GEORGIA DEPARTMENT OF COMMUNITY HEALTH
FY 2006 Annual Report

Rhonda Medows, M.D., Commissioner

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Georgia Department of Community Health

Fiscal Year 2006 Annual Report

Rhonda Medows, M.D., Commissioner

Overview

The Georgia Department of Community Health (DCH) is involved in planning, purchasing and regulating health care in the state. Since its inception in 1999, DCH responsibilities have included the following:

- Acting as the lead planning agency for health issues in Georgia
- Capitalizing on the state's health care purchasing power
- Maximizing administrative efficiency in state health care programs
- Creating a better health care infrastructure throughout Georgia, which improves access and coverage
- Encouraging a healthy lifestyle for all Georgians
- Insuring more than 2.5 million Georgians through the Division of Medical Assistance (DMA) and the State Health Benefit Plan (SHBP) which provides coverage for state employees, retirees and their families
- Administering a budget that exceeds $9.6 billion
- Coordinating health planning for state agencies

DCH must ensure quality health care services for a diverse population, including the following:

- Members of the SHBP:
  - Public school teachers
  - Retirees
  - State employees
  - Public school employees
  - Eligible dependents
- Children covered by PeachCare for Kids™
- People covered by Medicaid, including those who are:
  - Aged
  - Low-income
  - Disabled

Mission and Priorities

The Georgia Department of Community Health champions:

ACCESS to affordable, quality health care in our communities
RESPONSIBLE health planning and use of health care resources
HEALTHY behaviors and improved health outcomes

FY 2006 DCH Health Policy Priorities:

- Medicaid Transformation
- Consumerism
- Financial Integrity of Health Care Programs
- Health Improvement and Resolving Disparities
- Uninsured: Community Based Solutions

Organizational Structure

Board of Community Health

DCH is governed by the Board of Community Health. The Board is comprised of nine people that have policy-making authority for the Department. The is appointed by the Governor and confirmed by the State Senate. The Board meets monthly.

At the end of FY 2006, the Board of Community Health members included:

- Jeff Anderson – Cumming, Chairman
- Richard L. Holmes – Peachtree City, Vice Chairman
- Christopher Byron Stroud, M.D. – Albany, Secretary
- Mary McCalman Covington – Carrollton
- Inman "Buddy" English, M.D. – Warner Robins
- Kim Gay – Sandy Springs
- Ross Mason – Madison
- Ann McKee Parker, Ph.D. – Atlanta
- Mark D. Oshnock – Atlanta

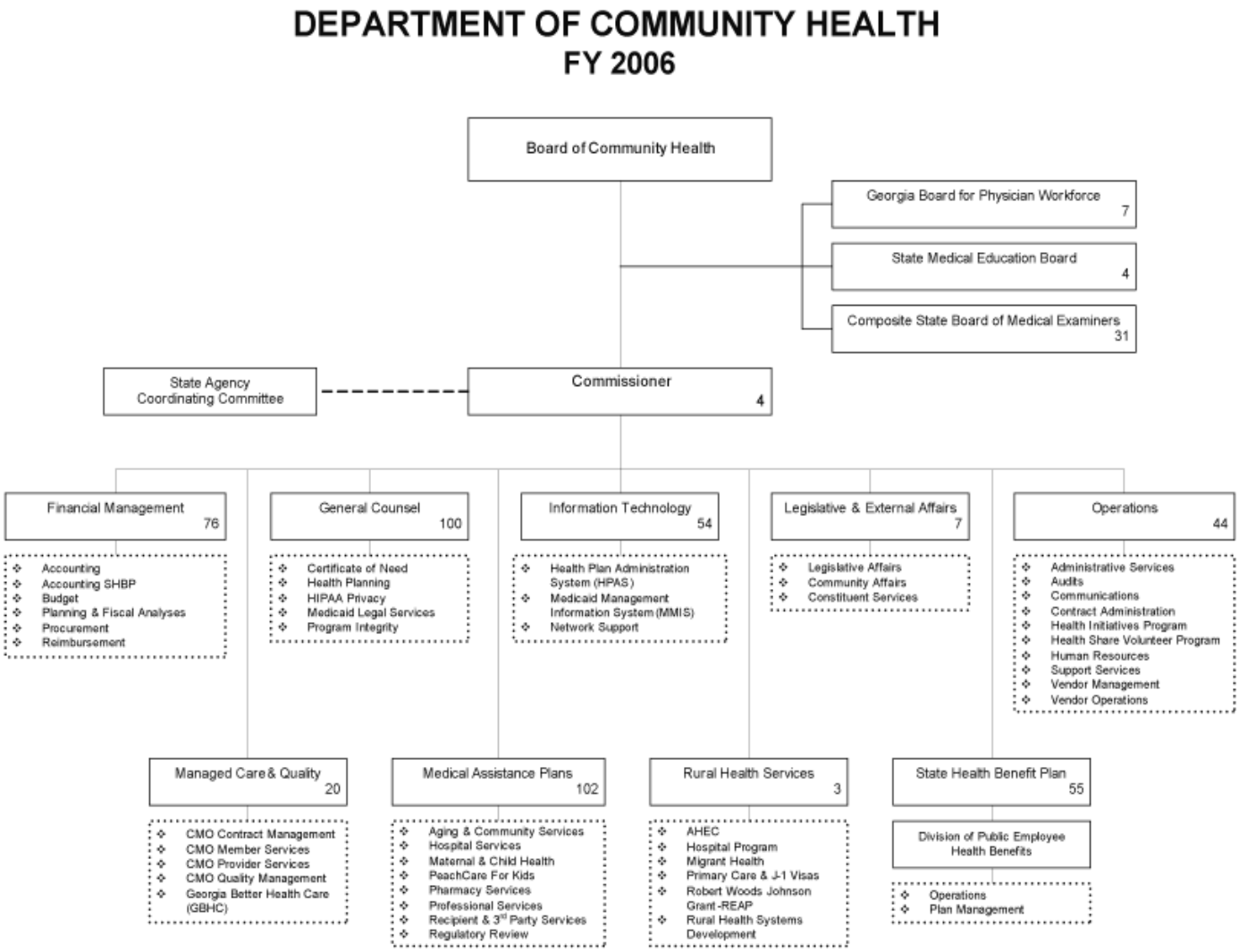
DCH Leadership

Dr. Rhonda Medows, was appointed by the Governor in December 2005 and serves as the commissioner of DCH.

DCH leadership includes nine division chiefs responsible for managing each of the following divisions represented in the DCH Organizational chart.

- Financial Management
- General Counsel
- Information Technology
- Legislative and External Affairs
- Operations
- Managed Care and Quality
- Medical Assistance Plans
- Rural Health Services
- State Health Benefit Plan

Organizational Chart



Initiatives for the Department in FY 2006

In 2006, DCH embarked upon the following successful initiatives

Customer Service
In January 2006, Governor Sonny Perdue held a statewide Customer Service Summit, asking for agency commitments to make Georgia's customer service "faster, friendlier and easier." DCH created an agency-wide plan to improve its customer service by emphasizing internal customer service; creating the first interagency collaborative team with Georgia Department of Human Resources (DHR) to streamline the Medicaid application process; and improving the DCH external Web site. This initiative proved to be a significant accomplishment for DCH.

Intranet Project
In February 2006, the DCH Commissioner asked the Office of Communications to research and obtain software to create an Intranet system to reach all DCH employees. The Intranet, designed in the format of a newspaper called "The DCH Dispatch," provides employees with a consolidation of announcements, important program changes and updates, trainings, surveys, DCH job openings, employee-posted accolades, and the latest policies and procedures. It also has live feeds from the Weather Channel, Kaiser Network, *New York Times* health section and many other helpful links.

Managed Care
The Division of Managed Care and Quality is responsible for establishing and directing the care management efforts of DCH. These efforts included planning for the transition of a large proportion of the Medicaid and PeachCare for Kids™ programs into a managed care environment beginning in FY 2006. The managed care program was phased in across six regions of the state beginning with 670,000 members in the Atlanta and Central regions, effective June 1, 2006. The program is scheduled to go statewide to all regions on September 1, 2006 (FY 2007).

Office of Inspector General
In February 2006, Commissioner Medows created the Office of Inspector General (OIG). The OIG's mission is to safeguard DCH from risk, both internally and externally.

Medicaid Management Information System
In FY 2006, DCH began the process of replacing the Medicaid Management Information System (MMIS). The current system was designed in 2001 by Affiliated Computer Systems (ACS). It is called the Georgia MultiHealthNetwork (MHN). It will be replaced by a system or systems that use the best tools available to automate as many inefficient processes as possible.

In FY 2006, there were over 51,000 providers, covering the entire state of Georgia and contiguous states, who submitted 46 million Medicaid and PeachCare for Kids™ claims.

The new system will be able to tightly control provider enrollment and claims payment, efficiently handle management of both FFS and managed care activities (including a managed care expansion phase-in), quickly and accurately create reports for decisive management and have the flexibility to adapt to policy changes.

In June 2006, an Advanced Planning Document was submitted to Centers for Medicare and Medicaid Services (CMS) for approval. When DCH receives the approval, a Request for Proposals will be released and a vendor procured with an expected implementation date of July

1, 2009.

Georgia Volunteer Health Care Program
In 2005, House Bill 166, the Health Share Volunteers in Medicine Act passed and created the Georgia Volunteer Health Care Program, subsequent law: O.C.G.A. 31-8-190 et seq.; and three Acts (O.C.G.A. § 43-1-28, O.C.G.A. § 43-11-52 and O.C.G.A. § 43-34-45.1); and empowered DCH to establish free health care clinics throughout the state.

FY 2006 DCH Expenditures

The following chart details DCH FY 2006 expenditures by major operational area. The benefits data is based on the date of payment for medical claims and includes non-claims payments, adjustments and offsets. The benefits data does not reflect FY 2006 member incurred costs (i.e. the date on which the service was performed, because member services provided in a given fiscal year are not necessarily paid in the same fiscal year. For example, a member service may have been provided during FY 2006 and the claim paid during FY 2007.

FY 2006 DCH Expenditures*	Amount	Percent of Total
Benefits (Based on Date of Payment)*		
Aged, Blind and Disabled Medicaid**	$3,529,666,085	
Low Income Medicaid**	$2,279,578,654	
PeachCare for Kids™	$243,480,979	
Indigent Care Trust Fund	$286,846,185	
Payments to Nursing Homes	$242,656,677	
State Health Benefit Plan Payments (Including HMO Premium Payments)	$2,026,146,818	
Subtotal	**$8,608,375,398**	**93.64%**
Services Support (Contracts)		
Systems Support	$126,999,872	
Department of Human Resources Administration Contract	$115,270,160	
State Health Benefit Plan	$157,157,908	
Medicaid and PeachCare for Kids™ Contractual Services	$83,580,090	
Subtotal	**$483,008,030**	**5.25%**
Medical Education and Licensing		
Georgia Board for Physician Workforce	$38,440,853	
State Medical Education Board	$1,407,433	
Composite State Board of Medical Examiners	$2,328,543	
Subtotal	**$42,176,829**	**0.46%**
Health Care Access and Improvement		
Health Planning and Certificate of Need	$1,396,789	
Rural Health	$5,438,652	
Health Initiatives	$2,398,949	
Georgia Volunteer Health Care Program	$128,102	
Subtotal	**$9,362,492**	**0.10%**
Administration* **		
State Health Benefit Plan Administration	$10,985,820	
Medicaid and PeachCare for Kids™ Administration	$39,487,464	
Subtotal	**$50,473,284**	**0.55%**
Totals	**$9,193,396,033**	**100%**

*Based on date of payment and includes claims payments, non-claims payments, adjustments and offsets. Does not reflect FY 2006 member incurred costs (i.e. the date on which the service was performed), because member services provided in a given fiscal year are not necessarily paid in the same fiscal year. For example, a member service may have been provided during FY 2006 and the claim paid during FY 2007..

**Beginning in FY 2006, the General Assembly appropriated Medicaid funds in two separate programs: Aged, Blind and Disabled Medicaid; and, Low Income Medicaid.

***Includes rent and utilities, state agency services, telecommunications, accounting and auditing and other support services.

Division of Medical Assistance

Overview

In FY 2006, the Division of Medical Assistance provided access to health care for 2.1 million Georgians at a cost of $6.6 billion through the administration of the following programs:

1. Low Income Medicaid (LIM)
   This program provides health care to eligible low income families, breast and cervical cancer patients, foster children and refugees (states are federally required to cover this group which consists of legal immigrants). The majority of LIM members are eligible for the Georgia Families care management program, which began on June 1, 2006 in selected regions of the state. Georgia Families is scheduled to go statewide on September 1, 2006 in FY 2007.

2. Aged, Blind and Disabled Medicaid (ABD)
   This program provides health care for people who are aged, blind or disabled under a fee-for-service (FFS) provider reimbursement model.

3. PeachCare for Kids™
   Georgia participates in the federal State Children's Health Insurance Program (SCHIP) through PeachCare for Kids™. PeachCare for Kids™ serves uninsured children living in Georgia whose family income is up to 235 percent of the federal poverty level (FPL). All PeachCare for Kids™ members access health care through the Georgia Families care management program.

The federal government pays the largest share of Medicaid costs. The state's Medicaid program receives varying levels of federal reimbursement for different services and functions. For example, the federal government pays 90 percent of the cost for family planning and more than 60 percent for most other benefits. Information systems costs are 75 percent federally funded and other administrative costs received 50 percent federal funding. In FY 2006, Georgia drew an average of $1.58 in federal-matching funds for each dollar of state funds.

Medicaid and PeachCare for Kids™ reimburse health care providers for services administered to eligible individuals. People who are eligible for Medicaid receive a member card, very similar to an insurance card, to use for services from participating providers.

The Division also administers the Indigent Care Trust Fund (ICTF) which was established in 1990 to expand Medicaid eligibility and services, to support rural and other health care providers, (primarily hospitals serving the medically indigent), and to fund primary health care programs for medically indigent Georgians. The ICTF supports these functions with Disproportionate Share Hospital (DSH) funds, Nursing Home Provider Fees, Care Management Organization (CMO) Quality Assessment Fees; Breast Cancer Tag Fees, ambulance fees and penalties from non-compliance with Certificate of Need (CON) requirements.

The following table presents enrollment and financial data for the three health care programs administered by the Division of Medical Aassistance: Low Income Medicaid; Aged, Blind and Disabled Medicaid; and PeachCare for Kids™.

FY 2006 Enrollment and Financial Data by Program	
Totals For Medicaid And PeachCare For Kids™	
Members	2,104,843
Member Months	19,477,550
Members Average	1,623,129.2
Patients*	1,859,597
Net Payment**	$6,476,347,838
Net Payment per Member per Month	$332.50
Net Payment per Patient	$3,482.66
Providers	51,292
Claims Paid	46,348,435
Aged, Blind and Disabled Medicaid	
Members	452,826
Member Months	4,481,589
Members Average	373,466
Patients*	439,602
Net Payment **	$3,666,143,916
Net Payment per Member per Month	$818.05
Net Payment per Patient	$8,339.69
Providers	47,245
Claims Paid	22,402,332
Low Income Medicaid	
Members	1,401,620
Member Months	12,117,455
Members Average	1,009,788
Patients*	1,215,676
Net Payment **	$2,486,940,604
Net Payment per Member per Month	$205.24
Net Payment per Patient	$2,045.73
Providers	40,597
Claims Paid	20,238,769
PeachCare For Kids™	
Members	331,805
Member Months	2,878,506
Members Average	239,875
Patients*	283,610
Net Payment**	$323,263,317
Net Payment per Member per Month	$112.30
Net Payment per Patient	$1,139.82
Providers	26,559
Claims Paid	3,714,224

* The PeachCare for Kids™ and Medicaid patient counts cannot be added to get the total due to members being eligible for each program at different times of the year.
**Net payment does not equal final expenditures. Net payments do not include any offsets or adjustments made to claims. In addition, net payment is based on date of payment and does not reflect FY 2006 member incurred costs (i.e. the date on which the service was performed), because member services provided in a given fiscal year are not necessarily paid in the same fiscal year. For example, a member service may have been provided during FY 2006 and the claim paid during FY 2007.

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Initiatives for FY 2006

In FY 2006, the Division of Medical Assistance focused its efforts in several key areas through initiatives, program reviews and reprocurements.

Medicaid Management Information System
In FY 2006, DCH began the process of replacing the Medicaid Management Information System (MMIS). The current system was designed in 2001 by Affiliated Computer Systems (ACS). It is called the Georgia MultiHealthNetwork (MHN). It will be replaced by a system or systems that use the best tools available to automate as many inefficient processes as possible. (see further detail on page 6 of this report)

Consumer Directed Care
In October 2005, consumer directed care was implemented in the Independent Care Waiver Program (ICWP) for persons aged 21 to 64. This option allows individuals who are accepted into the Independent Care Waiver program to hire, supervise and train their caregivers. At present ICWP is serving 53 members under the consumer directed care option. Consumer directed care was likewise implemented as an option for members receiving Natural Support Enhancement Services (NSE) in the Mental Retardation Waiver Program (MRWP) on July 1, 2006. Twenty-eight MWRP members were enrolled in consumer directed care.

Community Transition Efforts
The Community Care Services Program (CCSP) admitted 102 consumers from nursing facilities and transitioned them into the community. An additional 19 people enrolled in the ICWP waiver were transferred out of nursing homes.

Disease Management
The Division implemented a statewide disease management program called Georgia Enhanced Care (GEC) for 100,000 Medicaid Aged, Blind and Disabled (ABD) members in October 2005. The program includes an array of member and provider services including: disease and case management, health risk assessments, member self-management, access to a 24/7 nurse call line and provider education. These interventions are showing positive results in reducing hospital stays and emergency room (ER) visits.

Quality Improvement
The Durable Medical Equipment Program (DME) continues to revise and clarify rehabilitation policy that is fast becoming a standard in the nation. Medicare has adopted the Georgia Medicaid Rehab Policy. The policy standards involve certification requirements for providers, quality equipment, assessments/evaluations/recommendations from certified seating and positioning experts and reasonable reimbursement for services. Additionally, guidelines were completed for State Licensure of Orthotists and Prosthetists. Effective July 1, 2007, the Orthotists and Prosthetists program will enroll only certified and licensed Orthotists and Prosthetists practitioners. Current Orthotists and Prosthetists providers have until July 1, 2008 to obtain licensure.

