |
| Elbert | $13,212,556 | 19,335 | 4,202 | 21.73% | 0.35% | $3,144.35 |
| Emanuel | $20,840,786 | 21,023 | 6,624 | 31.51% | 0.55% | $3,146.25 |
| Evans | $7,185,794 | 9,949 | 2,924 | 29.39% | 0.24% | $2,457.52 |
| Fannin | $9,921,424 | 18,622 | 3,182 | 17.09% | 0.26% | $3,117.98 |
| Fayette | $10,348,803 | 88,609 | 3,207 | 3.62% | 0.27% | $3,226.94 |
| Floyd | $56,249,645 | 85,185 | 15,451 | 18.14% | 1.29% | $3,640.52 |
| Forsyth | $13,681,021 | 86,130 | 4,161 | 4.83% | 0.35% | $3,287.92 |
| Franklin | $11,782,073 | 19,080 | 3,473 | 18.20% | 0.29% | $3,392.48 |
| Fulton | $310,974,567 | 739,367 | 140,448 | 19.00% | 11.69% | $2,214.16 |
| Gilmer | $11,534,818 | 18,672 | 3,459 | 18.53% | 0.29% | $3,334.73 |
| Glascock | $3,300,519 | 2,512 | 538 | 21.42% | 0.04% | $6,134.79 |
| Glynn | $33,229,857 | 67,320 | 11,578 | 17.20% | 0.96% | $2,870.09 |
| Gordon | $17,982,145 | 41,052 | 6,831 | 16.64% | 0.57% | $2,632.43 |
| Grady | $13,312,723 | 21,501 | 5,599 | 26.04% | 0.47% | $2,377.70 |
| Greene | $7,743,383 | 13,651 | 3,161 | 23.16% | 0.26% | $2,449.66 |

## *Medicaid Recipients and Expenditures by County FY 2000*

| County | Benefits Paid | Estimated 2000 Population | Unduplicated Recipients | % Population Receiving Medicaid | % Total State Recipients | Expenditures per Recipient |
|---|---|---|---|---|---|---|
| Gwinnett | $90,652,508 | 522,095 | 38,345 | 7.34% | 3.19% | $2,364.13 |
| Habersham | $13,876,386 | 31,858 | 4,458 | 13.99% | 0.37% | $3,112.69 |
| Hall | $49,081,139 | 119,210 | 18,417 | 15.45% | 1.53% | $2,664.99 |
| Hancock | $8,950,420 | 9,134 | 2,708 | 29.65% | 0.23% | $3,305.18 |
| Haralson | $14,511,571 | 24,653 | 4,604 | 18.68% | 0.38% | $3,151.95 |
| Harris | $6,858,715 | 22,315 | 2,311 | 10.36% | 0.19% | $2,967.86 |
| Hart | $11,506,791 | 21,833 | 3,672 | 16.82% | 0.31% | $3,133.66 |
| Heard | $5,644,859 | 10,082 | 2,030 | 20.13% | 0.17% | $2,780.72 |
| Henry | $20,110,217 | 104,667 | 8,086 | 7.73% | 0.67% | $2,487.04 |
| Houston | $35,382,530 | 105,808 | 14,401 | 13.61% | 1.20% | $2,456.95 |
| Irwin | $7,315,808 | 8,982 | 2,115 | 23.55% | 0.18% | $3,459.01 |
| Jackson | $18,130,278 | 37,641 | 6,230 | 16.55% | 0.52% | $2,910.16 |
| Jasper | $4,602,875 | 10,155 | 2,031 | 20.00% | 0.17% | $2,266.31 |
| Jeff Davis | $9,267,689 | 12,751 | 3,094 | 24.26% | 0.26% | $2,995.37 |
| Jefferson | $15,124,508 | 17,767 | 5,270 | 29.66% | 0.44% | $2,869.93 |
| Jenkins | $7,082,367 | 8,447 | 2,455 | 29.06% | 0.20% | $2,884.87 |
| Johnson | $7,548,591 | 8,316 | 2,250 | 27.06% | 0.19% | $3,354.93 |
| Jones | $7,718,740 | 23,020 | 2,688 | 11.68% | 0.22% | $2,871.56 |
| Lamar | $6,969,151 | 14,706 | 2,661 | 18.09% | 0.22% | $2,619.00 |
| Lanier | $5,221,491 | 6,986 | 1,810 | 25.91% | 0.15% | $2,884.80 |
| Laurens | $31,265,815 | 43,772 | 11,208 | 25.61% | 0.93% | $2,789.60 |
| Lee | $6,639,074 | 22,767 | 2,738 | 12.03% | 0.23% | $2,424.79 |
| Liberty | $18,740,040 | 59,162 | 9,824 | 16.61% | 0.82% | $1,907.58 |
| Lincoln | $2,501,411 | 8,276 | 1,449 | 17.51% | 0.12% | $1,726.30 |
| Long | $3,526,279 | 8,585 | 2,187 | 25.47% | 0.18% | $1,612.38 |
| Lowndes | $49,874,756 | 85,231 | 17,981 | 21.10% | 1.50% | $2,773.75 |
| Lumpkin | $8,283,512 | 18,981 | 2,826 | 14.89% | 0.24% | $2,931.18 |
| Macon | $13,106,084 | 21,770 | 4,001 | 18.38% | 0.33% | $3,275.70 |
| Madison | $12,589,686 | 10,018 | 4,244 | 42.36% | 0.35% | $2,966.47 |
| Marion | $5,039,461 | 13,244 | 1,675 | 12.65% | 0.14% | $3,008.63 |
| McDuffie | $13,705,421 | 24,312 | 5,408 | 22.24% | 0.45% | $2,534.29 |
| McIntosh | $4,973,469 | 6,712 | 2,540 | 37.84% | 0.21% | $1,958.06 |
| Meriwether | $14,591,897 | 23,112 | 5,011 | 21.68% | 0.42% | $2,911.97 |