Increase for Nursing Home Residents' Personal Needs Allowance
In FY 2006, the Georgia General Assembly appropriated funds to provide a monthly supplement of $20 per month for the Personal Needs Allowance (PNA) for all persons residing in nursing homes, as well as persons in the Hospice Program residing in a nursing home. Prior to this change, the PNA was $30 per month. The appropriation increased the PNA to $50 per month,

effective July 1, 2006.

SOURCE – Service Options Using Resources in a Community Environment
An independent analysis of the cost effectiveness of the SOURCE program by Myers and Stauffer L.C., a certified public accounting firm, indicated that the average cost per member per month is considerably lower than for nursing facility residents with a comparable degree of impairment. The study also stated that Georgia's program offers more balance between institutional and non-institutional long-term care options than many states have yet achieved.

Two new SOURCE sites opened in 2006: Georgia Case Management in Athens, Georgia and the Atlanta Regional Commission/SOURCE Partner Atlanta, Fulton/Dekalb and metro counties. Six SOURCE satellite offices were opened throughout Georgia to reduce or avoid the need for nursing home placement and increase options in the community.

Addressing Mental Health Needs in the Elderly
The Community Care Services Program (CSSP) collaborated with the Fuqua Research Center at Wesley Woods, Emory University, to identify and treat depression, and to prevent suicide among Georgia's elderly population. To accomplish this, caregivers and other service providers received training on how to recognize symptoms of depression, and in referral and intervention strategies. A statewide rollout of this initiative to improve the quality of life for at-risk community elders is underway.

CCSP also collaborated with the Rollins School of Public Health, Emory University, to establish a culturally appropriate, skills-based training program to equip caregivers, aides, nurses, social workers and families with evidence-based strategies to deal with dementia related problem behaviors. The project extends the capacity of caregivers to provide care in the community for family members.

Medicaid

The Medicaid program is a federal and state partnership to provide access to health care for certain low-income individuals and families who fit into an eligibility group that is recognized by federal and state law. The federal government provides matching funds to the state of Georgia to cover over 60 percent of the costs incurred in reimbursing health care providers for serving covered individuals**.**

Eligibility Criteria
A person must meet the eligibility requirements within one of the following coverage groups to be eligible for Medicaid: the aged (over 65), blind, permanently or totally disabled; pregnant women; children, parents or caregivers who meet income requirements and care for a Medicaid-eligible child. In all cases, the person must meet both the income and resource limits set for their respective coverage group and any established non-financial requirements. Non-financial requirements include criteria such as: age, United States citizenship or lawful alien status and Georgia residency. The table below presents detail on the different categories of Medicaid eligibility in Georgia.

Medicaid – Major Coverage Groups	Description
Supplemental Security Income (SSI) Recipients	Aged, blind or disabled individuals who receive SSI
Nursing Homes	Aged, blind or disabled individuals who live in nursing homes and have low incomes and limited assets
Community Care	Aged, blind or disabled individuals who need regular nursing care and personal services, but who can stay at home with special community care services
Qualified Medicare Beneficiaries	Aged, blind or disabled individuals who have Medicare Part A (hospital) insurance and have incomes less than 100 percent of the federal poverty level and limited resources. Medicaid will pay the Medicare premiums (A and B), co-insurance and deductibles only
Hospice	Terminally ill individuals who are not expected to live more than six months may be eligible for coverage.
Low-Income Medicaid	Adults and children who meet the income standards of the Temporary Assistance for Needy Families (TANF) program
Right from the Start Medicaid for Pregnant Women (RSM Adults)	Pregnant women with family incomes at or below 200 percent of the federal poverty level
Right from the Start Medicaid (RSM Children)	Children from under one to 19 years whose family incomes are at or below the appropriate percentage of the federal poverty levels for their age and family size
Medically Needy	Pregnant women, children, aged, blind and disabled

Medicaid – Major Coverage Groups	Description
	individuals whose family incomes exceed the established income limit may be eligible under the Medically Needy Program (MNP). The MNP allows a person to use incurred/unpaid medical bills to "spend down" the difference between his/her income and the income limit to become eligible
Breast and Cervical Cancer Program	Uninsured and underinsured women under age 65 who have been screened by the public health department and then diagnosed with either breast or cervical cancer may be eligible for treatment
Refugee Medicaid Assistance	Legal immigrants who are classified as refugees, asylums, Cuban/Haitian entrants, Vietnamese Americans and victims of human trafficking are eligible for Medicaid benefits during their first eight months in the United States, or after having been granted status in one of the above. Coverage of this group is federally required and 100 percent reimbursed by the federal government
Emergency Medical Assistance	Immigrants, including undocumented immigrants, who would have been eligible for Medicaid except for their immigrant status, are potentially eligible for Emergency Medical Assistance (EMA). This includes people who are aged, blind, disabled, pregnant women, children or parents of dependent children who meet eligibility criteria. Services rendered to EMA recipients are limited to emergency care only as described in the Federal Regulations (1903 (v) of the Social Security Act and the Code of Federal Regulation 42 CFR 440.255)

Covered Services

A broad range of services are offered under Georgia's Medicaid program:

- Ambulance Services
- Ambulatory Surgical Services
- Certified Registered Nurse Anesthetists
- Childbirth Education Services
- Children's Intervention Services
- Community Based Alternatives (SOURCE)
- 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)
- 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 (NET)
- Nurse Midwifery Services
- Nurse Practitioner Services
- Nursing Facility Services
- Oral Surgery
- 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
    - Chronically Mentally Ill
    - Early Intervention
    - Perinatal
    - Therapeutic Residential Intervention
- Vision Care Services
- Waiver Services
    - Community Care
    - Independent Care
    - Mental Retardation
    - Community Habilitation and Support
    - Traumatic Brain Injury

Historic Expenditures and Enrollment

The following chart shows the historical trends in Medicaid enrollment and claims payments for FY 1996 through FY 2006. The claims payment data is based on all claims paid in FY 2006 and does not reflect FY 2006 member incurred costs (i.e. the date on which the service was performed), because member services provided in a given fiscal year are not necessarily paid in the same fiscal year. For example, a member service may have been provided during FY 2006 and the claim paid during FY 2007.

Note: Appendix A provides detail on Medicaid enrollment and expenditures by county.

Historical Trends in Medicaid Claims Payments and Enrollment: FY 1994 to FY 2006*

Time Period	Patients	Net Payments	Net Payment per Patient	Percent Change of Net Payments per Patient
FY 1996	1,184,137	$3,125,050,130	$2,639.10	-3.75%
FY 1997	1,244,801	$3,162,117,908	$2,540.26	-3.26%
FY 1998	1,238,244	$3,043,018,566	$2,457.53	3.07%
FY 1999	1,273,719	$3,226,445,622	$2,533.09	9.91%
FY 2000	1,250,931	$3,482,779,559	$2,784.15	1.31%
FY 2001	1,355,238	$3,822,786,433	$2,820.75	26.05%
FY 2002	1,254,944	$4,461,972,245	$3,555.52	0.25%
FY 2003	1,377,535	$4,910,314,033	$3,564.57	8.38%
FY 2004	1,562,312	$6,035,789,070	$3,863.37	-1.30%
FY 2005	1,647,002	$6,280,565,991	$3,813.33	-0.93%
FY 2006	1,628,759	$6,153,084,521	$3,777.77	-3.75%

*Based on dates of payment from July to June for each fiscal year. Does not reflect incurred costs (i.e. the date on which the service was actually performed as opposed to paid). Net payments will not match fiscal year expenditures. Net payments reflect the actual claims for member services before any adjustments or offsets.

Membership

The following table provides data on Medicaid enrollment groups or aid categories by the number of patients and the net payment for FY 2006. Medicaid demographic data is also presented. PeachCare for Kids™ enrollment data is not included in the table but can be found under the PeachCare for Kids™ section of this report. The Net Payment data is based on all claims paid in FY 2006 and does not reflect FY 2006 member incurred costs (i.e. the date on which the service was performed), because member services provided in a given fiscal year are not necessarily paid in the same fiscal year. For example, a member service may have been provided during FY 2006 and the claim paid during FY 2007.

FY 2006 Medicaid Membership Profile				
Aid Category Group	**Patients***	**Percent of Total Patients***	**Net Payment****	**Percent of Total Net Payments****
Breast Cervical Cancer Screen	4,081	0.2%	$42,136,146	0.68%
Aged with and without Medicare	80,047	4.5%	$994,474,422	16.16%
Blind Disabled with and without Medicare	242,524	13.7%	$2,317,437,115	37.66%
Specially Low Income Medicare Beneficiary (SLMB)	1,014	0.1%	$66,312	0.00%
Other Waivers	18,513	1.0%	$189,746,120	3.08%
Medically Needy	143	0.0%	$699,902	0.01%
Qualified Medicare Beneficiary (QMB)	63,419	3.6%	$44,491,250	0.72%
Low Income Medicaid (LIM)	505,716	28.5%	$930,477,966	15.12%
Right from the Start Medicaid Child (RSM Child)	696,247	39.3%	$1,126,560,764	18.31%
Right from the Start Medicaid Adult (RSM Adult)	159,284	9.0%	$504,931,337	8.21%
Refugee	1,811	0.1%	$2,063,186	0.03%
Unique Count Totals	**1,628,759**	**100%**	**$6,153,084,521**	**100.00%**

Age Groups	**Patients***	**Percent of Total Patients**	**Net Payment****	**Percent of Total Net Payments****
Under 1 year	207,147	12%*	$589,591,572	9.58%
1 to 5 years	373,952	21%	$490,037,312	7.96%
6 to 20 years	559,097	32%	$1,071,343,470	17.41%
21 to 44 years	323,961	18%	$1,459,698,784	23.72%
45 to 64 years	139,393	8%	$1,269,296,022	20.63%
65 and older	148,195	8%	$1,273,117,362	20.69%
Unique Count Totals	**1,628,759**	**100%**	**$6,153,084,521**	**100.00%**

Gender	Patients*	Percent of Total Patients*	Net Payment	Percent of Total Net Payments**
Female	990,092	619%	$3,846,549,648	62.51%
Male	635,532	39%	$2,306,534,873	37.49%
Unique Count Totals	**1,628,759**	**100%**	**$6,153,084,521**	**100.00%**

Residence	Patients*	Percent of Total Patients*	Net Payment**	Percent of Total Net Payments**
Rural	624,267	37%	$2,457,751,734	39.94%
Urban	1,053,894	63%	$3,695,332,787	60.06%
Unique Count Totals	**1,628,759**	**100%**	**$6,153,084,521**	**100.00%**

Race	Patients*	Percent of Total Patients*	Net Payment**	Percent of Total Net Payments**
Unknown	141,689	8%	$583,512,986	9.48%
White	712,665	42%	$2,936,323,152	47.72%
Black	781,768	46%	$2,528,630,153	41.10%
American Indian/Alaskan	1,377	0%	$4,752,289	0.08%
Asian/Pacific Islander	22,951	1%	$64,762,005	1.05%
Hispanic	20,890	1%	$35,103,935	0.57%
Unique Count Totals	**1,628,759**	**100.00%**	**$6,153,084,521**	**100.00%**

*Patients do not add to the Unique Count Total due to missing information associated with some claim records. Percent of Total Patients represents the percent share of the patient categories summed up and not the percent share of the unique count totals for patients.

**Based on dates of payment from July to June for each fiscal year. Does not reflect member incurred costs (i.e. the date on which the service was performed), because member services provided in a given fiscal year are not necessarily paid in the same fiscal year. For example, a member service may have been provided during FY 2006 and the claim paid during FY 2007. Net payments will not match fiscal year expenditures. Net payments reflect the actual claims for member services before any adjustments or offsets. The net payments associated with claim records that are missing certain demographic data are spread based on the distribution of net payments for existing claims for the specific demographic profile. Missing data was associated with less than 0.15 percent of net payments.

Categories of Medical Services

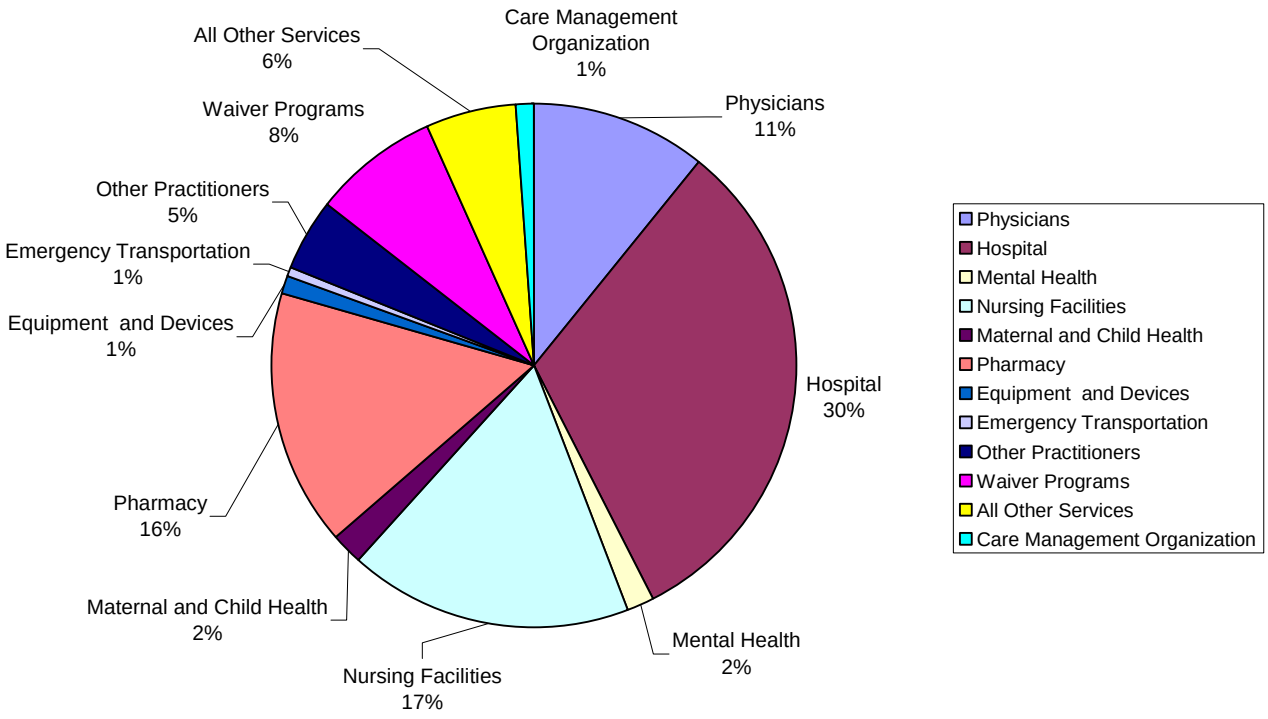
Presented on the following pages are overviews of the different medical services provided in the Medicaid program. The service profile begins with an overview of FY 2006 expenditures for Medicaid services and then provides more detailed information for each service component. Each service description includes a chart that details the number of unique patients, claims payments, net pay per patient and providers with paid claims for FY 2006. The data is based on all claims paid in FY 2006 and does not reflect FY 2006 member incurred costs (i.e. the date on which the service was performed), because the incurred costs associated with a given fiscal year are not necessarily all paid in the same fiscal year.

FY 2006 Profiles of Medicaid Services		
Medicaid Service	**Net Payment***	**Percent of Total Net Payment**
Physicians	$673,039,441	11%
Hospital	$1,934,434,114	31%
Mental Health	$110,181,744	2%
Nursing Facilities	$1,068,084,056	17%
Maternal and Child Health	$125,591,734	2%
Pharmacy	$977,372,804	16%
Equipment and Devices	$60,058,751	1%
Emergency Transportation	$34,707,926	1%
Other Practitioners	$277,497,895	5%
Waiver Programs	$483,804,525	8%
All Other Services	$342,212,578	6%
Care Management Organization**	$66,098,956	1%
Total	**$6,153,084,524**	100%

*Based on dates of payment from July 2005 to June 2006 and includes claim-based expenditures only. Does not reflect FY 2006 member incurred costs (i.e. the date on which the service was performed), because member services provided in a given fiscal year are not necessarily paid in the same fiscal year. For example, a member service may have been provided during FY 2006 and the claim paid during FY 2007.

**Care Management began on June 1, 2006.

Medicaid Services Distribution FY 2006



Physician Services

- Pays for services provided by licensed physicians
- Seventy-nine percent of all members received services from a physician in FY 2006
- Accounted for approximately 11 percent of Medicaid benefit expenditures in FY 2006

Category of Service – Physician Services	Unique Patients	Net Payment*	Net Payment Per Patient	Providers with Paid Claims
Physician Services	1,293,686	$673,039,441	$520.25	28,388
Net Payments Sub Total		**$673,039,441**		

*Based on dates of payment from July 2005 to June 2006 for each fiscal year. Does not reflect incurred costs (i.e. the date on which the service was performed). This is because the incurred costs associated with a given fiscal year are not necessarily all paid in the same fiscal year.

Pharmacy

In FY 2006, the Division's Pharmacy Unit continued its efforts to expand the preferred drug list and supplemental rebate program. During this period, DCH collected $63,006,888 from manufacturers with the supplemental rebate effort. These collections were in addition to the CMS rebates, which were $274,777,243. In total, DCH collected $337,784,132 in drug rebates. The drug rebates offset Medicaid pharmacy expenditures.

The pharmacy also worked with CMS and the Social Security Administration to move the full-benefit dual eligible members, people who are eligible to receive both Medicaid and Medicare benefits, to Medicare D for their primary prescription drug coverage. The unit also worked with the selected CMO plans to assist with the members' transition into a managed care environment.

DCH sought Pharmacy Benefit Management (PBM) services by releasing a procurement during FY2006. This procurement asked for services such as: point-of-sale claims processing, retrospective drug utilization review, prospective drug utilization review, Drug Utilization Review Board support, preferred drug list maintenance and enhancement, general clinical support, benefit design consultation, provider education, provider relations, technical and clinical call center support, fraud and abuse monitoring and maximum allowed cost schedule development and maintenance.

Pharmacy expenditures are 16 percent of the total Medicaid expenditures in FY 2006.

Category of Service – Pharmacy	Unique Patients	Net Payment*	Net Payment Per Patient	Providers with Paid Claims
Pharmacy	1,145,275	$965,627,630	$843.14	2,153
Pharmacy Durable Medical Equipment Supplier	70,006	$11,745,174	$167.77	2,025
Net Payments Sub Total		**$977,422,140**		

*Based on dates of payment from July 2005 to June 2006 for each fiscal year. Does not reflect incurred costs (i.e. the date on which the service was performed). This is because the incurred costs associated with a given fiscal year are not necessarily all paid in the same fiscal year.