## *Medicaid Recipients and Expenditures by County FY 2000*

| County | Benefits Paid | Estimated 2000 Population | Unduplicated Recipients | % Population Receiving Medicaid | % Total State Recipients | Expenditures per Recipient |
|---|---|---|---|---|---|---|
| Miller | $5,311,863 | 6,409 | 1,564 | 24.40% | 0.13% | $3,396.33 |
| Mitchell | $17,650,034 | 21,176 | 6,729 | 31.78% | 0.56% | $2,622.98 |
| Monroe | $11,452,198 | 19,645 | 3,380 | 17.21% | 0.28% | $3,388.22 |
| Montgomery | $4,186,360 | 7,741 | 1,736 | 22.43% | 0.14% | $2,411.50 |
| Morgan | $6,274,837 | 15,091 | 2,482 | 16.45% | 0.21% | $2,528.14 |
| Murray | $12,349,423 | 32,682 | 4,600 | 14.08% | 0.38% | $2,684.66 |
| Muscogee | $93,746,100 | 182,752 | 36,488 | 19.97% | 3.04% | $2,569.23 |
| Newton | $24,152,972 | 57,847 | 9,498 | 16.42% | 0.79% | $2,542.95 |
| Oconee | $5,147,690 | 23,737 | 2,010 | 8.47% | 0.17% | $2,561.04 |
| Oglethorpe | $4,418,800 | 11,418 | 1,841 | 16.12% | 0.15% | $2,400.22 |
| Paulding | $15,535,846 | 73,534 | 6,194 | 8.42% | 0.52% | $2,508.21 |
| Peach | $10,559,114 | 24,462 | 5,080 | 20.77% | 0.42% | $2,078.57 |
| Pickens | $10,032,466 | 19,679 | 2,861 | 14.54% | 0.24% | $3,506.63 |
| Pierce | $10,270,167 | 15,794 | 3,569 | 22.60% | 0.30% | $2,877.60 |
| Pike | $5,215,003 | 12,645 | 1,763 | 13.94% | 0.15% | $2,958.03 |
| Polk | $20,860,755 | 36,308 | 6,707 | 18.47% | 0.56% | $3,110.30 |
| Pulaski | $6,194,822 | 8,401 | 2,033 | 24.20% | 0.17% | $3,047.13 |
| Putnam | $7,517,227 | 17,559 | 3,132 | 17.84% | 0.26% | $2,400.14 |
| Quitman | $1,136,566 | 2,486 | 711 | 28.60% | 0.06% | $1,598.55 |
| Rabun | $6,415,083 | 13,406 | 2,053 | 15.31% | 0.17% | $3,124.74 |
| Randolph | $6,613,368 | 7,881 | 2,647 | 33.59% | 0.22% | $2,498.44 |
| Richmond | $143,474,005 | 191,329 | 45,921 | 24.00% | 3.82% | $3,124.37 |
| Rockdale | $16,633,350 | 68,305 | 6,659 | 9.75% | 0.55% | $2,497.88 |
| Schley | $1,873,265 | 3,945 | 900 | 22.81% | 0.07% | $2,081.41 |
| Screven | $10,146,766 | 14,431 | 3,676 | 25.47% | 0.31% | $2,760.27 |
| Seminole | $8,110,031 | 9,788 | 2,783 | 28.43% | 0.23% | $2,914.13 |
| Spalding | $29,233,255 | 57,626 | 11,528 | 20.00% | 0.96% | $2,535.85 |
| Stephens | $14,908,143 | 25,421 | 4,603 | 18.11% | 0.38% | $3,238.79 |
| Stewart | $4,691,677 | 5,468 | 1,520 | 27.80% | 0.13% | $3,086.63 |
| Sumter | $25,478,420 | 31,324 | 9,314 | 29.73% | 0.78% | $2,735.50 |
| Talbot | $3,164,089 | 6,935 | 1,555 | 22.42% | 0.13% | $2,034.78 |
| Taliaferro | $1,101,829 | 1,908 | 551 | 28.88% | 0.05% | $1,999.69 |
| Tattnall | $14,205,095 | 18,975 | 4,714 | 24.84% | 0.39% | $3,013.38 |