Hospital Services

- Covers inpatient hospital services when services cannot be provided on an outpatient basis
- Most adult inpatient hospital stays and outpatient surgical procedures must be certified prior to admission
- Outpatient hospital services may include emergency room care, outpatient surgery and clinic services
- Hospital services accounted for approximately 31 percent of total Medicaid benefit expenditures in FY 2006

This marks the third consecutive year that the outpatient hospital program recorded a decrease in expenditures due to better program management that includes:

- Implementing more prior approval (PA) requirements
- Removing the under 21 age exclusion, so now all members require pre-certification (for inpatient services) and PAI (for outpatient services)

- Requiring CPT/HCPCS coding with Revenue Codes
- Requiring Specific Injectable Drug Coding
- Implementing PA requirement for Radiology Services done in an outpatient setting.

Georgia Medical Care Foundation reported a $30.2 million cost reduction resulting from the "PA required" implementation since June 2005.

Category of Service - Hospital	Unique Patients	Net Payment*	Net Payment Per Patient	Providers with Paid Claims
Inpatient Hospital Services	276,634	$1,407,097,940	$5,086.50	624
Outpatient Hospital Services	847,688	$527,336,174	$622.09	988
Net Payments Sub Total		**$1,934,531,761**		

**Based on dates of payment from July 2005 to June 2006 for each fiscal year. Does not reflect incurred costs (i.e. the date on which the service was performed). This is because the incurred costs associated with a given fiscal year are not necessarily all paid in the same fiscal year.

Nursing Facility Services

- Covers institutional care for members whose health conditions are such that they are unable to remain at home or in the community
- Are regulated by DHR's Office of Regulatory Services in nursing home licensing and certain quality measures
- Accounts for approximately 17 percent of total Medicaid benefit expenditures in FY 2006

Category of Service – Nursing Facility Services	Unique Patients	Net Payment*	Net Payment Per Patient	Providers with Paid Claims
Swing-bed Hospital Services	451	$677,658	$1,502.57	36
Skilled Care in a Nursing Facility	43,646	$944,693,364	$21,644.44	350
Skilled Care in a State Owned Nursing Facility	1,147	$19,902,842	$17,352.09	6
State Owned Intermediate Care for Mental Retardation	1,030	$96,467,711	$93,657.97	11
Intermediate Care Nursing Facility-Mental Retardation	123	$6,342,482	$51,564.89	1
Net Payments Sub Total		**$1,068,084,056**		

*Based on dates of payment from July 2005 to June 2006 for each fiscal year. Does not reflect incurred costs (i.e. the date on which the service was performed). This is because the incurred costs associated with a given fiscal year are not necessarily all paid in the same fiscal year.

Maternal and Child Health Services

- Covers prenatal and perinatal care, family planning, children's preventive care through Health Check, helps children with physical and developmental problems, and assists children at risk
- Represented approximately two percent of total Medicaid benefit expenditures in FY 2006

Category of Service – Maternal and Child Health	Unique Patients	Net Payment*	Net Payment Per Patient	Providers with Paid Claims
Family Planning Services	23,573	$2,358,922	$100.07	158
Health Check Services (EPSDT)	486,901	$50,338,219	$103.38	2,885
Pregnancy Related Services	8,621	$760,449	$88.21	101
Children at Risk Targeted Case	5,079	$2,204,857	$434.11	23
Perinatal Case Management	36,131	$3,482,983	$96.40	155
Diagnostic Screening and Prevention	109,606	$6,092,450	$55.59	248
Early Intervention Case Management	6,797	$5,381,316	$791.72	231
Children's Intervention Services	40,768	$44,110,454	$1,081.99	3,253
Childbirth Education Program	244	$7,940	$32.54	7
Children's Intervention School	22,850	$10,854,144	$475.02	148
Net Payments Sub Total		$125,591,734		

*Based on dates of payment from July 2005 to June 2006 for each fiscal year. Does not reflect incurred costs (i.e. the date on which the service was performed). This is because the incurred costs associated with a given fiscal year are not necessarily all paid in the same fiscal year.

Other Practitioner Services

- Includes: physician's assistant services, Health Check dental program for children under 21, adult dental program, vision care, nurse midwifery, oral maxillofacial surgery, podiatry, psychological services, advanced registered nurse practitioners services and licensed clinical social work
- Represents approximately five percent of total Medicaid benefit expenditures during FY 2006

Category of Service – Other Practitioner Services	Unique Patients	Net Payment*	Net Payment Per Patient	Providers with Paid Claims
Physician Assistant Services	143,949	$12,891,894	$89.56	1,752
Health Check Dental - under 21	426,530	$168,198,369	$394.34	1,641
Adult Dental Program	57,392	$20,182,814	$351.67	1,052
Vision Care	147,191	$12,696,193	$86.26	919
Nurse Midwifery	22,945	$13,669,628	$595.76	231
Oral Maxillofacial Surgery	2,545	$336,285	$132.14	99
Podiatry	51,629	$3,765,293	$72.93	419
Psychological Services	44,131	$24,278,309	$550.14	801
Advanced Nurse Practitioners	198,841	$21,453,205	$107.89	2,968
Licensed Clinical Social Work	269	$25,904	$96.30	29
Net Payments Sub Total		**$277,497,894**		

*Based on dates of payment from July 2005 to June 2006 for each fiscal year. Does not reflect incurred costs (i.e. the date on which the service was performed). This is because the incurred costs associated

with a given fiscal year are not necessarily all paid in the same fiscal year.

Mental Health Services

- Covers a comprehensive range of services provided by outpatient mental health rehabilitative programs
- Covers people with chronic mental illnesses, mental retardation, or substance abuse who may receive community-based services, which enable them to continue living independently in the community. Community care is a less-costly alternative to either hospitalization or nursing home care
- Accounted for approximately two percent of total Medicaid benefit expenditures during FY 2006

Category of Service – Mental Health Services	Unique Patients	Net Payment*	Net Payment Per Patient	Providers with Paid Claims
Community Mental Health Services	64,754	$110,181,744	$1,701.54	441
Net Payments Sub Total		**$110,181,744**		

* Based on dates of payment from July 2005 to June 2006 for each fiscal year. Does not reflect incurred costs (i.e. the date on which the service was performed). This is because the incurred costs associated with a given fiscal year are not necessarily all paid in the same fiscal year.

Waiver Services for Home and Community-Based Care

Waiver services include four home and community-based programs that are covered by Medicaid. The federal government issues waivers that allow exceptions to specific Medicaid requirements. Waivers permit the state to pay for home and community-based services as an alternative to institutional care. Each waiver program offers core services including the following: 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 8 percent of the total Medicaid benefit expenditures in FY 2006.

The CCSP home and community-based waiver programs for the aged help aged or disabled people remain in their homes or return to the community from nursing homes:

- **Decreasing Depression in Community Elders** project improves the quality of life for at-risk community elders. The CCSP partnered with the Fuqua Research Center at Wesley Woods, Emory University, to identify and treat depression and to prevent suicide among Georgia's elderly population by training caregivers and other service providers to recognize depression symptoms. Statewide rollout of this initiative is underway

- **Specialist Providers in Teams for Dementia Care (SPRINT-D**) project extends the capacity of caregivers to provide care in the community for family members. The CCSP partnered in this community-based prevention research grant project with the Rollins School of Public Health, Emory University, to establish a culturally appropriate, skills-based training program to equip care givers, aides, nurses, social workers and families with evidence-based strategies to deal with dementia-related problem behaviors

- **Nursing Facility to Community Transition** allowed 102 consumers to move from the nursing home environment to community-based care

Other waiver programs are:

- The **Mental Retardation Waiver Program** and **Community Habilitation and Support Services Waiver Program** that help people with developmental disabilities and/or mental retardation remain in their own homes or move to a community residential facility to prevent placement in an Intermediate Care Facility for People with Mental Retardation

- The **Independent Care Waiver Program** (ICWP) helps adult Medicaid members with severe disabilities live in their own homes or in the community instead of a hospital or nursing home. Implemented October 2005, the consumer directed care option allows the individuals on this waiver program to hire, fire and train their care givers. ICWP serves 759 members, 53 of which are under the consumer directed care option. There are 19 members enrolled in the waiver who have transferred out of the nursing home environment. The ICWP waiver renewed for five years March 1, 2006

Other services included:

- **SOURCE** links frail, older or disabled people with primary care and an array of long-term health services in the person's home or community to avoid preventable hospitalization and nursing home care. In FY 2005, there were eight SOURCE sites, providing services in 159 counties for more than 8,000 people in Georgia
- **Dedicated Case Management** services are used by people needing mental health services and some mental retardation waiver services
- **Georgia Pediatric Program (GAPP)** (GAPP In-home Private Duty Nursing; GAPP Medically Fragile Daycare) serves medically fragile members under the age of 21. Members must have multiple system diagnoses and require continuous skilled-nursing care to be considered for GAPP services. Members served by GAPP are required to meet the same level of care for their medical condition that requires skilled-nursing care equivalent to the care received in an institutional setting, i.e., hospital or skilled-nursing facility, or admission to a hospital or nursing facility. In FY 2006, 712 members received GAPP services.

Category of Service – Waiver Services	Unique Patients	Net Payment*	Net Payment Per Patient	Providers with Paid Claims
Dedicated Case Management Services	12,677	$16,600,175	$1,309.47	6
Community Care Services	13,763	$115,822,553	$8,415.50	477
Independent Care Waiver Services	677	$27,216,668	$40,201.87	106
Mental Retardation Waiver Program	7,329	$167,843,808	$22,901.32	488
Community Habilitation and Support	1,192	$57,346,806	$48,109.74	81
Waiver Home Care Services	19	$91,670	$4,824.74	7
SOURCE Case Management Program	9,462	$8,648,400	$914.01	9
SOURCE	9,467	$58,018,650	$6,128.51	180
GAPP In-home Private Duty Nursing	475	$24,571,958	$51,730.44	18
GAPP Medically Fragile Daycare	237	$7,643,838	$32,252.48	5
Net Payments Sub Total		**$483,804,525**		

*Based on dates of payment from July 2005 to June 2006 for each fiscal year. Does not reflect incurred costs (i.e. the date on which the service was performed). This is because the incurred costs associated with a given fiscal year are not necessarily all paid in the same fiscal year.

Emergency Transportation

Late in FY 2005, the ambulance program added four new procedure codes for payment. Two of the procedure codes require PA and two others require pre-payment review. These requirements were to monitor the transport codes used for appropriateness and accuracy of billing based on the definitions as described in the Ambulance Services Policies and Procedures Manual. These efforts resulted in a cost savings for the program. The pre-payment review reduced 164 claims to more appropriate transport codes as documented by the providers resulting in a cost savings of $21,097.60. For providers who failed to comply with the policy requiring the proper documentation to support their billing, 67 claims were denied resulting in a cost savings of $11,225.79. The total savings was $32,323.39. To further upgrade proper use of transport codes, the Ambulance Services program implemented a retrospective review of 911 calls. With the goal of subsequent cost containment, the program provided training in appropriate billing to providers.

- Covers Emergency Ground Ambulance and Emergency Air Ambulance Services, which in FY 2005, accounted for 0.4 percent of total Medicaid benefit expenditures
- The Non-Emergency Transportation (NET) total for two vendors was $68,790,663. Expenditures were $56,207,822 for Logisticare and $12,582,841 for Southeastrans respectively. This expenditure is accounted for in "All Other Services"

Category of Service – Emergency Transportation	Unique Patients	Net Payment*	Net Payment Per Patient	Providers with Paid Claims
Emergency Ground Ambulance	108,570	$32,040,481	$295.11	209
Emergency Air Ambulance	991	$2,667,445	$2,691.67	12
Net Payments Sub Total		**$34,707,926**		

*Based on dates of payment from July 2005 to June 2006 for each fiscal year. Does not reflect member incurred costs (i.e. the date on which the service was performed). This is because the incurred costs associated with a given fiscal year are not necessarily all paid in the same fiscal year.

Equipment and Devices

- Covers the rental or purchase of medical equipment and devices such as: hospital beds, wheelchairs, oxygen equipment, walkers, artificial limbs and braces
- Accounted for one percent of total Medicaid benefit expenditures in FY 2006

Category of Service – Equipment and Devises	Unique Patients	Net Payment*	Net Payment Per Patient	Providers with Paid Claims
Durable Medical Equipment Services	125,880	$47,747,555	$379.31	935
Orthotics and Prosthetics/Hearing	18,743	$12,311,196	$656.84	243
Net Payments Sub Total		**$60,058,751**		

*Based on dates of payment from July 2005 to June 2006 for each fiscal year. Does not reflect member incurred costs (i.e. the date on which the service was performed). This is because the incurred costs associated with a given fiscal year are not necessarily all paid in the same fiscal year.

All Other Services

Covered services such as: ambulatory and surgical centers, rural health clinics, NET, laboratory, x-ray, dialysis, home health, protective services, hospice, therapy and specialized services for specific populations including adults with AIDS and children at risk for incarceration.

- Disease Management – DMA implemented a statewide disease management program called Georgia Enhanced Care (GEC) for 100,000 Medicaid ABD members in October 2005. The program includes an array of member and provider services including: disease and case management, health risk assessments, member self-management, access to a 24/7 nurse call line and provider education
- Effective June 1, 2006 the Georgia Families care management initiative was implemented in the Atlanta and central regions of the state. The initiative was set to go statewide to four other regions on September 1, 2006

Category of Service – All Other Services	Unique Patients	Net Payment*	Net Pay Per Patient	Providers w/ Paid Claims
Home Health Services	9,196	$6,959,611	$756.81	103
Independent Laboratory Service	325,753	$32,325,224	$99.23	150
NET Exceptional Transportation	2	-$62	-$31.11	2
Speech Therapy-Medicare Only	10	$241	$24.06	2
Physical Therapy-Medicare Only	1,431	$36,995	$25.85	144
Rehab Therapy-Medicare Only	1,084	$32,162	$29.67	43
Federally Qualified Health Center	49,854	$12,917,895	$259.11	70
Hospital-based Rural Health Center	31,533	$4,426,043	$140.36	56
Free Standing Rural Health Clinic	21,689	$4,282,773	$197.46	36
Chiropractics – Medicare Only	832	$36,045	$43.32	121
Ambulatory Surgical Center/Birthing	22,156	$9,751,781	$440.14	153
Non-Emergency Transportation	na	$68,205,489	na	2
Hospice	6,344	$61,154,599	$9,639.75	94
Dialysis Services – Technical	8,860	$40,967,093	$4,623.83	427
Dialysis Services - Professional	3,923	$1,699,504	$433.22	475
Targeted Case Management-AIDS	1,151	$289,567	$251.58	21
At Risk of Incarceration	8,735	$8,273,412	$947.16	1
Child Protective Services	36,413	$38,460,488	$1,056.23	1
Adult Protective Services	2,458	$3,369,915	$1,371.00	1
Disease State Management	106,561	$16,074,677	$150.85	2
Care Management Organization**	na	$66,098,956.05	na	3
Therapeutic Residential Intervention Services	4,899	$32,645,322	$6,663.67	2
Unknown	12,273	$303,804	$24.75	1,370
Net Payments Sub Total		**$408,311,534**		

*Based on dates of payment from July 2005 to June 2006 for each fiscal year. Does not reflect incurred costs (i.e. the date on which the service was performed). This is because the incurred costs associated with a given fiscal year are not necessarily all paid in the same fiscal year.

**Care Management began on June 1, 2006. Encounter data detailing patients and utilization will be available in FY 2008.

Medicaid Upper Payment Limit (UPL) Program

The Upper Payment Limits (UPL) program provides financial support to eligible hospitals and nursing homes. Eligible providers receive reimbursement to fill the gap between what Medicaid paid and what Medicare would have paid for Medicaid services. The state must provide matching funds to cover its share of this gap; the federal government, through the Georgia's Medicaid matching percentage covers the rest. In Georgia the state match is primarily generated by local governments that own public hospitals and in received by the sate as an intergovernmental transfer (IGT). The state uses the IGT to match and draw down available federal UPL funds. UPL payments are then made back to the eligible hospital or nursing home. State appropriations provide the state funds used to match federal UPL funds for critical access hospitals. In FY 2006, Georgia used $43 million in IGTs to draw down $109 million in federal UPL payments. However, payments were only made to nursing homes in FY 2006. Hospitals received their FY 2006 UPL payment in early FY 2007 which will be reported in the FY 2007 Annual Report. Appendix B shows the FY 2006 Upper Payment Limit and the IGT amount for each nursing home.

Indigent Care Trust Fund

The ICTF was established in 1990 to provide funding to expand Medicaid eligibility and services, to support rural and other health care providers, primarily hospitals serving the medically indigent and to fund primary health care programs for medically indigent Georgians. The ICTF supports these programs and facilities through a variety of non-federal contributions which are used to draw down federal Medicaid funds or any other funds from a public source or charitable organization. Non-federal source contributions to the ICTF in FY 2006 included the following:

- IGTs from hospitals participating in the DSH program. DSH IGTs involve a transfer of funds between the governmental entity that owns an eligible public hospital to the state of Georgia. DCH, uses this money to draw down the federal Medicaid funds to help reimburse hospitals for their uncompensated Medicaid and indigent care.
- Nursing home Provider Fees
- Medicaid CMO Quality Assessment Fees
- Penalties for non-compliance with CON requirements
- Ambulance license fees
- Fees collected from the initial sale of breast cancer license tags
- Appropriated state funds

The ICTF is allowed to retain and use interest earned from funds contributed to the trust fund. The ICTF is also allowed to carry forward any prior year funds that have been reserved to cover liabilities incurred but not yet paid.

Some funds received by the ICTF are used for specific purposes, as designated by state statute:

- Any nursing home provider fees remitted to the ICTF must be matched with federal Medicaid funds and made available to provide support to nursing homes that disproportionately serve the medically indigent
- Any Medicaid CMO Quality Assessment fees remitted to the ICTF are matched with federal Medicaid funds and also made available for medical assistance payments to providers for Medicaid services
- Certain proceeds from the sale of breast cancer license tags are used to fund screening and

treatment-related programs for people with breast cancer who were also medically indigent. Programs can include the following: education, screening, grants-in-aid to cancer patients, pharmacy assistance programs for cancer patients and other projects to encourage public support for the special license plate and the activities it funded

- Ambulance license fess received from the DHR are matched with federal Medicaid funds and used to offset the cost of Medicaid emergency ambulance services

The following chart shows the ICTF expenditures by ICTF program area for FY 2006.