## *Medicaid Recipients and Expenditures by County FY 2000*

| County | Benefits Paid | Estimated 2000 Population | Unduplicated Recipients | % Population Receiving Medicaid | % Total State Recipients | Expenditures per Recipient |
|---|---|---|---|---|---|---|
| Taylor | $6,327,733 | 8,306 | 2,429 | 29.24% | 0.20% | $2,605.08 |
| Telfair | $11,479,890 | 11,558 | 3,209 | 27.76% | 0.27% | $3,577.40 |
| Terrell | $8,338,833 | 11,146 | 3,630 | 32.57% | 0.30% | $2,297.20 |
| Thomas | $34,190,056 | 42,953 | 10,326 | 24.04% | 0.86% | $3,311.06 |
| Tift | $22,646,147 | 36,673 | 8,946 | 24.39% | 0.74% | $2,531.43 |
| Toombs | $23,174,533 | 25,828 | 7,707 | 29.84% | 0.64% | $3,006.95 |
| Towns | $5,380,178 | 8,529 | 1,135 | 13.31% | 0.09% | $4,740.24 |
| Treutlen | $5,576,185 | 6,003 | 1,779 | 29.64% | 0.15% | $3,134.45 |
| Troup | $29,356,278 | 58,783 | 10,802 | 18.38% | 0.90% | $2,717.67 |
| Turner | $7,184,645 | 9,160 | 2,838 | 30.98% | 0.24% | $2,531.59 |
| Twiggs | $5,918,444 | 10,126 | 2,165 | 21.38% | 0.18% | $2,733.69 |
| Union | $9,586,473 | 16,519 | 2,450 | 14.83% | 0.20% | $3,912.85 |
| Upson | $15,514,184 | 27,075 | 5,067 | 18.71% | 0.42% | $3,061.81 |
| Walker | $27,642,719 | 63,082 | 8,773 | 13.91% | 0.73% | $3,150.89 |
| Walton | $20,243,361 | 54,485 | 7,708 | 14.15% | 0.64% | $2,626.28 |
| Ware | $33,124,647 | 35,364 | 11,729 | 33.17% | 0.98% | $2,824.17 |
| Warren | $5,368,413 | 6,059 | 1,835 | 30.29% | 0.15% | $2,925.57 |
| Washington | $13,364,339 | 20,033 | 4,922 | 24.57% | 0.41% | $2,715.23 |
| Wayne | $14,998,541 | 25,437 | 5,550 | 21.82% | 0.46% | $2,702.44 |
| Webster | $990,927 | 2,193 | 441 | 20.11% | 0.04% | $2,247.00 |
| Wheeler | $5,046,172 | 4,875 | 1,481 | 30.38% | 0.12% | $3,407.27 |
| White | $7,236,955 | 17,457 | 2,383 | 13.65% | 0.20% | $3,036.91 |
| Whitfield | $34,208,594 | 82,039 | 13,063 | 15.92% | 1.09% | $2,618.74 |
| Wilcox | $8,159,533 | 7,365 | 2,245 | 30.48% | 0.19% | $3,634.54 |
| Wilkes | $5,760,898 | 10,568 | 2,333 | 22.08% | 0.19% | $2,469.31 |
| Wilkinson | $4,817,788 | 10,838 | 2,237 | 20.64% | 0.19% | $2,153.68 |
| Worth | $11,495,869 | 22,485 | 5,257 | 23.38% | 0.44% | $2,186.77 |
| **STATEWIDE** | **$3,343,199,902** | **7,642,207** | **1,201,669** | **15.72%** | **100.00%** | **$2,782.13** |

*Source: DMA Decision Support System*

*Statewide totals reflect unduplicated recipients and expenditures reported elsewhere in this report.

# Division of Health Planning

## *FY 2000 milestones*

*Intent to assess financial accessibility*

To improve access to health care for the uninsured, the division announced plans to assess on an annual basis the indigent care commitment of every hospital facility. The assessment will ensure that a percentage of a hospital's adjusted gross revenue will go toward providing services to indigent patients.

*Expedited Certificate-of-Need (CON) review of non-clinical services*

The division and Health Strategies Council passed a rule allowing for a 45-day expedited review cycle of CON proposals for non-clinical services. Proposals for the construction of parking decks, renovations of a hospital's physical infrastructure, and construction of new medical office buildings may be eligible for the expedited review. The rule also allows the applicant to pay a lower CON application filing fee.

*Letter of non-reviewability for certain ambulatory surgery centers*

The Health Strategies Council passed a proposed CON rule change clarifying the criteria for physician-owned, office-based, single-specialty ambulatory surgery centers to apply for an exemption from the CON process.

*Expanding Traumatic Brain Injury services*

The division implemented the Traumatic Brain Injury (TBI) grant designed to establish a system of coordinated services for people with TBI. The federal funding is used to assess the needs of people with traumatic brain injuries, determine what services are available and develop additional necessary services. In FY 2000, the program established pilot support groups to discuss the needs of culturally diverse and rural populations. More than 100 representatives of health care providers and payers attended a coalition building summit to gain support for future TBI grant initiatives.