FY 2006 Indigent Care Trust Fund Expenditures by Program Area		
Disproportionate Share Hospital (DSH) Payments*	$208,862,239	39.5%
Medicaid Payments to Nursing Homes	$242,656,677	45.8%
Medicaid Payments for Low Income Medicaid Providers	$54,655,317	10.3%
Prior Year Expenditures from the Medicaid Expansion for Pregnant Women and Children	$17,032,277	3.2%
Ambulance Medicaid Rate Subsidy	$5,179,394	1.0%
Breast Cancer Initiatives	$1,036,066	0.2%
Total	**$529,421,970**	100.0%

*FY 2006 DSH payments were approximately half of the amount paid in FY 2005 due to a two-part payment of available federal FY 2006 DSH funds. Fifty percent of the DSH funds were distributed in April 2006 while the rest were distributed in July 2006, which will be reported in the FY 2007 annual report.

Medicaid Disproportionate Share Hospital (DSH) Program

The Disproportionate Share Hospital (DSH) Program is a federal program designed to increase health care access for the poor. Hospitals that treat a disproportionate number of Medicaid and other low income patients qualify for DSH payments through the Medicaid program based on the hospital's estimated uncompensated cost of services to the uninsured and Medicaid members. To qualify for DSH, a hospital must meet the following federal criteria:

- The hospital must provide non-emergency obstetrical services to Medicaid recipients (if those services were provided on or before December 22, 1987)
- The hospital must have a Medicaid inpatient utilization rate of at least 1 percent

Hospitals must also meet one of the following state criteria to qualify for DSH:

- A hospital whose Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments
- A hospital whose Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments
- A hospital which has a low-income utilization rate exceeding 25 percent
- A hospital with total Medicaid and PeachCare for Kids™ covered charges for paid inpatient and outpatient claims exceeding 15 percent of total charges for all payer sources

- A non-State hospital with the largest number of Medicaid admissions in its Metropolitan Statistical Area
- A children's hospital
- A hospital that has been designated a Regional Perinatal Center by the Department of Human Resources
- A Georgia hospital that has been designated a Medicare rural referral center and a Medicare disproportionate share hospital provider by its fiscal intermediary; or a Georgia hospital which is a Medicare rural referral center and which has 10 percent or more Medicaid patient days and 30 percent or more Medicaid deliveries
- A state-owned and operated teaching hospital administered by the Board of Regents
- A rural, public hospital with less than 250 beds

For both federal and state DSH criteria, a hospital will be considered a rural hospital if a hospital's county is not in a Metropolitan Statistical Area, as defined by the United States Office of Management and Budget, or if the population of the hospital's county is 35,000 or less.

DSH is financed with federal and state funds. The state must provide matching funds to draw down the federal DSH funds. In Georgia, the state match is primarily generated through an Intergovernmental Transfer (IGT) which is a transfer of funds between the governmental entity that owns an eligible public hospital and the state of Georgia. The IGT funds are deposited into the Indigent Care Trust Fund (ICTF). DCH, uses this money to draw down the federal funds to help reimburse hospitals for their uncompensated Medicaid and indigent care. Since private hospitals cannot provide an IGT, the state provides the matching funds for eligible private hospitals to participate in DSH.

In FY 2006, Georgia received $75.3 million in IGTs to generate $208.9 million in federal Medicaid funds. Note: the FY 2006 DSH payments were approximately half of the amount paid in FY 2005 due to a two-part payment of available federal FY 2006 DSH funds. Fifty percent of the DSH funds were distributed in April 2006 while the rest were distributed in July 2006, which will be reported in the FY 2007 annual report. Appendix C shows the FY 2006 DSH Interim Payment and the IGT amount for eligible hospitals.

PeachCare for Kids™

In 1997, Congress created Title XXI of the Social Security Act to provide health care for the growing number of uninsured children in the United States. This legislation provided states with the opportunity to create the State Children's Health Insurance (SCHIP) program to increase access to affordable health insurance. In Georgia, this program is PeachCare for Kids™. The program began covering children in 1999, providing comprehensive coverage to uninsured children. The health benefits include primary, preventive, specialist, dental care and vision care.

PeachCare for Kids™ enrollment growth continues, ranking Georgia with the fourth largest number of covered children in the country only behind larger states of California, New York and Texas. Data show 286,610 children were enrolled at the close of FY 2006.

The program has also improved health care access and continuity of care for its members. The annual Health Plan Employer Data and Information Set Measures show that from FY 2003 to FY 2005, there was a three percent increase in the number of PeachCare for Kids™ members who saw their primary care provider at least once in the previous year.

Eligibility Criteria
The requirements to qualify for PeachCare for Kids™ enrollment are presented in the table below.

Eligibility Criteria	Description
Age 18 and Under	Children are eligible until the last day before the month of their 19th Birthday
Ineligible for Medicaid	By federal statute, children eligible for Medicaid are ineligible for PeachCare for Kids™
Uninsured	Children must be uninsured the six months prior to applying for PeachCare for Kids™. There are exceptions for children who have involuntarily lost coverage (i.e., child was covered through parent's employer and the parent lost the job, employer dropped coverage for dependent children.)
Income up to 235 percent of Federal Poverty Level	This equals approximately $45,000 for a family of four.
United States Citizenship	Children must be citizens of the United States or legal residents for five years. Note: Citizenship applies only to the child. Citizen children of non-citizen parents may be eligible for PeachCare for Kids™. Children must be residents of Georgia to be eligible.

Member Premiums

Families participating in the PeachCare for Kids™ must pay a monthly premium to maintain coverage. There is no cost for children age five and under. In FY 2006, the monthly premium for coverage was $10 to $35 for one child and a maximum of $70 for two or more children living in the same household, depending on household income. Premiums are due the first day of the month prior to the month of coverage. If the monthly premium for coverage is late or not received, then the child will become ineligible for program coverage. There are no co-payments or deductibles required for benefits covered by the program.

In FY 2006, the PeachCare for Kids™ program collected $27,199,146 in premium payments.

Covered Services

A broad range of services is offered under PeachCare for Kids™:

- Children's Intervention Services
- Dental Services
- Dialysis Services
- Durable Medical Equipment Services
- Health Check (Early and Periodic Screening, Diagnosis and Treatment)
- Home and Community Based Services
- Hospice Services
- Inpatient and Outpatient Hospital Services
- Laboratory and Radiological Services
- Mental Health Clinic Services
- Emergency Transportation Services
- Nurse Practitioner Services
- Orthotic and Prosthetic Services
- Podiatry
- Pharmacy Services
- Physician Services
- Prenatal Care and Pregnancy Related Services
- Specified Over the Counter Medications
- Substance Abuse Treatment
- Vision Care Services

Historic Expenditures and Enrollment

The following chart shows the historical trends in PeachCare for Kids™ enrollment and claims payments for FY 2003 through FY 2006. The claims payment data is based on all claims paid in FY 2006 and does not reflect FY 2006 member incurred costs (i.e. the date on which the service was performed). This is because the incurred costs associated with a given fiscal year are not necessarily all paid in the same fiscal year.

Historical Trends in PeachCare for Kids™ Claims Payments and Enrollment: FY 2003 to FY 2006*

Time Period	Patients	Net Payments	Net Payment per Patient	Percent Change of Net Payments per Patient
FY 2003	204,760	$218,527,081	$1,067.24	
FY 2004	244,770	$266,352,780	$1,088.18	1.96%
FY 2005	260,770	$276,310,869	$1,059.60	-2.63%
FY 2006	283,610	$323,263,317	$1,139.82	7.57%

*Based on dates of payment from July to June for each fiscal year. Does not reflect incurred costs (i.e. the date on which the service was actually performed as opposed to paid). Net payments will not match fiscal year expenditures. Net payments reflect the actual claims for member services before any adjustments or offsets.

PeachCare for Kids™ Profile - Membership

The following table provides demographic data on PeachCare for Kids™ and includes the number of patients and claims paid in each demographic category. The Net Payment data is based on all claims paid in FY 2006 and does not reflect FY 2006 member incurred costs (i.e. the date on which the service was performed). This is because the incurred costs associated with a given fiscal year are not necessarily all paid in the same fiscal year.

Note: Appendix D provides detail on PeachCare for Kids™ enrollment and expenditures by county.

FY 2006 PeachCare for Kids™ Membership Profile				
Age Groups	**Patients***	**Percent of Total Patients***	**Net Payment****	**Percent of Total Net Payments****
Under 1 year	2,266	0.80%	$1,971,911	0.61%
1 to 5 years	85,169	30.03%	$84,530,332	26.15%
6 to 13 years	148,151	52.24%	$155,863,308	48.22%
14 to 18 years	66,470	23.44%	$80,897,767	25.03%
Unique Count Totals	**283,610**	**100.00%**	**$323,263,317**	**100.00%**

Gender	**Patients***	**Percent of Total Patients***	**Net Payment****	**Percent of Total Net Payments****
Female	139,629	49.23%	$149,028,919	46.10%
Male	144,176	50.84%	$174,234,398	53.90%
Unique Count Totals	**283,610**	**100.00%**	**$323,263,317**	**100.00%**

Residence	**Patients***	**Percent of Total Patients***	**Net Payment****	**Percent of Total Net Payments****
Rural	103,097	36.35%	$121,372,921	37.55%
Urban	183,226	64.60%	$201,890,396	62.45%
Unique Count Totals	**283,610**	**100.00%**	**$323,263,317**	**100.00%**

Race	**Patients***	**Percent of Total Patients***	**Net Payment****	**Percent of Total Net Payments****
Unknown	26,099	9.20%	$29,429,714	9.10%
White	137,777	48.58%	$175,333,159	54.24%
Black	86,166	30.38%	$78,715,363	24.35%
American Indian/Alaskan	103	0.04%	$94,176	0.03%
Asian/Pacific Islander	8,608	3.04%	$10,071,576	3.12%
Hispanic	30,666	10.81%	$29,619,330	9.16%
Unique Count Totals	**283,610**	**100.00%**	**$323,263,317**	**100.00%**

*Patients do not sum to the Unique Count Total due to missing information associated with some claim records. Percent of Total Patients represents the percent share of the patient categories summed up and not the percent share of the unique count totals for patients.

**Based on dates of payment from July to June for each fiscal year. Does not reflect member incurred

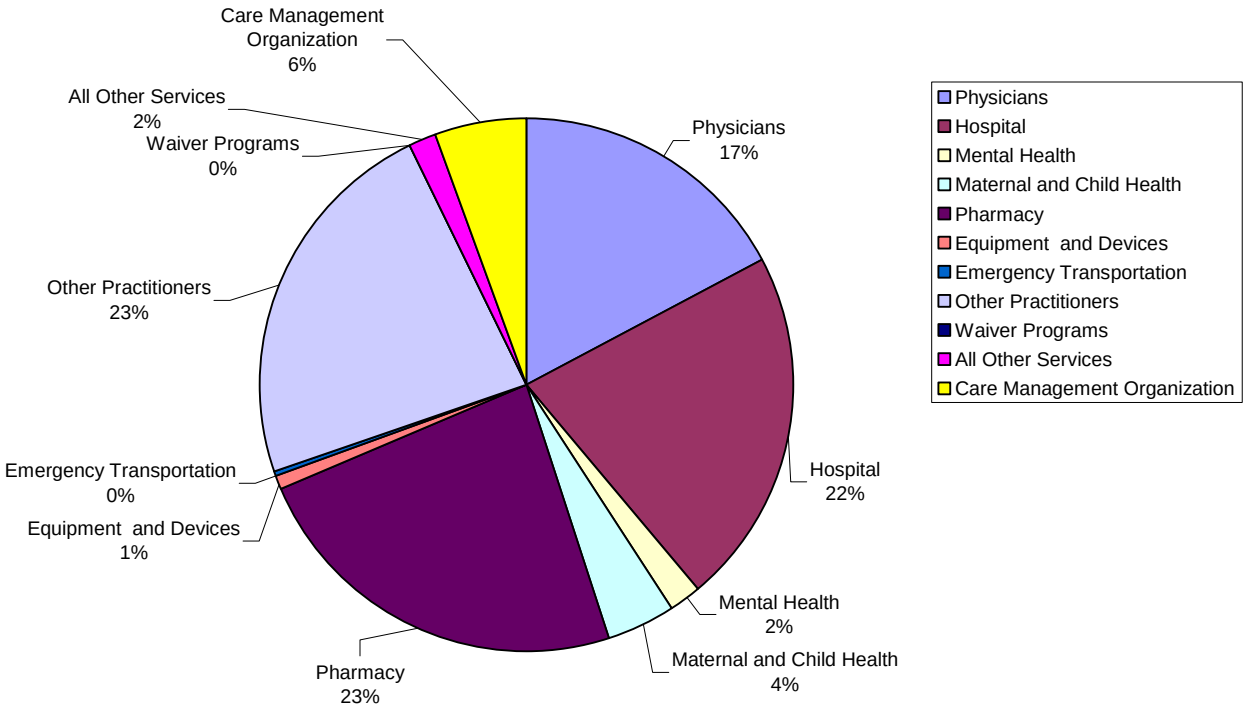
costs (i.e. the date on which the service was performed), because member services provided in a given fiscal year are not necessarily paid in the same fiscal year. For example, a member service may have been provided during FY 2006 and the claim paid during FY 2007.. Net payments will not match fiscal year expenditures. Net payments reflect the actual claims for member services before any adjustments or offsets. The net payments associated with claim records that are missing certain demographic data are spread based on the distribution of net payments for existing claims for the specific demographic profile.

Categories of Medical Services

Presented on the following pages are overviews of the different medical services provided in PeachCare for Kids™ program. The service profile begins with an overview of FY 2006 expenditures for services and then provides more detailed information for each service component. Each service description includes a chart that details the number of unique patients, claims payments, net payment per patient and providers with paid claims for FY 2006. The data is based on all claims paid in FY 2006 and does not reflect FY 2006 member incurred costs (i.e. the date on which the service was performed). This is because the incurred costs associated with a given fiscal year are not necessarily all paid in the same FY.

FY 2006 Profiles of PeachCare for Kids™ Services		
Service	**Net Payment**	**Percent of Total Net Payment**
Physicians	$55,315,807	17.11%
Hospital	$70,417,882	21.78%
Mental Health	$6,267,788	1.94%
Maternal and Child Health	$13,811,708	4.27%
Pharmacy	$75,756,498	23.43%
Equipment and Devices	$2,512,491	0.78%
Emergency Transportation	$1,344,496	0.42%
Other Practitioners	$74,473,863	23.04%
Waiver Programs	$0	0.00%
All Other Services	$5,541,406	1.71%
Care Management Organization	$17,821,378	5.51%
Total	**$323,263,317**	**100.00%**

PeachCare Services Distribution FY 2006



Category of Service	Unique Patients	Net Payment*	Net Pay Per Patient	Providers with Paid Claims
Physician Services	214,026	$55,315,807	$258.45	14,510
Net Payments Sub Total		**$55,315,807**		
Hospitals				
Inpatient Hospital Services	3,879	$27,638,065	$7,125.05	178
Outpatient Hospital Services	101,321	$42,779,817	$422.22	427
Net Payments Sub Total		**$70,417,882**		
Community Mental Health Services	4,963	$6,267,788	$1,262.90	234
Net Payments Sub Total		**$6,267,788**		
Maternal and Child Health Services				
Family Planning Services	1,924	$221,598	$115.18	140
Health Check Services (EPSDT)	104,549	$6,654,989	$63.65	2,443
Pregnancy Related Services	6	$412	$68.63	5
Perinatal Targeted Case Management	1	$73	$72.60	1
Diagnostic Screening and Prevention	4,371	$179,317	$41.02	216
Early Intervention Case Management	254	$143,505	$564.98	112
Children's Intervention Services	5,737	$4,912,377	$856.26	1,819
Children's Intervention School Services	4,086	$1,699,437	$415.92	143
Net Payments Sub Total		**$13,811,708**		

Category of Service	Unique Patients	Net Payment*	Net Payment Per Patient	Providers with Paid Claims
Pharmacy	206,016	$74,923,175	$363.68	2,050
Pharmacy Durable Medical Equipment (DME) Supplier	8,678	$833,324	$96.03	1,471
Net Payments Sub Total		**$75,756,498**		
Equipment and Devices				
Durable Medical Equipment Services	6,429	$1,572,993	$244.67	400
Orthotics and Prosthetics/ Hearing	1,944	$939,498	$483.28	145
Net Payments Sub Total		**$2,512,481**		
Transportation				
Emergency Ground Ambulance Services	3,378	$991,056	$293.39	175
Emergency Air Ambulance Services	112	$353,440	$3,155.71	10
Net Payments Sub Total		**$1,344,496**		
Other Practitioner Services				
Physician Assistant Services	20,264	$1,706,035	$84.19	900
Health Check Dental Program - under 21	173,263	$60,216,406	$347.54	1,546
Vision Care	41,992	$3,996,342	$95.17	710
Nurse Midwifery	194	$24,891	$128.30	70
Oral Maxillofacial Surgery	391	$46,364	$118.58	48
Podiatry	2,118	$361,155	$170.52	270
Psychological Services	8,640	$5,301,525	$613.60	640
Advanced Nurse Practitioners	32,299	$2,824,145	$87.44	1,460
Net Payments Sub Total		**$74,473,863**		

Category of Service	Unique Patients	Net Payment*	Net Payment Per Patient	Providers with Paid Claims
All Other Services				
Home Health Services	87	$31,690	$364.26	31
Independent Laboratory Service	31,816	$1,573,689	$49.46	96
Federally Qualified Health Center	4,251	$987,067	$232.18	58
Hospital-based Rural Health Center	3,918	$579,475	$147.90	50
Free Standing Rural Health Clinic	3,046	$563,921	$185.14	33
Ambulatory Surgical Center/Birthing	2,474	$1,750,679	$707.63	78
Non-Emergency Transportation	na	15,043	na	3
Hospice	1	$2,502	$2,501.54	1
Dialysis Services – Technical	3	$24,732	$8,243.91	3
Dialysis Services – Profession	1	$8,600	$8,600.00	1
Children At-Risk Targeted Case Management	6	600	100	4
Therapeutic Residential Intervention Services (TRIS)	1	$3,469	$3,469.00	1
Care Management Organization	na	$17,821,378	na	3
Net Payments Sub Total		**$5,541,406**		

*Based on dates of payment from July 2005 to June 2006 for each fiscal year. Does not reflect member incurred costs (i.e. the date on which the service was performed) because member services provided in a given fiscal year are not necessarily paid in the same fiscal year. For example, a member service may have been provided during FY 2006 and the claim paid during FY 2007..

Third Party Liability

The Division includes the Third Party Liability Unit which is responsible for identifying members with health insurance and seeking reimbursement for Medicaid and PeachCare for Kids™ expenses when another liable party is identified. Specifically, the unit helps the Department recover benefits by making Medicaid the payer of last resort. This function includes:

- Requiring the third-party to pay before Medicaid (cost avoidance)
- Recouping benefits from the liable third party after the claim has been paid
- Trauma, casualty, or accident-related payment cases (tort recovery)
- Billing the liable party
- Paying health insurance premiums for members when it is cost effective
- Health Insurance Premium Payment (HIPP) Program

The following chart shows the payments recovered or passed on to primary insurance in FY 2006.

Third Party Liability FY 2006 Totals	
Source of Recovery	**Dollars Recovered**
From Casualty	$9,601,840.00
From Miller Trust	$65,527.00
From Other Health Insurance	$37,047,298.00
Total	**$46,714,665.00**
	Cost Avoidance Savings
Due to Medicare	$494,870,306.53
Due to Other Health Insurance	$227,352,404.55
Total	**$722,222,711.08**

Division of Managed Care and Quality

The Division of Managed Care and Quality is responsible for establishing and directing the care management efforts of DCH. These efforts included planning for the transition of a large proportion of the Medicaid and PeachCare for Kids™ programs into a managed care environment beginning in FY 2006. The managed care program was phased in across six regions of the state beginning with 670,000 members in the Atlanta and Central regions, effective June 1, 2006. The program is scheduled to go statewide to all regions on September 1, 2006 (FY 2007).

Program Description

Georgia's care management program provides health care services to the following coverage groups:

- PeachCare for Kids™
- Low Income Medicaid adults and children
- Right from the Start Medicaid pregnant women and children
- Breast and cervical cancer patients
- Refugees (legal immigrants who meet federal criteria)

Medicaid members who are foster children or aged, blind and disabled are excluded from the care management program.

Members continue to receive the same benefits that were offered with Medicaid and PeachCare for Kids™. However, the health plans also offer additional benefits such as:

- Expanded access to plans and providers
- Added member education on accessing care, referrals to specialists, member benefits and wellness education
- More efficient health care service delivery and better member care

The division of Managed Care and Quality additionally provides:

- Care outcome and quality metrics monitoring
- Health improvement strategy development
- Plan monitoring for compliance

Care Management Organization (CMO)

From the 10 bids received in April 2005, DCH announced in mid-July 2005 the award of three CMO vendor contracts. The successful CMO bidders: AMERIGROUP Community Care, Peach State Health Plan and WellCare® of Georgia, Inc.; immediately began to assume the responsibility for health care services for Medicaid and PeachCare for Kids™ members. An enrollment broker vendor, Maximus, also signed their contract and readied for their unique role.

As the division developed the program design details. The new vendors established their presence as licensed Georgia corporations (a contractual requirement), developed provider networks, hired and trained their staff and forged community partnerships. They also produced marketing material, which the DCH Division of Managed Care and Quality and Communications Office carefully reviewed.

The CMO program in Georgia is unique. While the program design is a traditional managed care model, no other state had attempted a program initiation of this scope and magnitude in both rural and urban areas.

The CMO program was originally scheduled to go live on January 1, 2006. DCH made every effort to ensure that the members clearly understood their choices and the changes in their health care through an extensive marketing program. In November 2005, Maximus opened a call center to answer program questions. In December 2005, they began to collect member CMO choices. As a final control, DCH engaged a readiness review vendor to assess all preparations. The information technology was complex and required an extensive re-design. Using an abundance of caution directed by the DCH commitment to provide continuity of services to the Medicaid population, DCH delayed the January 1, 2006, program start.

CMO by Region and County

Region	Counties	CMOs
Atlanta Start Date – June 1, 2006	Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Henry, Jasper, Newton, Paulding, Pickens, Rockdale, Spalding, Walton	AMERIGROUP®, Peach Stat Health Plan™, WellCare®
Central Start Date – June 1, 2006	Baldwin, Bibb, Bleckley, Chattahoochee, Crawford, Crisp, Dodge, Dooly, Harris, Heard, Houston, Johnson, Jones, Lamar, Laurens, Macon, Marion, Meriwether, Monroe, Muscogee, Peach, Pike, Pulaski, Talbot, Taylor, Telfair, Treutlen, Troup, Twiggs, Upson, Wheeler, Wilcox, Wilkinson	Peach State Health Plan™, WellCare®
East Start Date – September1, 2006	Burke, Columbia, Emanuel, Glascock, Greene, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Putnam, Richmond, Taliaferro, Warren, Washington, Wilkes	AMERIGROUP®, WellCare®
North Start Date – September1, 2006	Banks, Catoosa, Chattooga, Clarke, Dade, Dawson, Elbert, Fannin, Floyd, Franklin, Gilmer, Gordon, Habersham, Hall, Hart, Jackson, Lumpkin, Madison, Morgan, Murray, Oconee, Oglethorpe, Polk, Rabun, Stephens, Towns, Union, Walker, White, Whitfield	AMERIGROUP®, WellCare®
Southeast Start Date – September1, 2006	Appling, Bacon, Brantley, Bryan, Bulloch, Camden, Candler, Charlton, Chatham, Effingham, Evans, Glynn, Jeff Davis, Liberty, Long, McIntosh, Montgomery, Pierce, Screven, Tattnall, Toombs, Ware, Wayne	AMERIGROUP®, WellCare®
Southwest Start Date – September1, 2006	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Clay, Clinch, Coffee, Colquitt, Cook, Decatur, Dougherty, Early, Echols, Grady, Irwin, Lanier, Lee, Lowndes, Miller, Mitchell, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Terrell, Thomas, Tift, Turner, Webster, Worth	Peach State Health Plan™, WellCare®

State Health Benefit Plan Division (SHBP)

DCH administers the SHBP, which provides health insurance coverage to state and school system employees, contract groups, retirees and eligible dependents. Within DCH, the SHBP division is responsible for the day-to-day management of the SHBP operations. At the end of FY 2006, SHBP covered 641,422 lives. Teachers and school personnel represented 72 percent and retirees comprised about 18 percent of the covered lives.

Operating Units

Within the division, there are seven operating units. Their responsibilities include the following:

- Processing member eligibility transactions
- Assisting employer groups
- Processing member appeals
- Reviewing vendor performance and clinical standards
- Enforcing contract compliance among vendors
- Managing the annual enrollment/change period
- Conducting member educational programs
- Monitoring the health benefit plan design

During FY 2006, the operating units accomplished the following:

- Processed more than 309,466 coverage transactions for members
- Updated 68,437 member records for dependent audit information
- Responded to more than 239,229 phone calls, 2,502 e-mails and 1,269 pieces of correspondence
- Received 180,673 eligibility calls from members through the SHBP call center
- Responded to 55,504 calls from Human Resources staff at payroll locations
- Received 708 appeals and closed 738 during the fiscal year (carry over from previous year)
- Monitored claims processing and customer service centers to verify that the work met the standards for quality, accuracy and timeliness
- Reviewed clinical standards and practices used within cost-containment programs, including the programs for medical and behavioral health utilization management, case management, prior approval, organ and tissue transplants and demand management
- Processed 546 Health Insurance Portability and Accountability Act (HIPAA) requests for release of information
- Produced and mailed 57,921 Preferred Provider Organization (PPO) and Indemnity identification cards during the year
- Produced and mailed 21,769 dependent audit letters to determine eligibility for coverage
- Researched 874 vendor issues
- Recovered $1,040,055 from subrogation
- Hospital High Cost Claim Reviews resulted in recovery of $1,624,888
- Generated 336,039 member eligibility questionnaire/correspondence that were produced and mailed to members

Coverage Options

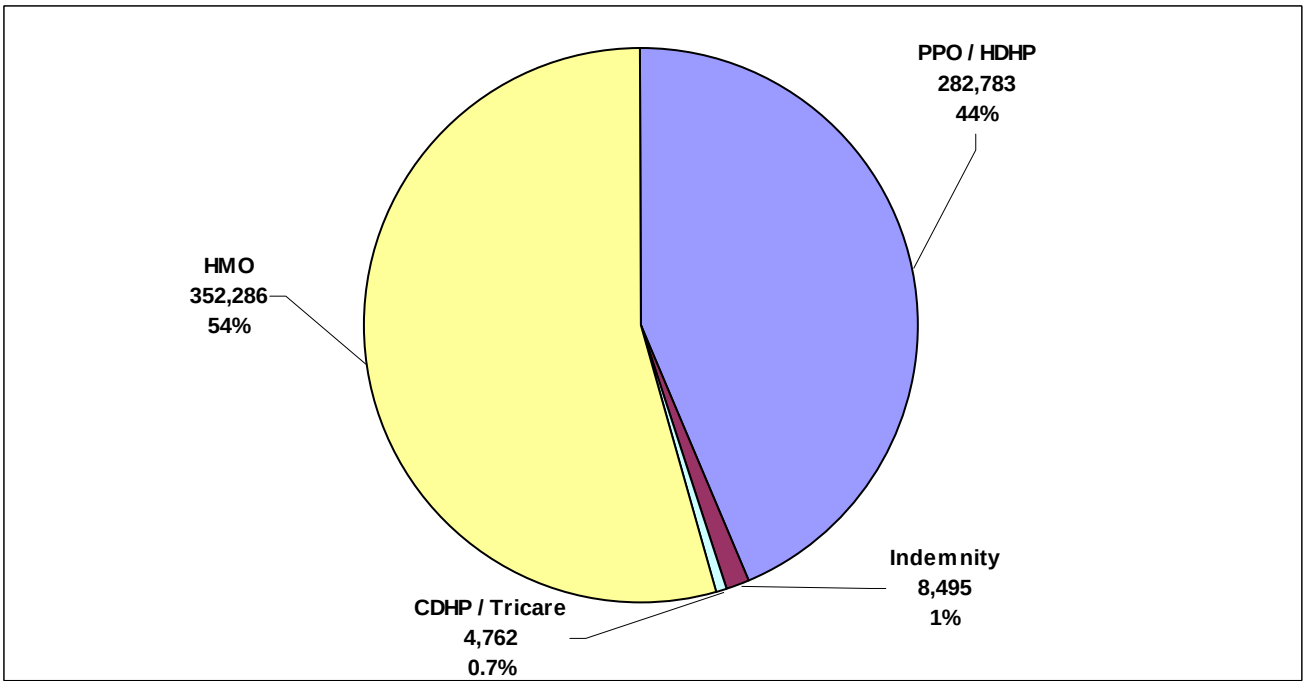
The SHBP offered a PPO, Indemnity Plan, four Health Maintenance Organization (HMO) options, a TRICARE Supplement and a High Deductible Health Plan effective January 1, 2006.

- The PPO option allows members the choice of using either in-network or out-of-network providers, with a higher level of benefit coverage available when using in-network providers. The Georgia PPO provider network consisted of over 10,000 participating physicians and 133 Georgia hospitals. Members could also have selected the PPO Choice option, which had the same benefits as the PPO option, but allowed members to nominate eligible out-of-network providers to receive reimbursements as if the provider were participating within the network
- SHBP no longer offered the Indemnity Premier, PPO Premier and PPO Choice Premier options. The names of the Indemnity Basic, PPO Basic and PPO Choice Basic changed to the Indemnity, PPO and PPO CCO Plans. The Indemnity and PPO options removed the maximum out-of-pocket limit for pharmacy benefits and the co-pay for non-preferred medications increased to $100
- The Indemnity option is a traditional fee-for-service plan. This option uses contracted health care providers. Use of these providers protects members from balance billing
- HMO choices for FY 2006 included: United Healthcare, BlueChoice, CIGNA and Kaiser Permanente. Members who lived or worked in the county or surrounding counties where an HMO is offered were allowed to select that HMO option. Eligible HMO option members could also select an HMO Consumer Choice option, which had the same benefits as the respective HMO, but allowed members to nominate eligible out-of-network providers to receive reimbursements as if the provider were participating within the HMO's network. Some members with full Medicare coverage could select Kaiser Medicare Advantage option, which would replace the member's traditional Medicare coverage. Except in emergencies, HMO participants must use network providers to receive coverage
- All of the HMO options implemented deductibles and co-insurances. These amounts applied to all services except physician office visit services, maternity and newborn care, preventive care and pharmacy
- For military members who are eligible for TRICARE, SHBP offered a TRICARE Supplement. Members had to have a Defense Enrollment Eligibility Report System (DEERS) number to use this option. The TRICARE supplement coordinates benefits with TRICARE
- SHBP offered a High Deductible Health Plan for the first time effective January 1, 2006. This Plan is a consumer-driven health plan option and offers employees a new way to manage their health care dollars. In return for low monthly insurance premiums, employees must satisfy a higher deductible and pay coinsurance after satisfying the deductible. Employees who participated in this Plan could elect to participate in a Health Savings Account (HSA). The HSA allowed employees the ability to set aside tax-free dollars to pay for eligible health care expenses. Any unused dollars roll over to the next year. Typically, HSAs earn interest and may offer investment options

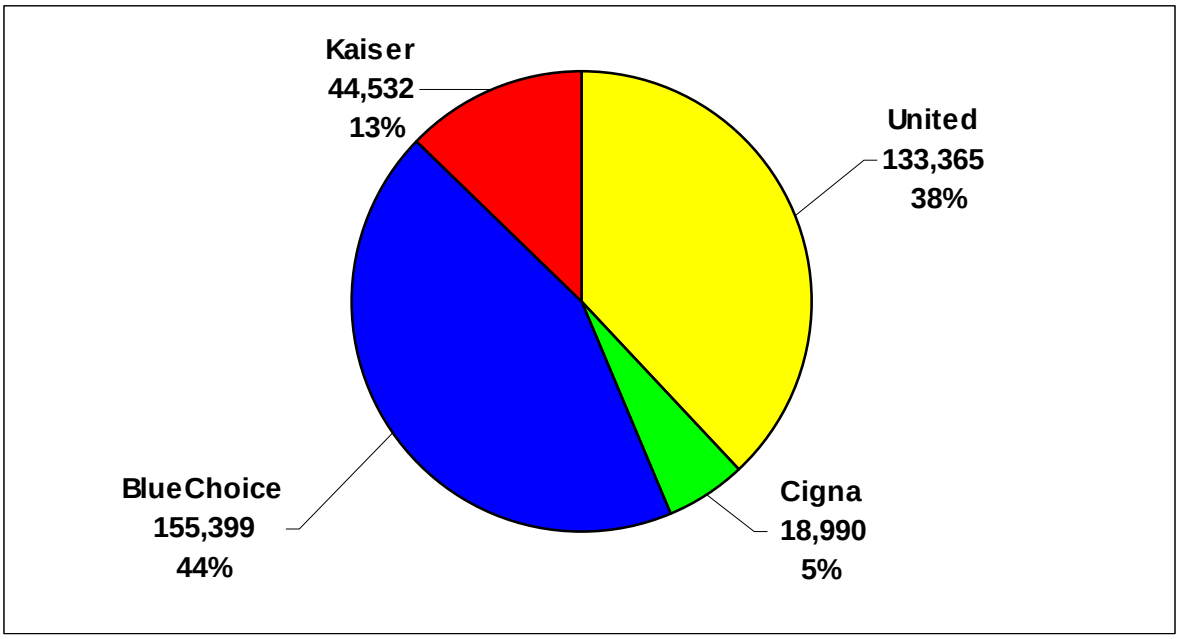
Effective July 1, 2005, SHBP implemented two surcharges. Any member or their covered dependents who had used tobacco products within the previous 12 months had to pay a $40 per month tobacco surcharge.

If the employee's spouse was eligible for coverage through his/her employment, but chose not to take it, the member paid a $30 per month spousal surcharge.

All Covered Lives- All Coverage Options
The following charts show the distribution by option of State Health Benefit Plan members.



Covered Lives - HMO Options
The following chart shows the distribution in the HMOs of the total SHBP members who chose the HMOs.



Open Enrollment and Retiree Option Change Period Activity

Open Enrollment dates were October 17 through November 8, 2005, for coverage effective January 1, 2006. The following projects were completed prior to the new Plan Year effective January 1, 2006:

- Two hundred fifty-five thousand, seven hundred thirty eight Web transactions occurred on the Health Plan's Web site for Health Plan coverage effective January 1, 2006,. This was the first year that members had to go online to answer surcharge questions and make option selections for Open Enrollment or they would roll-over into their current option with the surcharges applied
- To update/correct members' records, data entries of 309,466 were made by SHBP staff
- Prepared and posted Train-The-Trainer presentations to the DCH Web site for Open Enrollment processing instructions for human resources staff in state agencies and school systems
- To answer benefit questions, staff held 12 benefit fairs across the state and met with 4,000 active members
- Staff wrote, edited, printed and distributed 299,100 Health Plan Decision Guides for active employees to more than 750 payroll locations
- The Plan sent 80,710 retiree option change packets to retired members; and individuals on COBRA and Leave Without Pay
- Forty retiree meetings were held across the state and approximately 10,000 retirees were given an explanation of SHBP's coordination or benefits with Medicare Part D prescription drug coverage

Covered Lives

The tables below describe plan membership by employment group and active or retired status. Total covered lives includes members, spouses and other dependents.

FY 2006 SHBP Plan Member Group

Group	Total Lives	Employees	Dependents	Percentage
Active	524,811	245,698	279,113	81.82%
Retirees	113,344	80,347	32,997	17.67%
Contract	1,698	1,137	561	0.27%
COBRA*	1,236	713	523	0.19%
Board Members	333	146	187	0.05%
Total	641,422	328,041	313,381	

*COBRA is the Consolidated Omnibus Reconciliation Act that allows members to continue their health insurance coverage under specified circumstances.

Covered Lives	Total Lives	Employees	Dependent	Percent Total Lives
State Employees - Active	137,022	68,932	68,090	21.36%
State Employees - Retired	40,652	27,821	12,831	6.34%
Teachers - Active	241,769	106,626	135,143	37.7%
Teachers - Retired	51,429	3,6881	14,548	8.02%
School Service Personnel - Active	146,020	70,140	75,880	22.77%
School Service Personnel - Retired	21,263	15,645	5,618	3.32%
Contract Groups/Board Members - Active	2,007	1,268	739	0.31%
Contract Groups/Board Members - Retired	24	15	9	0.004%
COBRA	1,236	713	523	0.20%
Total	641,422	328,041	313,381	

Active teachers and school service personnel accounted for 60.46 percent of the covered lives; active state employees represented approximately 21.36 percent. Overall, retirees account for 17.68 percent of the plan population.