*Health Strategies Council*

A major duty of the Health Strategies Council is the ongoing development and refinement of Georgia's State Health Plan. During FY 2000, the Council initiated several changes, including a recommendation that existing home health programs be allowed to apply at any time for an expanded service area due to merger or purchase, an appointment of a technical advisory committee (TAC) to assist with updating the state's old rules for radiation therapy services, and revisions to the state's Rural Health Care Plan as a result of changes in federal laws governing critical access hospitals.

## *Description of the Division of Health Planning*

Georgia's health planning program was established more than 20 years ago to ensure the financial and geographic accessibility of quality health care services to all Georgians. Formerly the State Health Planning Agency (SHPA), the agency became the Division of Health Planning, part of the Department of Community Health, in July 1999. The division works to contain health care costs by avoiding unnecessary duplication of services, equipment and facilities. The division helps to enforce quality-of-care standards and encourages providers to assume a share of responsibility for the health care needs of low-income citizens.

# Division of Health Planning

## *Description of the Division of Health Planning*

The division administers the Certificate-of-Need (CON) program, which approves the development and expansion of health care services and facilities, and works with the Health Strategies Council to develop policies for health care services. Staff also distribute almost 1,300 surveys to health care facilities to collect information about capacity and utilization, patient flow patterns, indigent charity care and types of services offered.

### *Health Strategies Council*

The Health Strategies Council is responsible for developing Georgia's state health plan and addressing policy issues concerning access to health care services through an open, public process. The council's 25 members are appointed by the Governor. During FY 2000 the council focused on updating the state's cancer plan and rules for radiation therapy services, and revising the rural health component plan (which increased the number of hospitals eligible for Critical Access designation). The council also passed rule changes allowing for an expedited CON review process for non-clinical services and enabling home health agencies to apply outside the regular time frames for the expansion of their service area.

### *Health Planning Review Board*

The Health Planning Review Board conducts appeal hearings on CON decisions. The board conducted 10 hearings in FY 2000.

## *Statistical Summary*

| | |
|---|---|
| **FY 2000 expenditures:** | $1,721,487 |
| **Revenue collected:** | $125,070 |
| **CON applications received:** | |
| 83 applications representing proposed capital expenditures of | $657,344,040 |
| **CON applications approved:** | |
| 74 applications totaling | $600,912,991 in capital expenditures |
| **Savings from denied, withdrawn or cancelled CON applications:** | $56,431,049 |
| **Requests for determinations (on need for a CON):** | 254 |
| **Surveys received from health care facilities:** | 1,253 |

# Division of Health Planning

## *Planning and Data Management*

The division collects and analyzes information about Georgia's health care system, which is used in identifying trends and developing policy recommendations and planning initiatives.

All health care facilities and services operating under the state's certificate-of-need laws are required to complete an annual survey for review by the Department's Division of Health Planning. The survey reports produce important data used in the Department's certificate-of-need determination processes and the overall planning efforts to improve health care for Georgians.

The division also uses survey data to show health care trends in the state, such as utilization and payment sources for hospital, home health and nursing home services and indigent/charity care provided. An overview is available on the Department's web site at *www.dch.state.ga.us*.

## *Georgia Health Care at a Glance*

| Type of Facility | Supply | 1999 Utilization |
|---|---|---|
| **General Hospitals** | 158 hospitals | 826,189 admissions |
| | 24,242 beds | 4,000,247 patient days |
| | 3.3 beds per 1,000 population | 541 days per 1,000 population |
| **Specialty and** | 27 hospitals | 28,655 admissions |
| **Psychiatric Hospitals** | 2,594 beds | 400,342 patient days |
| **Cardiac** | 55 providers (including mobile) | 83,439 catheterizations |
| **Catheterization** | | 64,553 diagnostic |
| | | 18,886 therapeutic (no mobile) |
| **Open Heart Surgery** | 16 providers | 10,449 surgeries |
| **Obstetrical Hospital** | 101 hospitals | 349,052 patient days |
| **Services** | 1,807 beds | 130,873 deliveries |
| **Ambulatory Surgery** | 68% of total surgeries | 83.5 procedures per 1,000 population |
| **Hospital-based** | 164 outpatient ORs | 427,163 patients |
| | 362 shared OR equivalents | |
| **Freestanding** | 130 ORs | 93,569 patients |
| **General Nursing Homes** | 368 homes | 34,762 admissions |
| | 38,945 licensed beds | 12,813,112 patient days |
| | 56 beds per 1,000 age 65+ | |
| **Home Health Agencies** | 122 agencies | 132,696 patients |
| | | 4,221,698 visits |
| | | 32 visits per patient |

*Source: Survey reports from provider facilities; population estimates; Governor's Office of Planning and Budget.*

# Division of Health Planning

## *Regulatory Compliance*

The division conducts the CON review program, the primary means for implementing policies adopted by the Health Strategies Council. The program helps avoid unnecessary duplication of equipment and facilities and promotes improved quality-of-care standards by requiring health care providers to obtain a CON before offering new services, purchasing major medical equipment, or constructing new facilities. Providers who must comply with the CON program include hospitals, nursing facilities, home health agencies, outpatient surgery centers, and freestanding diagnostic imaging and radiation therapy centers.