Expenditures

The table below explains the total expenditures by type of health plan:

Total FY 2006 Expenditures	
Average Expenditure Per Covered Life	**$3,420.98**
PPO, Indemnity, HDHP, CDHP Option Expenditures	$1,887,469,315
HMO/TRICARE Supplement Premiums	$138,677,503
Contracts	$157,157,908
Administrative Support	$10,985,820
Total Expenditures	**$2,194,290,546**

Operations Division

The Operations Division consists of the following units:

- The Administrative Services Unit, which has three subunits: Contract Administration, Vendor Management and Support Services
- The Audits Unit which conducts and oversees internal and external audits
- The Communications Unit, responsible for media and public relations, as well as Web site management
- The Human Resources Office, providing internal and external employment services for state employees and constituents. This office sponsors the annual Charitable Contributions Program, which is a Governor's initiative to raise funds for charities and non-profit organizations through donations from state employees and employee recognition and faithful service programs
- The Vendor Operations for Affiliated Computer Services (ACS), a group of experts who provide support with managing the agency's Medicaid fiscal agent, ACS
- The Office of Procurement Services that manages all contracts for services
- The Office of Health Improvement, The State Office of Rural Health and the Georgia Volunteers in Health Program that are three separate program areas

Contracts Administration
Office of Procurement Services

Contracts Administration from July 1, 2005, through February 28, 2006, was the unit under the Operations Division of DCH responsible for the administration of all procurement activity and the execution of the resulting contracts.

The procurement and contracts functions divided March 1, 2006, with the contract development and maintenance aspects transferring to the Office of General Counsel and the procurement functions remaining under the Operations Division as the Office of Procurement Services (OPS).

OPS began by setting standards for all DCH procurement initiatives as they continued to assist all DCH divisions develop sound and comprehensive procurement process that would address DCH's needs with measurable performance objectives.

During 2006, Operations for DCH secured $2,529,651 in services through procurement under the Contracts Administration Unit. OPS released $116 billion in procurements for DCH during 2006. These procurements were for five-year engagements and reflect the anticipated spending over that period.

Medical Assistance Procurements

- NET – a statewide procurement to provide transportation services to Medicaid members. NET provides medically necessary transportation for any eligible Medicaid member and companion, if required, who have no other means of transportation to any Medicaid reimbursable service for the purpose of receiving medical care
- Quality Assurance and Control Services, Administrative Services Organization – a legislatively-mandated procurement to generate cost savings in the provision of medical services to Georgia's Medicaid population

– Georgia Medicaid Management Program, Administrative Services Organization – a legislatively-mandated procurement to provide medical management services and other related services for specified Fee-For-Service members of the Medicaid population
– PBM for Medicaid – a procurement that provides for a third-party administrator to approve and pay pharmacy claims for Medicaid members

Non-Purchasing Initiatives

– OPS developed a revised comprehensive a policy and procedure manual. DCH departments use this manual as a guide to adhering to the new State mandates initiated by the Department of Administrative Service (DOAS) when requesting procurements for goods and services
– Training on Notice of Intent to Award and Negotiations was a collaboration production of DCH policy and new DOAS procedure to the award procurements
– Conducted training initiatives to keep staff and DCH employees updated with the new process and procedure in the State Procurement Office and DCH procurement changes
– Assisted in the establishment of a Grants Department to administer grant funding in needed areas

Grants and Vendor Management Services

The Grants and Vendor Management Services unit monitors vendor performance. Cost containment and value maximization applied systematically assures the continued viability of contracted and grant-funded services.

In FY 2006, this unit:

- Conducted four on-site audits, initiated 96 desk audits and assessed a total of $2,056,684.67 in liquidated damages (excluding the NET program). A desk audit is an examination of the vendor's file including the contract, its expenses and deliverables, the profile and an assessment survey, which is completed by the project manager to determine if the vendor meets the terms of the contract. Liquidated damages is the dollar amount assessed a vendor or contractor for non-compliance of the policies, procedures and standards established in the contract
- Established a Grants Office in March 2006 for the administration, management and oversight of grants within DCH; awarded 27 grants for a total of $3,111,019
- Re-procured vendors for a NET Broker Services program , and contracted with two brokers to provide service to Georgia Medicaid members. The state has five NET service regions: Atlanta, North, Central, East and Southwest. LogistiCare provided 2,176,498 trips to approximately 241,591 Medicaid members in the Central, East and Southwest regions. In October 2005, Southeastrans took over an emergency contract in a region that had numerous problems. This contractor provided 869,978 trips to 112,359 Medicaid members in the North and Atlanta regions. The defaulting vendor was assessed $16,600 in liquidated damages

State Office of Rural Health

The State Office of Rural Health (SORH) works to improve access to health care in rural and underserved areas to reduce health status disparities of the populations in Georgia. The office has the following objectives:

- Empowering communities to strengthen and maintain the best possible health care using existing resources
- Building strong partnerships to meet local and regional needs
- Providing incentives to local areas to implement integrated service delivery systems; and
- Acting as the single point of contact for all regional issues related to health care

The office has a 12-member advisory council with the length of service determined by lottery.

In FY 2006, SORH focused on building regional rural health systems, increasing the number of community and migrant health centers, supporting rural hospitals and identifying ways to make health care available to Georgians in underserved rural and urban areas. Major projects were:

- Received and administered $6,883,820 in federal and state funding for programs supporting the provision of health care for the rural and urban underserved populations of Georgia. Of the total funding, $3,448,380 were from federal sources, and $3,235,440 were received from state sources
- Administered major grant initiatives for FY 2006 totaling $615,000 which included:
  – $200,000 for Rural Health Networks
  – $355,000 for the development of volunteer clinics
  – $60,000 for Federally Qualified Health Center Board Development
- Through the Georgia Farmworker Health Program (GFHP) provided services to 11,664 migrant and seasonal farm workers and their dependents, accounting for 17,411 medical encounters and 14,889 enabling encounters, such as outreach services, medical interpretation, transportation and health education provided by non-medical personnel
- Obtained loan repayment/scholarships from the National Health Service Corps (NHSC) benefiting 22 medical/dental providers in Georgia underserved areas, amounting to a minimum of $550,000 in federal loan repayment
- Placed 18 medical providers in underserved areas through the J-1 Visa Waiver Program for a total of 90 J-1 physicians serving in Georgia during FY 2006

Georgia Volunteer Health Care Program

In 2005, House Bill 166, the Health Share Volunteers in Medicine Act passed and created the Georgia Volunteer Health Care Program, subsequent law: O.C.G.A. 31-8-190 et seq.; and three Acts (O.C.G.A. § 43-1-28, O.C.G.A. § 43-11-52 and O.C.G.A. § 43-34-45.1); and empowered DCH to establish free health care clinics throughout the state.

Through this legislation, DCH began to offer state-sponsored Sovereign Immunity protection to uncompensated, licensed health care professionals who donate care to eligible patients. The state is responsible for any litigation associated with services rendered by these health care professionals as long as the volunteer health care professional acted within the scope of services defined under the law. A licensed health care professional may volunteer in a free clinic and/or in his or her own private office as long as a designated DCH volunteer completes the required paperwork for the patient. DCH volunteers are free-clinic support staff who document a patient's eligibility for the program and who provide notices to the patient.

Beginning in FY 2005 and continuing in FY 2006, the definition of an eligible patient was:

- A person who was Medicaid eligible under Georgia law, or
- A person who was without health or dental coverage and
- A person whose income was at or below 200 percent of the Federal Poverty Level (FPL), or
- A client of DCH or DHR and his/her income is at or below 200 percent of the FPL.

House Bill 1224, passed in the 2006 legislative session, recommended compensation for DCH free-clinic volunteers and the addition of an income criterion of at or below 200 percent of the Federal Poverty Level for a client of DCH or DHR. These changes to the law became effective on July 1, 2006.

DCH's legal counsel and the program director developed program rules. There were two public comment hearings. The DCH rule 111-5-1 became effective July 3, 2006. To ensure that the rules and the associated processes to enforce them were addressed the intent of the law, DCH engaged in the development and review process the Medical Association of Georgia, the Georgia Hospital Association and the Georgia Dental Association.

DCH established a fully staffed central office and regional support locations in the Atlanta, Macon, Augusta, Savannah, Albany and Gainesville areas.

Office of Health Improvement

The OHI is composed of three offices: Office of Minority Health (OMH), Georgia Commission on Men's Health (CMH), and Office of Women's Health (OWH). In addition to the three program areas, OHI houses the Georgia HIV/AIDS TAKE Project. These offices are dedicated to wellness, prevention and healthy improvement of various populations.

The OHI focuses on education, heightening awareness and developing networks to improve the health disparities in Georgia for four major diseases: heart disease and stroke, diabetes, cancer and HIV/AIDS. These diseases adversely affect Georgia's minority populations, who make up roughly one-fifth of Georgia's population. In 2004, Georgia ranked 45 out of 50 states surveyed in health status. This was the state's lowest ranking in 15 years.

In order to combat the growing health disparities, the office functions to:

- Eliminate disparities in health status between minority and non-minority populations
- Recommend ways to promote the benefits of regular checkups, preventive screening tests and healthy lifestyle practices for men
- Raise awareness, educate and empower people to have control over their health issues
- Serve as a clearing house for health information related to women, men and minorities
- Develop policies and plans that support community partnerships and actions to identify and solve health problems
- Link various health professionals and facilities to the people who are in need of personal health services
- Evaluate the effectiveness, accessibility and quality of personal and population-based health services
- Foster awareness among Georgia's citizens of the current health crisis affecting specific ethnic populations
- Encourage physical activity, healthy diets and other positive behavioral lifestyle improvement to promote healthy living

Office of Health Improvement Advisory Councils
The councils have been appointed to assist OHI in the development and implementation of its program activities and initiatives.

- **The Georgia Commission on Men's Health,** created to address the deteriorating health of men
- **The Women's Health Advisory Council (WHAC)** is comprised of 11 member, appointed by the Governor, who represent major public and private agencies and organizations in the state. The council provides input and serves as a resource in the development of a state comprehensive plan to address women's health. They also encourage innovative responses by public and private entities that are attempting to address women's health issues. They make recommendations regarding the development and implementation of key initiatives, and promote and lead efforts to improve the health status and quality of life of women in Georgia through education, research, policy development and coordination of women's health programming
- **The Minority Health Advisory Council** (MHAC) actively participates in developing comprehensive policy initiatives and advocates for the implementation of sound public health policies, programs and initiatives that serve to eliminate health disparities, remove barriers to access for minority populations, promote prevention and healthy lifestyle changes, enhance cultural awareness and sensitivity among caregiver, community groups and policy makers and foster collaborative partnerships

OHI Federally Funded Initiatives
The Georgia HIV/AIDS TAKE (Take Action, Keep Educated) Project funded by grant monies received from the U.S. Department of Health and Human Services (HHS), identifies needs within Georgia for HIV/AIDS prevention and services among minority populations and assesses perceived barriers to providing and accessing HIV/AIDS services.

OHI Grant Programs
In FY 2006, the OHI sponsored three grant programs to improve health outcomes for the Hispanic/Latino community, the state's seniors and Georgia's females totaling $290,500. The grants were aimed at building the capacity to address key health issues for these groups.

- The "Let's Be Healthy: Seamos Saludables!" grant program provides health outreach services to Hispanic/Latinos and migrant farm workers in South Georgia. Nursing and Community Health Outreach Services in Americus, Georgia, and Southeast Georgia Communities Project in Lyons, Georgia, won the two competitive grants. They will help raise awareness, promote screenings and prevention practices to their communities. They will develop a curriculum of self-care for those with chronic illnesses that will be customized and translated into Spanish

- The Generating Active Elders through Nutrition Education (GANE) grant was awarded to the Central Savannah River Area Regional Development Center in Augusta and the Southeast Georgia Communities Regional Development Center in Waycross. The GANE project launched community-based education sessions coordinated by local neighborhood senior citizen organizations, community groups and churches to teach seniors to apply proper nutrition, exercise and overall health awareness as they age. The local collaborators facilitated the attendance of senior aged residents, families and care givers during informational programs

- The Women, Infants and Children Health Initiative (WISH) grant was awarded to the Compassionate Care Clinic in Milledgeville, Georgia, to address the health needs of girls and women. WISH focuses on the regional specific female non-reproductive health from infancy through post-menopausal years of life

- Twenty three contracts were managed by OHI through the Georgia Breast Cancer License Tag Fund. The grants were awarded to public and private entities in partnership with the Georgia Cancer Coalition.

- OHI managed and monitored state appropriations of $2.5 to $6 million for the Georgia Cancer Coalitions Centers of Excellence

- The Office of Minority Health and TAKE Project contracted with Georgia News Network (GNN) to produce minority health message campaign. Fifty-two 30-second minority health messages were produced reached approximately 1,186, 600 unduplicated listeners

General Counsel Division

The General Counsel Division is responsible for:

- Providing overall legal guidance ;
- Drafting rules and regulations for promulgation by the Board of Community Health;
- Contract administration;
- Developing policies and procedures for compliance with federal and state privacy and public records requirements; and
- Overseeing the State's health planning function

The General Counsel Division consists of three main units:

- Contracts Administration
- Legal Services, including Provider Enrollment for Medicaid and Georgia Better Health Care
- Health Planning

In addition, the office oversees the DCH's privacy and security, ethics and compliance initiatives and ensures the Department's compliance with the Open Records Act.

Contracts Administration:

Contracts Administration oversees the development and retention of agency contracts and agreements

- DCH contracts were valued at approximately $514.3 million
- In FY 2006, there were more than 400 active contracts

Legal Services:

Provides legal services for all aspects of the Medicaid and PeachCare for Kids™ programs, including representation of DCH in administrative proceedings. It also:

- Supports the Department of Law in medical assistance litigation
- Drafts Medicaid and PeachCare for Kids™ policy and procedures as well as rules and regulations

In FY 2006, Legal Services' caseload was comprised of:

Type	Number
Recipient cases:	459
Provider cases:	120
Special Needs Trust:	146
Other in-house projects:	207

Members may appeal DCH decisions which result in:

- Denial of services
- Reduction in services
- Termination from the Medicaid/PeachCare for Kids™ programs

The types of member appeals consist of:

- Adult waiver cases, generally arising from the denial of participation and reduction in waiver services
- Independent Care Waiver Program providing in-home assistance and care for qualified members as an alternative to nursing facility placement are the primary source of appeals
- GAPP covering services to medically fragile children who require continuous skilled nursing care
- The Katie Beckett/Deeming Waiver program enabling otherwise ineligible chronically ill children to qualify for Medicaid Services
- SOURCE, case management program for the chronically-ill (members 65 and older or under 65 and disabled)

Providers may appeal DCH decisions which result in:

- A change in the providers' rate of reimbursement
- Recoupment of payments
- Termination of the providers' participation in the Medicaid/PeachCare for Kids™ program

Legal Services is the gatekeeper for the Georgia Medicaid program by reviewing and evaluating all applications for practitioner, supplier and facility enrollment in the program.

Control of fraud and abuse in the Medicaid program begins with the provider enrollment process. Legal Services received and processed more than 11,000 applications for participation and additional locations during FY 2006. Of these, more than 8,000 applications were approved for participation in the various categories of service; 243 applicants were denied enrollment.

Health Planning

- Administers and reviews CON applications for 24 types of health care services
- Collects health care data
- Recommends rules and regulations to the Health Strategies Council and the Board of Community Health
- Reviews architectural plans for health care facilities
- Provides staff support for the Health Strategies Council, Health Planning Review Board and the State Commission on the Efficacy on the CON Program

Annually, the Health Planning unit:

- Reviewed approximately 150 applications for CON
- Surveyed every hospital; nursing home; ambulatory surgery center; home health agency; diagnostic, treatment, or rehabilitation center and personal care home in the state to obtain utilization and supply data as well as financial information
- Issued approximately 130 letters of determination and non-reviewability regarding the CON program
- Reviewed and approved architectural plans for approximately 100 large health care construction projects

The Health Planning Review Board, an independent body whose membership is appointed by the Governor, hears appeals from decisions of hearing officers conducting administrative hearings to review the grant or denial of applications for CON.

The Health Strategies Council is an independent body whose membership is appointed by the Governor and is tasked with:

- Adopting a state health plan to address Georgia's health care system for financial, geographic, cultural and administrative accessibility
- Reviewing and recommending changes to rules governing the Certificate of Need program
- Formulating long-term, comprehensive approaches for health insurance coverage of all people in Georgia

Office of Inspector General

In February 2006, Commissioner Medows created the Office of Inspector General (OIG). The OIG's mission is to safeguard DCH from risk, both internally and externally.

Director of Program Integrity (PI) Doug Colburn became the first Inspector General. The PI Unit (from the General Counsel division) joined the Audit Unit (from Operations) and a newly-created Internal Investigation Unit to form the OIG.

The PI Unit is responsible for the identification, investigation and reconciliation of fraud and abuse in Georgia's Medicaid, PeachCare for Kids™ and SHBP. The Unit's goal is to purge the system of those who would take advantage of it while assisting entities that made errors with corrective action, education and accountability. There are six teams that comprise the Unit: Investigations, Hospital, Pharmacy, Physician Services, Waivers and Professional Services. PI staff includes nurses and clinicians, statistical analysts and law enforcement.

The PI Unit receives cases through a variety of sources, such as a telephone hot line, the Internet and inter-agency referrals. The first step is to establish a foundation of data analysis for each case. The PI Unit employs the latest technology to comb though claims information and build reports to support the investigation. Investigators and clinical teams develop the allegations of fraud and abuse. These teams include professionals with expertise in investigations, hospital, pharmacy, medical, mental health and waivers. If a question of medical necessity arises, peer reviewers from that specialty review the case. The PI Unit uses claims and data analysis to develop studies to predict fraudulent or abusive trends or identify vague or ambiguous policy.

In the pursuit of accountability, the PI Unit works collaboratively with local, state and federal agencies. Some of these agencies are the Georgia Bureau of Investigation, the Georgia Medicaid Fraud Control Unit, the Office of the State Inspector General, Federal Bureau of Investigation, the Georgia Attorney General's Office and the Federal Department of Health and Human Services. By working collaboratively with other agencies, the PI Unit is better able to detect and pursue fraud and abuse.