Generally, a CON is required before a health care facility or provider can proceed with a construction or renovation project and/or any other capital expenditure that exceeds $1,155,881; purchase or lease major medical equipment costing more than $642,157; offer a health care service which was not provided on a regular basis during the previous 12-month period; and add new beds to a health care facility.

The division also grants letters of non-reviewability for single-specialty, physician-owned, office-based ambulatory surgery centers, allowing facilities meeting specific criteria to bypass the CON review process. Further, hospitals and other facilities may apply for a letter of exemption for the purchase of magnetic resonance imaging (MRI) equipment.

Since its inception in 1979, the CON review process has saved an estimated $2.4 billion in unnecessary capital expenditures on health care projects which either failed to meet planning guidelines or were withdrawn by the applicants during review.

In FY 2000 the division

- approved 44 CON projects for private general, acute care and specialty hospitals totaling $514,453,165 in capital expenditures.
- reviewed 83 CON applications (some of which were received prior to FY 2000), with a reversal rate on appeal of less than 2%.

## *Georgia's Certificate-of-Need Activity FY 1990-2000*

### Status of CON Applications Submitted and Dollar Amounts Involved

| Year Submitted | Applications Submitted | Applications Approved | Percentage Approved | Amount Reviewed | Amount Saved |
|---|---|---|---|---|---|
| FY 1990 | 136 | 86 | 63% | $280,970,152 | $71,388,125 |
| FY 1991 | 155 | 119 | 77% | $515,930,351 | $210,462,520 |
| FY 1992 | 107 | 77 | 72% | $508,067,933 | $140,984,293 |
| FY 1993 | 133 | 68 | 51% | $371,310,261 | $163,967,049 |
| FY 1994 | 127 | 84 | 66% | $260,455,530 | $108,091,061 |
| FY 1995 | 143 | 83 | 58% | $379,440,269 | $104,853,516 |
| FY 1996 | 76 | 59 | 78% | $420,946,923 | $38,802,798 |
| FY 1997 | 71 | 50 | 70% | $333,674,960 | $152,212,107 |
| FY 1998 | 93 | 42 | 45% | $188,203,943 | $80,646,742 |
| FY 1999 | 95 | 68 | 72% | $461,631,476 | $108,302,482 |
| FY 2000 | 83 | 74 | 89% | $657,344,040 | $56,431,049 |
| **TOTALS** | **1,219** | **813** | **67%** | **$4,377,975,836** | **$1,219,799,778** |

**Amount reviewed:** Total cost of projects submitted for review (does not include operational costs)
**Amount saved:** Total cost of projects denied, withdrawn and cancelled (does not include operational costs)

*Source: Division records*

## *FY 2000 milestones*

*Responding to health plan deficits*

The State Health Benefit Plan (SHBP) experienced considerable operating losses from FY 1997 through FY 1999 as a result of higher costs for prescription drugs and medical services and a significant increase in plan use by members. During FY 2000, the plan took a number of major steps to end the operating losses.

- New PPO option
  Effective July 1, 2000, the SHBP replaced the Standard Option with a new Preferred Provider Organization (PPO) option. During FY 2000, staff worked to design the PPO's in-network coverage to provide additional benefits while reducing plan expenditures. First-year savings generated from the PPO are expected to be $25 million (including the savings for the Board of Regents Health Plan). Savings are generated through lower, negotiated rates with PPO providers.

  The new PPO option includes in-network coverage for preventive care office visits. Members pay a small copayment with no deductibles. Examples of covered office visits for preventive care include annual physicals for men, women and children; well-baby exams and routine immunizations.

- Contracting directly with hospitals
  Effective January 1, 2000, the plan discontinued the Prudent Buyer Program (PBP), replacing it with individual contracts between the state and each acute care hospital in Georgia. New contracts with hospitals provide a lower, more competitive reimbursement based on a patient's diagnosis. Estimated savings from the new contracts totaled $18 million for FY 2000.

- Increased contributions
  In March 2000 the Board of Community Health approved an increase for FY 2001 employer contribution rates for specified school system personnel as well as an average premium increase of 16% for all members in the indemnity option and HMOs. Effective July 1, 2000, the employer contribution rate increased from 9.26% to 13.1% of state-based salaries for certificated personnel. The new rate will provide an equal employer contribution rate for both local county school systems (certificated personnel only) and state agencies. The premium and rate changes will increase plan revenue an estimated $155.3 million for FY 2001.

*Managing disease*

By analyzing data from the SHBP information and utilization management systems, the plan develops strategies, such as disease state management programs, to improve health outcomes. Beginning on January 1, 2000, the plan offered two new disease state management programs that focus on providing education, literature and other resources to plan participants with congestive heart failure and cancer of the breast, lung, or colon. Program participants have access to enhanced benefits, including coverage for approved educational services. The plan also expanded the diabetes management program to allow more people to participate. During the fiscal year, 570 people participated in the diabetes program and 283 took part in the cancer programs. Of the 1,500 members eligible for the congestive heart failure program, 140 participated during the year.