In FY 2006, The PI Unit was responsible for recovering approximately $17.4 million. These monies were actual recoveries. Of the 1,226 cases opened, 726 cases closed and 14 cases were referred to the Medicaid Fraud Control Unit.

The Internal Affairs Investigations Unit investigates employee and vendor misconduct and performs new employee background checks. This unit enters all complaints into a secure database. The unit has two investigators assigned. Both have received training from the Georgia Peace Officers Standards and Training Council in Internal Affairs and federal Equal Opportunity Act, Title Seven investigations.

The Audit Unit is the central contact point for all internal and external audits. These include both state and federal reviews performed by agencies including Health and Human Services, the CMS and the Georgia Department of Accounts and Audits. In FY 2007, this unit will also create a performance audits group which will review departmental controls and make recommendations improvements to the respective division chief.

Office of Legislative and External Affairs

The Office of Legislative Affairs serves as DCH's primary point of contact for all activities related to the Georgia General Assembly and the annual Legislative Session. During each session, the DCH legislative unit analyzes bills that affect Medicaid, SHBP and health care in general. The Legislative and External Affairs Unit also is responsible for ensuring the passage of the department's legislative agenda each year.

The Office of Legislative and External Affairs includes the Office of Constituent Services (OCS). OCS is the customer service agent for Georgia's Medicaid program. OCS interacts daily with members, providers, legislators and others, as well as helping Georgians understand the Medicaid program and the department's business functions as a whole. OCS responds to thousands of calls, e-mails, letters, faxes and inquiries relating to the Medicaid program.

Division of Financial Management

The Division of Financial Management represents DCH's financial interests when working with the Governor's Office, General Assembly, Board of Community Health, the Centers for Medicare and Medicaid Services and other stakeholders. The Office of Planning and Fiscal Analyses, Financial and Accounting Services, Reimbursement Services and the Budget Office comprise the division.

Division of Information Technology (IT)

The Division of Information Technology supports DCH with four units.

The MMIS Unit supports the various systems used for information collection, processing, analysis and reporting to support all Medicaid and PeachCare for Kids™ claim payment functions. The MMIS system consists of all federally required subsystems as specified by the CMS within the DHHS.

The SHBP Unit supports the MEMS that monitors health insurance coverage to state employees, school system employees, retirees and their dependents.

The IT Infrastructure Unit provides IT Security and Technical Support at the desktop, server, storage and network levels for all DCH divisions.

The Project Management Office (PMO) promotes project management standards throughout DCH. As a centralized support function, the PMO staff assist DCH managers to plan, develop and implement IT components in health care initiatives. Using PMO discipline and skills, DCH divisions focus and deliver more effectively on specific business needs.

Two areas of focus for the PMO are:

- Creating a more collaborative working environment for IT and business
- Serving as process management stewards to improve and streamline IT's ability to deliver on DCH business needs

Attached Agencies

The following three administratively attached agencies are housed in DCH:

Composite State Board of Medical Examiners

The Composite State Board of Medical Examiners (CSBME) licenses and regulates physicians, physician's assistants, respiratory care professionals, acupuncturists, perfusionists, auricular detoxification specialists, paramedics and cardiac technicians. The CSBME also maintains a comprehensive database that offers public access to information about licensed physicians in the state. Twelve physicians and one consumer representative serve on this board.

Georgia Board for Physician Workforce

The 15-member Georgia Board for Physician Workforce (GBPW) monitors and evaluates the supply and distribution of physicians by specialty and geographic location to identify underserved areas of the state. GBPW also develops medical educational programs through financial aid to medical schools and residency-training programs.

State Medical Education Board

The State Medical Education Board (SMEB) administers medical scholarships and loans to promote medical practices in rural areas. Initiatives include the Country Doctor Scholarship and Loan Repayment programs, which encourage physicians to practice in the state's underserved areas. SMEB has 15 members and publishes a biennial report, submitted directly to the General Assembly.

Appendices

Appendix A – FY 2006 Medicaid Distribution by County

The following chart details patient and payment data for each of the counties in Georgia.

FY 2006 Medicaid Distribution by County						
County	**Patients***	**Net Payments****	**Net Payment Per Patient**	**Percent of Total Population**	**Providers**	**Claims Paid**
Appling	6,254	$22,903,342	$ 3,662.19	0.38%	4,187	184,009
Atkinson	2,812	$8,712,811	$ 3,098.44	0.17%	1,888	79,679
Bacon	2,905	$12,228,069	$ 4,209.32	0.18%	1,817	98,816
Baker	1,131	$2,911,413	$ 2,574.19	0.07%	1,146	29,011
Baldwin	10,320	$87,152,270	$ 8,444.99	0.63%	4,894	287,997
Banks	3,192	$8,474,092	$ 2,654.79	0.20%	2,672	81,737
Barrow	10,353	$34,187,960	$ 3,302.23	0.64%	5,789	252,389
Bartow	18,077	$57,513,068	$ 3,181.56	1.11%	6,990	443,071
Ben Hill	5,808	$24,218,247	$ 4,169.81	0.36%	2,597	168,464
Berrien	4,779	$17,039,333	$ 3,565.46	0.29%	2,195	137,265
Bibb	41,209	$176,466,026	$ 4,282.22	2.53%	7,431	1,157,758
Bleckley	2,711	$11,375,568	$ 4,196.08	0.17%	1,946	85,223
Brantley	4,499	$14,000,353	$ 3,111.88	0.28%	2,278	122,702
Brooks	4,623	$17,016,873	$ 3,680.92	0.28%	1,906	135,334
Bryan	4,043	$14,861,032	$ 3,675.74	0.25%	2,257	104,656
Bulloch	12,332	$43,473,886	$ 3,525.29	0.76%	4,189	321,569
Burke	7,594	$27,157,171	$ 3,576.14	0.47%	2,474	218,228
Butts	4,682	$18,622,340	$ 3,977.43	0.29%	3,680	120,326
Calhoun	1,897	$8,133,371	$ 4,287.49	0.12%	1,367	57,543
Camden	7,272	$18,578,897	$ 2,554.85	0.45%	2,489	162,258
Candler	3,383	$17,546,308	$ 5,186.61	0.21%	1,865	120,199
Carroll	21,232	$72,128,004	$ 3,397.14	1.30%	7,464	572,763
Catoosa	9,226	$29,415,653	$ 3,188.34	0.57%	2,815	227,946
Charlton	2,671	$8,715,342	$ 3,262.95	0.16%	1,672	75,166
Chatham	46,285	$187,022,229	$ 4,040.67	2.84%	5,888	1,235,764
Chattahoochee	970	$2,215,073	$ 2,283.58	0.06%	988	19,709
Chattooga	5,839	$20,316,750	$ 3,479.49	0.36%	2,647	180,643
Cherokee	16,459	$53,506,507	$ 3,250.90	1.01%	7,792	362,273
Clarke	19,698	$68,306,760	$ 3,467.70	1.21%	6,362	480,086
Clay	1,258	$4,559,776	$ 3,624.62	0.08%	1,241	33,914
Clayton	65,572	$178,633,741	$ 2,724.24	4.03%	13,289	1,179,400
Clinch	2,438	$9,380,274	$ 3,847.53	0.15%	1,620	91,028
Cobb	75,869	$239,113,818	$ 3,151.67	4.66%	15,739	1,480,759
Coffee	11,852	$41,074,865	$ 3,465.65	0.73%	3,964	361,733
Colquitt	12,667	$42,850,528	$ 3,382.85	0.78%	3,678	343,868
Columbia	10,525	$37,465,925	$ 3,559.71	0.65%	3,132	265,694

FY 2006 Medicaid Distribution by County						
County	**Patients***	**Net Payments****	**Net Payment Per Patient**	**Percent of Total Population**	**Providers**	**Claims Paid**
Cook	4,646	$17,482,573	$ 3,762.93	0.29%	2,100	128,236
Coweta	14,680	$46,019,250	$ 3,134.83	0.90%	5,946	329,262
Crawford	2,873	$9,975,471	$ 3,472.14	0.18%	2,099	69,527
Crisp	7,209	$29,366,911	$ 4,073.65	0.44%	2,903	216,210
Dade	2,631	$9,324,390	$ 3,544.05	0.16%	1,605	72,258
Dawson	2,664	$8,001,080	$3,003.41	0.16%	3,007	65,809
Decatur	8,524	$406,800,523	$3,328.70	0.52%	2,760	221,511
DeKalb	122,210	$29,914,220	$3,509.41	7.50%	19,203	2,378,229
Dodge	5,236	$22,573,035	$4,311.12	0.32%	2,546	190,337
Dooly	3,346	$14,160,390	$4,232.04	0.21%	2,109	104,174
Dougherty	29,640	$109,185,050	$3,683.71	1.82%	5,931	799,295
Douglas	19,425	$59,674,489	$3,072.05	1.19%	8,377	395,252
Early	4,445	$15,432,810	$3,471.95	0.27%	1,975	120,946
Echols	968	$2,126,422	$2,196.72	0.06%	802	18,980
Effingham	6,749	$22,795,925	$3,377.67	0.41%	2,557	165,044
Elbert	5,146	$19,223,142	$3,735.55	0.32%	2,291	162,535
Emanuel	7,376	$30,139,763	$4,086.19	0.45%	3,280	241,701
Evans	3,416	$10,487,218	$3,070.03	0.21%	1,855	96,303
Fannin	4,148	$16,999,724	$4,098.29	0.25%	2,840	133,680
Fayette	6,962	$22,455,946	$3,225.50	0.43%	4,740	146,859
Floyd	24,156	$103,298,926	$4,276.33	1.48%	8,088	727,940
Forsyth	8,562	$28,473,130	$3,325.52	0.53%	5,436	185,715
Franklin	5,176	$18,718,582	$3,616.42	0.32%	3,174	148,974
Fulton	212,208	$644,358,960	$3,036.45	13.03%	27,658	3,639,878
Gilmer	5,317	$20,449,036	$3,845.97	0.33%	3,519	152,220
Glascock	777	$4,633,282	$5,963.04	0.05%	1,139	27,911
Glynn	14,539	$52,093,890	$3,583.04	0.89%	3,881	398,431
Gordon	10,947	$36,110,594	$3,298.67	0.67%	4,268	281,224
Grady	6,621	$18,429,732	$2,783.53	0.41%	2,002	166,511
Greene	3,489	$12,458,947	$3,570.92	0.21%	2,462	91,869
Gwinnett	91,202	$246,856,445	$2,706.70	5.60%	15,316	1,647,495
Habersham	6,779	$21,779,713	$3,212.82	0.42%	3,129	168,926
Hall	31,981	$97,717,117	$3,055.47	1.96%	8,753	752,128
Hancock	2,558	$10,981,433	$4,292.98	0.16%	1,991	75,862
Haralson	6,473	$26,978,389	$4,167.83	0.40%	3,893	214,175
Harris	3,063	$11,487,230	$3,750.32	0.19%	2,095	78,501
Hart	5,169	$19,669,380	$3,805.26	0.32%	2,699	145,169
Heard	2,884	$9,024,722	$3,129.24	0.18%	2,163	78,029
Henry	22,310	$60,827,563	$2,726.47	1.37%	8,750	426,139
Houston	20,580	$70,813,070	$3,440.87	1.26%	5,196	513,149

FY 2006 Medicaid Distribution by County						
County	**Patients***	**Net Payments****	**Net Payment Per Patient**	**Percent of Total Population**	**Providers**	**Claims Paid**
Irwin	2,658	$13,694,183	$5,152.06	0.16%	1,712	83,551
Jackson	9,436	$33,848,963	$3,587.22	0.58%	5,024	243,677
Jasper	2,753	$8,985,890	$3,264.04	0.17%	2,601	62,008
Jeff Davis	4,176	$14,667,228	$3,512.27	0.26%	2,768	128,612
Jefferson	5,699	$22,857,625	$4,010.81	0.35%	2,341	180,739
Jenkins	2,920	$11,065,883	$3,789.69	0.18%	1,963	83,827
Johnson	2,689	$13,366,530	$4,970.82	0.17%	1,960	97,059
Jones	4,297	$13,825,043	$3,217.37	0.26%	2,397	101,543
Lamar	3,593	$13,955,353	$3,884.04	0.22%	2,806	93,412
Lanier	2,408	$9,181,490	$3,812.91	0.15%	1,417	69,775
Laurens	12,930	$48,900,183	$3,781.92	0.79%	4,083	394,001
Lee	3,727	$11,876,635	$3,186.65	0.23%	2,037	92,107
Liberty	12,328	$40,262,526	$3,265.94	0.76%	4,729	305,365
Lincoln	1,698	$5,484,122	$3,229.75	0.10%	1,542	46,026
Long	2,977	$10,266,454	$3,448.59	0.18%	1,680	69,437
Lowndes	24,025	$95,515,135	$3,975.66	1.48%	6,913	651,808
Lumpkin	4,425	$15,008,635	$3,391.78	0.27%	3,012	123,697
Macon	4,413	$21,785,265	$4,936.61	0.27%	2,667	144,222
Madison	5,527	$19,303,768	$3,492.63	0.34%	2,688	151,639
Marion	2,163	$8,435,441	$3,899.88	0.13%	1,594	57,699
McDuffie	6,570	$22,793,414	$3,469.32	0.40%	2,251	178,074
McIntosh	2,798	$7,503,375	$2,681.69	0.17%	1,748	77,788
Meriwether	6,365	$23,665,554	$3,718.08	0.39%	3,769	161,651
Miller	1,846	$8,216,486	$4,450.97	0.11%	1,300	58,245
Mitchell	7,119	$27,531,620	$3,867.34	0.44%	2,810	209,587
Monroe	4,292	$17,628,575	$4,107.31	0.26%	2,953	117,522
Montgomery	2,203	$7,456,935	$3,384.90	0.14%	1,845	66,954
Morgan	3,206	$9,536,595	$2,974.61	0.20%	2,707	76,717
Murray	8,981	$25,968,357	$2,891.48	0.55%	2,975	242,631
Muscogee	41,807	$159,495,807	$3,815.05	2.57%	7,581	1,093,691
Newton	18,363	$52,724,596	$2,871.24	1.13%	7,392	407,254
Oconee	2,560	$8,561,427	$3,344.31	0.16%	1,973	61,580
Oglethorpe	2,591	$8,891,068	$3,431.52	0.16%	1,746	69,816
Paulding	12,808	$36,856,444	$2,877.61	0.79%	6,746	261,234
Peach	6,053	$19,052,378	$3,147.59	0.37%	2,808	145,023
Pickens	4,488	$18,017,647	$4,014.63	0.28%	3,378	125,560
Pierce	4,695	$18,905,261	$4,026.68	0.29%	2,419	152,940
Pike	2,607	$9,196,293	$3,527.54	0.16%	2,398	64,442
Polk	10,034	$37,078,827	$3,695.32	0.62%	4,318	303,593
Pulaski	2,259	$8,894,970	$3,937.57	0.14%	1,513	71,649

FY 2006 Medicaid Distribution by County						
County	**Patients***	**Net Payments****	**Net Payment Per Patient**	**Percent of Total Population**	**Providers**	**Claims Paid**
Putnam	3,927	$11,543,622	$2,939.55	0.24%	2,758	95,868
Quitman	722	$1,895,709	$2,625.64	0.04%	938	15,390
Rabun	2,739	$11,885,110	$4,339.22	0.17%	2,212	90,854
Randolph	2,416	$10,760,815	$4,453.98	0.15%	1,457	75,412
Richmond	50,603	$225,214,833	$4,450.62	3.11%	5,885	1,309,005
Rockdale	14,695	$41,153,313	$2,800.50	0.90%	6,430	301,914
Schley	1,082	$2,779,096	$2,568.48	0.07%	1,031	29,255
Screven	4,251	$16,734,938	$3,936.71	0.26%	2,334	127,572
Seminole	2,847	$10,510,586	$3,691.81	0.17%	1,461	85,836
Spalding	15,774	$56,914,129	$3,608.10	0.97%	6,136	372,164
Stephens	6,088	$24,489,788	$4,022.63	0.37%	3,281	198,132
Stewart	1,501	$7,207,987	$4,802.12	0.09%	1,408	48,676
Sumter	10,315	$39,554,227	$3,834.63	0.63%	3,270	312,525
Talbot	1,711	$5,392,997	$3,151.96	0.11%	1,574	44,451
Taliaferro	543	$1,613,830	$2,972.06	0.03%	929	15,990
Tattnall	5,509	$24,988,027	$4,535.86	0.34%	2,763	178,494
Taylor	2,543	$10,270,546	$4,038.75	0.16%	2,416	78,379
Telfair	3,624	$17,371,275	$4,793.40	0.22%	2,569	124,893
Terrell	3,397	$11,777,792	$3,467.12	0.21%	1,446	92,046
Thomas	12,784	$60,982,709	$4,770.24	0.78%	4,289	361,947
Tift	10,665	$37,789,524	$3,543.32	0.65%	3,354	286,632
Toombs	8,952	$37,876,745	$4,231.09	0.55%	3,448	276,760
Towns	1,503	$8,672,370	$5,770.04	0.09%	1,667	50,009
Treutlen	2,012	$8,052,546	$4,002.26	0.12%	1,651	65,549
Troup	16,830	$60,567,394	$3,598.78	1.03%	6,126	448,527
Turner	3,172	$12,832,554	$4,045.57	0.19%	1,848	94,002
Twiggs	2,492	$9,567,489	$3,839.28	0.15%	1,947	66,233
Union	3,315	$14,707,662	$4,436.70	0.20%	2,441	97,717
Upson	6,752	$27,308,552	$4,044.51	0.41%	3,480	196,167
Walker	13,302	$50,876,845	$3,824.75	0.82%	3,411	375,626
Walton	12,346	$40,568,912	$3,286.00	0.76%	6,251	305,798
Ware	11,243	$47,835,907	$4,254.73	0.69%	3,621	359,544
Warren	1,943	$7,772,802	$4,000.41	0.12%	1,435	58,030
Washington	5,073	$21,721,005	$4,281.69	0.31%	2,654	165,550
Wayne	7,390	$26,315,277	$3,560.93	0.45%	2,753	210,265
Webster	584	$1,650,324	$2,825.90	0.04%	833	15,968
Wheeler	1,722	$6,922,874	$4,020.25	0.11%	1,373	57,160
White	4,318	$14,023,213	$3,247.62	0.27%	2,618	112,722
Whitfield	20,038	$64,363,907	$3,212.09	1.23%	4,350	488,413
Wilcox	2,439	$11,638,783	$4,771.95	0.15%	1,983	84,912

FY 2006 Medicaid Distribution by County						
County	**Patients***	**Net Payments****	**Net Payment Per Patient**	**Percent of Total Population**	**Providers**	**Claims Paid**
Wilkes	2,699	$9,079,774	$3,364.13	0.17%	1,947	80,762
Wilkinson	2,522	$8,078,832	$3,203.34	0.15%	1,953	62,086
Worth	5,416	$16,981,777	$3,135.48	0.33%	2,362	141,872
Unique Count Totals	**1,628,759**	**$6,153,084,521**	**$3,777.77**	**100.00**	**50,947**	**44,635,881**

**Patients do not sum to the Unique Count Total due to missing information associated with some claim records and because of patient movement between counties.*

**Based on dates of payment from July to June for each fiscal year. Does not reflect member incurred costs (i.e. the date on which the service was performed), because member services provided in a given fiscal year are not necessarily paid in the same fiscal year. For example, a member service may have been provided during FY 2006 and the claim paid during FY 2007.. Net payments will not match fiscal year expenditures. Net payments reflect the actual claims for member services before any adjustments or offsets. The net payments associated with claim records that are missing certain demographic data are spread based on the distribution of net payments for existing claims for the county profile.