# Division of Public Employee Health Benefits

## *FY 2000 milestones*

### *New consumer choice options added to plan*

During FY 2000, division staff prepared to implement four new consumer choice options and three new Medicare + Choice options, effective July 1, 2000. Staff worked to develop premium rates, reprogram and test computer software, revise forms, and educate members about the new options through publications and onsite meetings with more than 800 agencies.

- Consumer choice options
  The PPO consumer choice option (PPO Choice) and the three HMO consumer choice options are the result of Georgia's Consumer Choice Option Law, which became effective for plan members on July 1, 2000. The law enables members who join the consumer choice version of an HMO or PPO option to request that an out-of-network provider licensed in Georgia be approved to deliver the member's care on an in-network basis if the provider agrees to the network fees and PPO requirements.

- Medicare + Choice options
  On January 1, 1998, Medicare implemented a third part, referred to as Medicare+Choice or M+C. During FY 2000, the division worked closely with each of the three HMOs offered under the plan to coordinate and develop a plan-specific M+C option for each HMO. The M+C product is an arrangement between Medicare and the HMO for the HMO to provide all the member's medical services for a fixed amount per member. M+C options became effective on July 1, 2000 for the SHBP. Members must be enrolled in Medicare Part A and Part B and live in an M+C service area to be eligible for the coverage. The member agrees to have all services provided by the HMO rather than traditional Medicare.

### *2000 — 2001 Plan Year Open Enrollment busiest ever*

In preparation for the implementation of new health plan options, the division had the busiest open enrollment period ever recorded and set several processing records:

- Processed 109,539 coverage transactions for coverage effective July 1, 2000 — more than four times as many option changes, terminations, and enrollments as in previous years.
- Created a new web site for online open enrollment transactions for most school systems. A total of 31,633 teachers and school personnel used the new site to submit their selections.
- Rewrote and redesigned all enrollment materials to include information about the standard PPO and CCO options.
- Coordinated the development and distribution of a PPO provider directory and assisted the PPO network contractor with implementing an online provider directory and other online services.
- Answered 26,517 member telephone calls placed to the division's internal eligibility unit.

## *FY 2000 milestones*

### *New Retiree Option Change Period*

To give retirees an opportunity to enroll in the new plan options, the DCH Board approved an annual Retiree Option Change Period (ROCP). The ROCP coincides with the open enrollment period for active plan members and allows retirees to choose any available option. A sample of the division's work related to the first ROCP:

- Held 134 special public meetings across the state attended by 11,413 retired members.
- Created a toll-free Retiree Help Line which answered almost 33,000 calls about plan changes.
- Created a web site to enable retirees to make online coverage changes. A total of 9,624 retirees submitted their coverage selections online.
- Sent more than 60,000 retired members a special package containing complete plan information and personalized change forms.

### *Internal quality improvements*

At the same time the division worked to implement plan changes, staff also sought ways to improve the quality of services offered to state agencies, school boards and plan members. The division worked with the Department of Audits to ensure proper collection of the employer share of health coverage from all local school systems. Underpayments identified for FY 1999 and 2000 totaled $9,272,050. Collections are underway. Local school systems are now required to submit payroll documentation supporting employee deductions and employer contributions. Review of the documentation helps ensure the accuracy of payments.

Among other improvements was the development of a comprehensive Open Enrollment manual to assist benefit coordinators and simplify plan administration. The division also enhanced services to plan members by installing a state-of-the-art telephone system that routes inbound calls, provides on-hold messages, and generates a variety of reports for quality-assurance purposes.

### *Coordinated administration of the Board of Regents Health Plan (BORHP)*

Effective July 1, 1999, the General Assembly authorized the Department of Community Health to contract with the Board of Regents for the administration and purchase of health benefits. As of June 30, 2000, the BORHP covered 90,000 lives. The Board of Regents retains final authority over health plan administration, determination of benefit design and premium contributions, selection of contractors, and approval of contract provisions.

During FY 2000, the division assisted in negotiations with BORHP vendors; prepared the competitive bidding process for the PPO option within the BORHP; provided advice and guidance regarding BORHP benefits and associated premiums; and assisted in orientation sessions and PPO option implementation, scheduled to become effective on January 1, 2001.

# Division of Public Employee Health Benefits

## *Description of the Division of Public Employee Health Benefits*

The Georgia Department of Community Health (DCH) administers the State Health Benefit Plan, which provides health insurance coverage to state employees, school system employees, retirees and their dependents. Within DCH, the Public Employee Health Benefits Division is responsible for the day-to-day management of State Health Benefit Plan (SHBP) operations. The SHBP covered 570,811 lives at the close of FY 2000. Prior to July 1, 1999, when DCH began operation, the Georgia Merit System administered the plan.

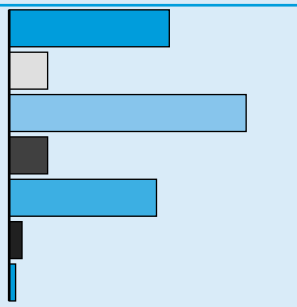
## *Statistical Summary*

| | |
|---|---|
| **Total FY 2000 expenditures** | **$1,304,630,541** |
| Standard and High Option Expenditures | $ 969,162,198 |
| HMO Premiums | $ 279,911,102 |
| Contracts | $ 51,782,727 |
| Administrative Support | $ 3,774,514 |
| | |
| **Total covered lives** | **570,811** |
| School System Employees, Retirees and Dependents | 388,429 |
| State Employees, Retirees and Dependents | 177,601 |
| Miscellaneous | 4,781 |
| | |
| **Average expenditure per covered life** | **$ 2,286** |

## *Covered Lives*

The table below describes plan membership by employment group and active or retired status. Total covered lives include members, spouses, and other dependents.

| Plan Member Group | Covered Lives | Percentage of Total Lives |
|---|---|---|
| State Employees - Active | 144,632 | 25% |
| State Employees - Retired | 32,969 | 6% |
| Teachers - Active | 209,406 | 37% |
| Teachers - Retired | 32,867 | 6% |
| School Service Personnel - Active | 131,603 | 23% |
| School Service Personnel - Retired | 14,553 | 2% |
| Miscellaneous - Retired/Active | 4,781 | 1% |
| **Grand Total** | **570,811** | **100%** |
| | | |
| Total Active | 485,649 | 85% |
| Total Retired | 85,162 | 15% |
| **Grand Total** | **570,811** | **100%** |



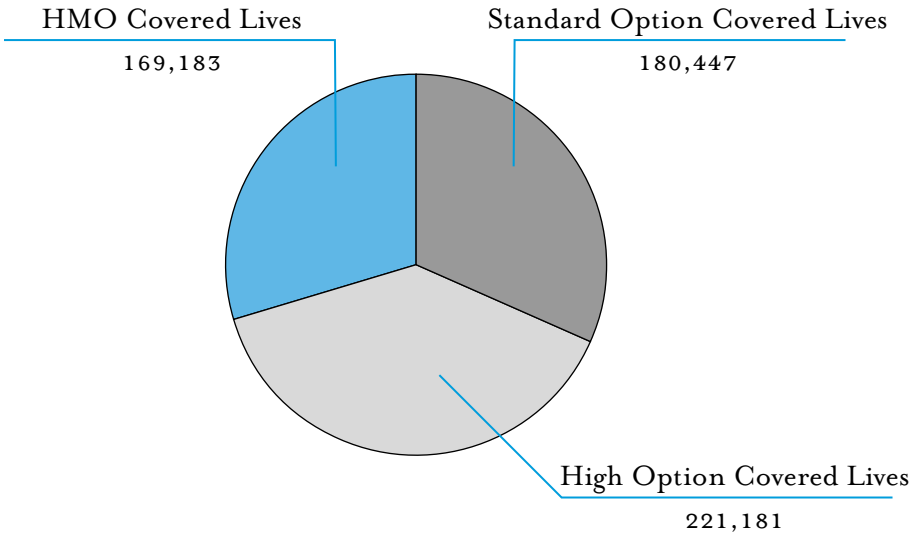
In FY 2000, teachers and school service personnel represented more than two-thirds of the covered lives; state employees accounted for almost one-third. Overall, retirees accounted for more than 85,000 covered lives, which represents 15% of the entire plan population.

# Division of Public Employee Health Benefits

## *Covered Lives*

### Coverage Options

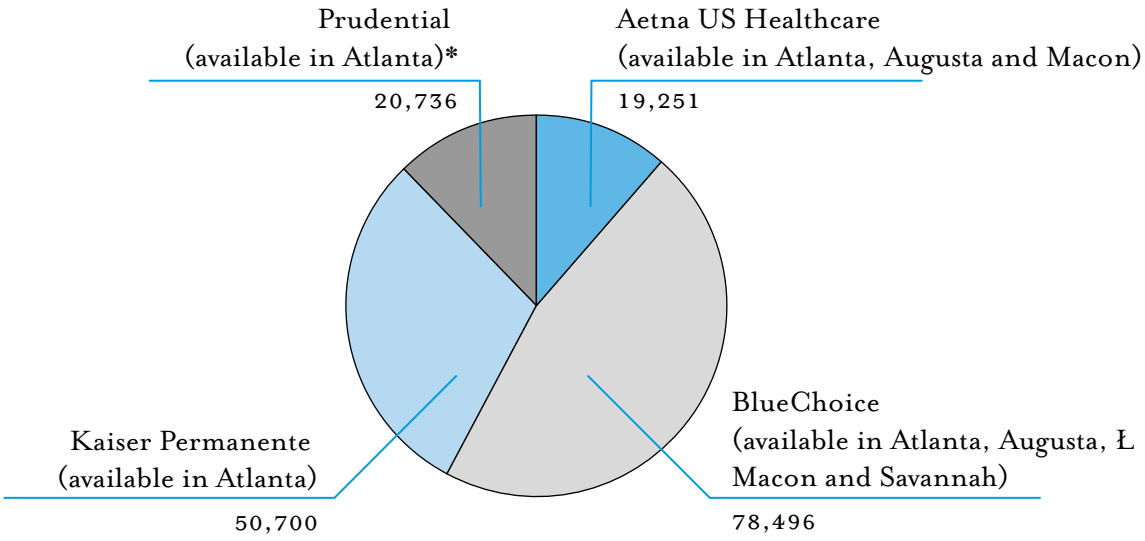
The State Health Benefit Plan offered three types of coverage during FY 2000: Standard Option, High Option, and Health Maintenance Organization (HMO) Options. Monthly employee contributions to premiums ranged from $38.52 to $67.46 for single coverage and from $112.48 to $174.94 for family coverage. Total monthly premiums (employee plus employer contributions) ranged from $181.38 to $293.66 for single coverage and from $383.20 to $543.20 for family coverage.




- Standard and High options are managed-indemnity choices available statewide that give members a full choice of providers. (Note: Standard Option became the Standard PPO Option effective July 1, 2000.)
- The HMO option is available to members who either live or work in a county within an approved service area. HMOs are available in the Atlanta, Augusta, Macon and Savannah areas. HMO choices for FY 2000 included Aetna US Healthcare, BlueChoice, Kaiser Permanente and Prudential. Except in emergencies, HMO participants must use network providers to receive coverage.

## *Covered Lives*

Below are the four HMOs offered under the SHBP in FY 2000 and the number of covered lives participating in each HMO at the close of the fiscal year:




*No longer offered.

### Expenditures

The SHBP contains both self-insured and fully-insured coverage options. The Standard and High options are self-insured, where employee and employer revenues are used to pay claims expenses directly. The HMOs offered by the plan are fully-insured and receive a premium payment from the plan. Administration and contracts represent only 4.3 % of total expenditures for the fiscal year. FY 2000 expenditures totaled $1,304,630,541.

Within the indemnity options, cost-management initiatives with providers generate savings for the plan. Through the Prudent Buyer Program, the plan received discounts off a hospital's normal charge. Effective January 1, 2000, the plan replaced the Prudent Buyer Program with direct contracts with all acute care hospitals in the state. The plan also obtained lower negotiated rates with doctors through the Participating Physician Program.

Additional savings were generated through the Medical Certification Program (MCP), which has dedicated staff who perform many plan services, including pre-certification of hospital admissions and certain outpatient procedures. The MCP also conducts case management and maintains the plan's transplant network. Combined savings from the MCP totaled $12,808,866.

# Division of Public Employee Health Benefits

## *Operating Units*

### *Eligibility*

Eligibility specialists counsel SHBP members and process enrollments, changes of coverage, updates, coverage continuation requests, retiree enrollments and coverage actions. During FY 2000, eligibility specialists processed 168,565 transactions.

### *Health Plan Support Services*

Health benefit staff provide administrative support to personnel representatives in state agencies, boards of education and other entities participating in the SHBP. In FY 2000, staff handled almost 141,000 letters, phone calls and coverage updates. Staff also had 1,244 in-person visits from plan members who had inquiries about their coverage.

### *Review Services*

Staff received more than 1,000 requests from SHBP members for administrative review of eligibility and/or claim payment issues. During FY 2000, appeals specialists closed 947 administrative review appeals. Additionally, Review Services staff and Formal Appeals Committee members processed a total of 80 formal appeals.

### *Contract Compliance*

The SHBP contracted with a number of vendors to provide services to members and closely reviewed each vendor's performance for contract compliance and quality assurance. On a regular basis, managers reviewed the performance of the plan's HMOs, third party claims administrator, demand management vendor, and utilization review vendor.

### *Managed Care*

The plan also monitors the cost containment programs of the Standard and High options. The programs include medical and behavioral health utilization management, case management, disease state management, prior approval, transplant network, and demand management.

## *Operating Units*

The table below lists the plan's primary vendors during the fiscal year and the principal services each provides:

| Vendor | Services |
|---|---|
| Blue Cross and Blue Shield of Georgia | claims processing (4,106,895 professional, 561,215 hospital and 3,537,607 prescription claims); prior approvals; claims pricing and payment; telephone and mail customer service (948,000 calls); medical policy development; and administration of sub-contracts for cost containment programs. |
| Centra | audits of high-cost hospital bills (subcontract through BlueCross) |
| SubroAudit | subrogation services (e.g., auto accident claims; subcontract through BlueCross) |
| Wellpoint | preferred drug formulary and rebates (subcontract through BlueCross) |
| UniCare/Cost Care | inpatient/outpatient medical/surgical precertification, case management, transplant network |
| Magellan Behavioral Health, Inc. | hospital admission certification for mental health care, outpatient therapy certification, intensive outpatient program, partial hospitalization program, and intensive case management |
| PAID Prescriptions | prescription drug benefit management |
| McKesson/HBOC | 24-hour demand management, nurse triage program, and emergency room referrals |
| MEDSTAT | claims data analysis |

### *System Support*

The SHBP operates the Membership Enrollment Management System (MEMS) that captures and maintains member information. MEMS is a mainframe-based system of 320 programs with over 11.3 million records in its database designed to capture and maintain information related to eligibility, enrollment and financial activity for the SHBP. The system records basic demographic information and a history of coverage for all employees, retirees and dependents in the plan. This internal system enables plan members to receive SHBP identification cards almost immediately. The plan also utilizes MEMS to produce billing records for state agencies and local school systems, and to track accounts receivable for claim refunds.

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