Appendix B – Nursing Home Upper Payment Limit (UPL) Payments

The Upper Payment Limits (UPL) program provides financial support to eligible hospitals and nursing homes. Eligible providers receive reimbursement to fill the gap between what Medicaid paid and what Medicare would have paid for medical services. The state must provide matching funds to cover its share of this gap, the federal government, through the Georgia's Medicaid matching percentage covers the rest. In Georgia the state match is generated by local governments that fund public hospitals in the form of an intergovernmental transfer (IGT). The state uses the IGT to match and draw down available federal UPL funds. UPL payments are then made back to the eligible hospital or nursing home.

Nursing Home	Upper Payment Limit Payment	InterGovernmental Transfer Amount
Allen Hall	$968,048	$382,960
Appling Convalescent Center	$941,202	$370,834
Appling Nursing Home	$286,885	$113,033
Avalon Health and Rehabilitation Center	$1,041,182	$410,226
Bel Arbor Health Care	$1,644,129	$647,787
BJC Medical Center Nursing Home	$896,058	$353,047
Bolingreen Nursing Home	$1,186,253	$467,384
Brentwood Terrace Health Care Center	$1,795,868	$707,572
Bryant Nursing Center	$952,155	$375,149
Calhoun Nursing Home	$539,275	$212,474
Chaplinwood Nursing Home	$1,062,233	$418,520
Chatuge Regional Nursing Home	$515,918	$203,272
Cherry Blossom Health Care	$1,252,290	$493,402
Coastal Manor	$716,956	$282,481
Cornerstone Health and Rehabilitation Center	$2,678,821	$1,055,455
Crestview Health and Rehab Center	$4,639,762	$1,828,066
Crisp Regional Nursing and Rehab Center	$369,459	$145,567
Dawson Manor	$1,215,452	$478,888
Dublinair Health Care and Rehabilitation Center	$2,373,209	$935,044
E. Central Georgia	$1,023,788	$405,011
Early Memorial Nursing Home	$1,439,750	$567,262
Effingham County ECF	$1,659,256	$653,747
Emanuel Medical Center Nursing Home	$31,336	$12,346
Florence Hand Home	$365,207	$143,892
Four County Health Care	$1,183,086	$466,136
Georgia Regional	$598,017	$236,576
Georgia Bapt Meriwether Nrsg Hm	$1,023,115	$403,107
Glenvue Nursing Home	$1,606,381	$632,914
Gordon Health Care Center	$1,467,356	$578,138
Gracewood Development Center	$4,669,239	$1,847,151
Gray Nursing Home	$940,524	$370,566
Green Acres Nursing Home	$803,112	$316,426
Greene Point Health Care	$873,555	$344,181

Nursing Home	Upper Payment Limit Payment	InterGovernmental Transfer Amount
Gwinnett Extended Care Center	$695,151	$273,889
Habersham Home	$592,275	$233,356
Heritage Inn of Barnesville	$2,040,820	$804,083
Heritage Inn of Sandersville	$662,619	$261,072
Joe Anne Burgin Nursing Home	$692,096	$272,686
Kentwood	$748,906	$295,069
Lakeview Development Center	$491,312	$194,363
Laurel Park Nursing Home	$550,273	$216,808
Lee County Health Care	$951,772	$374,998
Lillian G. Carter Nursing Center	$1,299,781	$512,114
Lynn Haven Nursing Home	$1,592,508	$627,448
Marion Memorial Nursing Home	$582,461	$229,490
Meadows Nursing Center	$27,699	$10,913
Memorial Manor Nursing Home	$528,779	$208,339
Miller Nursing Home	$714,384	$281,467
Mitchell Convalescent Center	$218,309	$86,014
Montezuma Health Care Center	$1,079,936	$425,495
Muscogee Manor and Rehab Center	$3,453,763	$1,360,783
New Horizons - NORTH	$727,616	$286,681
New Horizons - WEST	$972,918	$383,330
Northwest GA Reg.	$1,424,132	$563,387
Oak View Home	$1,484,325	$584,824
Oakview Nursing and Rehab Center	$1,604,900	$632,331
Oconee Health Care	$574,237	$226,249
Palemon Gaskins Mem Nsg Home	$111,374	$43,881
Palmetto Place	$650,676	$257,407
Parkside at Hutcheson Medical Center	$1,123,365	$442,606
Pecan Manor	$880,264	$348,232
Pelham Parkway Nursing Home	$793,022	$312,451
Phoenix Center	$1,128,027	$446,247
Piedmont Hall	$976,599	$386,343
Pierce County Nursing Home	$58,701	$23,128
Providence Healthcare of Sparta	$564,060	$222,240
Providence Healthcare of Thomaston	$1,503,643	$592,435
Riverside Nursing Center Of Thomaston	$805,032	$317,183
Rosehaven	$1,078,776	$426,764
Satilla Care Center	$208,046	$81,970
Seasons Health and Rehabilitation Center, The	$3,397,715	$1,338,700
Shady Acres Convalescent Center	$2,825,700	$1,113,326
Southland Nursing Home	$1,792,437	$706,220
Southwestern Development Center	$723,777	$286,326
Sparta Health Care	$1,110,608	$437,580

Nursing Home	Upper Payment Limit Payment	InterGovernmental Transfer Amount
St. Mary's Convalescent Center	$1,144,008	$450,739
Starcrest of Cartersville	$1,802,719	$710,271
Taylor County Health Care	$994,637	$391,887
The Retreat	$231,304	$91,134
Thomson Manor Nursing Home	$3,195,744	$1,259,123
Toombs Nursing Home	$1,618,002	$637,493
Traditions Health and Rehab Center	$3,436,181	$1,353,855
Treutlen County Nursing Home	$570,751	$224,876
Twin Fountains Home	$1,385,324	$545,818
Twin Oaks Convalescent Center	$1,482,806	$584,226
Union County Nursing Home	$921,681	$363,142
Washington Co. Ext Care Facility	$618,698	$243,767
Wellstar Paulding Nursing Center	$1,834,072	$722,624
Westwood Nursing Facility	$2,236,721	$881,268
Winthrop Manor Nursing Home	$1,307,513	$515,160
Total	**$108,981,832**	**$42,962,225**

Appendix C –

FY 2006 Disproportionate Share Hospital Payment by Hospital and County

The following chart shows the FY 2006 Disproportionate Share Hospital (DSH) interim payment and intergovernmental transfer (IGTs) amounts made to hospitals participating in the DSH program. DSH IGTs involve a transfer of funds between the governmental entity that owns an eligible public hospital and the state of Georgia. DCH uses this money to draw down the federal Medicaid funds to help reimburse hospitals for their uncompensated Medicaid and indigent care. Since private hospitals cannot provide an IGT, the state provides the matching funds for eligible private hospital to participate in DSH.

FY 2006 Disproportionate Share Hospital (DSH) Interim Payments and Intergovernmental Transfers by Hospital and County

Hospital Name	County	Interim Payment	InterGovernmental Transfer Amount
Appling Hospital	Appling	$297,743	$117,311
Athens Regional Medical Center	Clarke	$4,003,486	$1,577,373
Atlanta Medical Center	Fulton	$1,645,060	0
Bacon County Hospital	Bacon	$311,074	$122,563
Barrow Community Hospital	Barrow	$486,346	0
BJC Medical Center	Jackson	$465,544	$183,424
Bleckley Memorial Hospital	Bleckley	$261,948	$103,208
Brooks County Hospital	Brooks	$392,090	$154,483
Burke Medical Center	Burke	$148,303	$58,431
Calhoun Memorial Hospital	Calhoun	$122,865	$48,409
Camden Medical Center	Camden	$1,931,698	$761,089
Candler County Hospital	Candler	$784,136	$308,950
Charlton Memorial Hospital	Charlton	$432,832	$170,536
Chatuge Regional Hospital	Towns	$109,611	$43,187
Chestatee Regional Hospital	Lumpkin	$215,751	0
Children's Healthcare of Atlanta at Egleston	DeKalb	$2,489,706	0
Children's Healthcare of Atlanta at Scottish Rite	Fulton	$3,244,550	0
Clinch Memorial Hospital	Clinch	$260,314	$102,564
Cobb Memorial Hospital	Franklin	$224,317	0
Coffee Regional Medical Center	Coffee	$2,363,304	$931,142
Colquitt Regional Medical Center	Colquitt	$727,282	$286,549
Crawford Long Hospital of Emory University	Fulton	$2,055,041	0
Crisp Regional Hospital	Crisp	$1,528,282	$602,143
DeKalb Medical Center	DeKalb	$4,768,001	$1,878,592
Dodge County Hospital	Dodge	$807,717	$318,240
Donalsonville Hospital, Inc.	Seminole	$450,385	0
Dorminy Medical Center	Ben Hill	$460,281	$181,351
Early Memorial Hospital	Early	$579,883	$228,474
East Georgia Regional Medical Center	Bulloch	$228,056	0
Elbert Memorial Hospital	Elbert	$191,419	$75,419
Emanuel Medical Center	Emanuel	$604,991	$238,366
Emory Dunwoody Medical Center	DeKalb	$1,086,202	0

FY 2006 Disproportionate Share Hospital (DSH) Interim Payments and Intergovernmental Transfers by Hospital and County			
Hospital Name	**County**	**Interim Payment**	**InterGovernmental Transfer Amount**
Evans Memorial Hospital	Evans	$606,406	$238,924
Fairview Park Hospital	Laurens	$200,309	0
Flint River Community Hospital	Macon	$70,404	0
Floyd Medical Center	Floyd	$5,408,933	$2,131,120
Grady General Hospital	Grady	$890,326	$350,788
Grady Memorial Hospital	Fulton	$65,652,142	$25,866,944
Habersham County Medical Center	Habersham	$538,023	$211,981
Hamilton Medical Center	Whitfield	$1,759,369	0
Hart County Hospital	Hart	$175,575	$69,177
Higgins General Hospital	Haralson	$798,677	$314,679
Houston Medical Center	Houston	$1,532,710	$603,888
Hughes Spalding Children's Hospital	Fulton	$1,091,734	$430,143
Hutcheson Medical Center	Catoosa	$1,759,067	$693,072
Irwin County Hospital	Irwin	$629,357	$247,967
Jasper Memorial Hospital	Jasper	$271,964	$107,154
Jeff Davis Hospital	Jeff Davis	$478,362	$188,475
Jefferson Hospital	Jefferson	$341,183	$134,426
Jenkins County Hospital	Jenkins	$217,013	$85,503
John D. Archbold Memorial Hospital	Thomas	$2,422,517	$954,472
Liberty Regional Medical Center	Liberty	$753,818	$297,004
Louis Smith Memorial Hospital	Lanier	$376,701	$148,420
McDuffie Regional Medical Center	McDuffie	$178,869	$70,474
Meadows Regional Medical Center	Toombs	$1,892,189	$745,522
Medical Center of Central Georgia	Bibb	$9,891,836	$3,897,383
Medical College of Georgia Hospitals and Clinics	Richmond	$11,769,431	$4,637,156
Memorial Health University Medical Center	Chatham	$7,824,833	$3,082,984
Memorial Hospital of Adel	Cook	$229,441	0
Memorial Hospital of Bainbridge	Decatur	$933,078	$367,633
Miller County Hospital	Miller	$392,688	$154,719
Minnie G. Boswell Memorial Hospital	Greene	$168,531	0
Mitchell County Hospital	Mitchell	$809,717	$319,028
Monroe County Hospital	Monroe	$412,559	$162,548
Morgan Memorial Hospital	Morgan	$356,795	$140,577
Mountain Lakes Medical Center	Rabun	$230,329	0
Mountainside Medical Center	Pickens	$258,210	0
Northeast Georgia Medical Center	Hall	$5,653,984	$2,227,670
Oconee Regional Medical Center	Baldwin	$1,645,016	$648,136
Peach Regional Medical Center	Peach	$396,755	$156,321
Phoebe Putney Memorial Hospital	Dougherty	$6,929,092	$2,730,062
Phoebe Worth Medical Center	Worth	$388,496	0

FY 2006 Disproportionate Share Hospital (DSH) Interim Payments and Intergovernmental Transfers by Hospital and County			
Hospital Name	**County**	**Interim Payment**	**InterGovernmental Transfer Amount**
Polk Medical Center	Polk	$928,127	$365,682
Putnam General Hospital	Putnam	$445,379	$175,479
Redmond Regional Medical Center	Floyd	$185,328	0
Rockdale Medical Center, Inc.	Rockdale	$1,683,416	$663,266
Roosevelt Warm Springs Institute for Rehabilitation	Meriwether	$237,076	$93,408
Satilla Regional Medical Center	Ware	$1,347,866	$531,059
Screven County Hospital	Screven	$224,182	$88,328
Smith Northview Hospital	Lowndes	$219,091	0
South Fulton Medical Center	Fulton	$1,002,477	0
South Georgia Medical Center	Lowndes	$3,083,065	$1,214,728
Southeast Georgia Regional Medical Center	Glynn	$2,101,144	$827,851
Southern Regional Health Center	Clayton	$1,358,384	$535,203
Southwest Georgia Regional Medical Center	Randolph	$304,737	$120,066
Stephens County Hospital	Stephens	$1,372,563	$540,790
Stewart Webster Hospital	Stewart	$77,325	0
Sumter Regional Hospital, Inc.	Sumter	$1,655,155	$652,131
Sylvan Grove Hospital	Butts	$491,753	$193,751
Tanner Medical Center/Carrollton	Carroll	$1,628,193	$641,508
Tanner Medical Center/Villa Rica	Carroll	$1,288,909	$507,830
Tattnall Community Hospital	Tattnall	$159,890	0
Taylor Regional Hospital	Pulaski	$201,161	0
The Medical Center	Muscogee	$7,554,756	$2,976,574
Tift Regional Medical Center	Tift	$1,579,790	$622,437
Union General Hospital	Union	$112,008	$44,131
University Hospital	Richmond	$3,034,303	$1,195,515
Upson Regional Medical Center	Upson	$1,060,329	$417,770
Walton Medical Center	Walton	$242,949	0
Warm Springs Medical Center	Meriwether	$988,379	$389,421
Washington County Regional Medical Center	Washington	$1,001,250	$394,493
Wayne Memorial Hospital	Wayne	$1,127,200	$444,117
West Georgia Medical Center	Troup	$1,551,081	$611,126
Wheeler County Hospital	Wheeler	$247,780	0
Wills Memorial Hospital	Wilkes	$352,536	$138,899
Total		**$208,862,239**	**$75,291,717**

Appendix D – PeachCare for Kids™ Distribution by County

The following chart details patient and payment data for each of the counties in Georgia.

FY 2006 PeachCare for Kids™ Distribution by County					
County	**Patients***	**Net Payments****	**Net Payment Per Patient**	**Percent of Total Population**	**Claims Paid**
Appling	919	$1,019,936.85	$1,109.83	0.32%	13,910
Atkinson	474	$607,832.89	$1,282.35	0.17%	7,517
Bacon	602	$750,821.39	$1,247.21	0.21%	9,989
Baker	132	$114,228.25	$865.37	0.05%	1,672
Baldwin	732	$760,175.60	$1,038.49	0.26%	8,047
Banks	897	$925,942.61	$1,032.27	0.32%	13,802
Barrow	2,987	$3,608,171.46	$1,207.96	1.05%	38,667
Bartow	4,043	$4,681,672.52	$1,157.97	1.43%	56,129
Ben Hill	816	$955,722.11	$1,171.23	0.29%	11,862
Berrien	894	$1,004,876.39	$1,124.02	0.32%	13,395
Bibb	3,684	$3,819,099.38	$1,036.67	1.30%	39,048
Bleckley	330	$523,892.95	$1,587.55	0.12%	4,990
Brantley	933	$965,730.54	$1,035.08	0.33%	12,741
Brooks	702	$702,712.25	$1,001.01	0.25%	9,554
Bryan	1,122	$1,433,461.86	$1,277.60	0.40%	17,570
Bulloch	1,592	$2,008,875.91	$1,261.86	0.56%	24,301
Burke	927	$1,083,050.48	$1,168.34	0.33%	14,104
Butts	858	$911,625.15	$1,062.50	0.30%	9,779
Calhoun	220	$252,722.37	$1,148.74	0.08%	2,853
Camden	1,201	$1,313,896.92	$1,094.00	0.42%	17,188
Candler	406	$531,802.69	$1,309.86	0.14%	6,773
Carroll	3,674	$4,915,422.67	$1,337.89	1.30%	53,502
Catoosa	1,475	$1,622,661.96	$1,100.11	0.52%	21,795
Charlton	421	$589,494.92	$1,400.23	0.15%	6,147
Chatham	5,922	$6,689,047.42	$1,129.53	2.09%	75,415
Chattahoochee	121	$136,675.77	$1,129.55	0.04%	1,592
Chattooga	763	$809,559.62	$1,061.02	0.27%	10,646
Cherokee	5,924	$7,482,260.60	$1,263.04	2.09%	79,366
Clarke	1,973	$2,075,731.41	$1,052.07	0.70%	25,427
Clay	105	$140,091.12	$1,334.20	0.04%	1,540
Clayton	10,783	$10,018,619.95	$929.11	3.80%	107,344
Clinch	339	$436,835.00	$1,288.60	0.12%	5,312
Cobb	18,355	$18,727,601.77	$1,020.30	6.47%	200,703
Coffee	1,779	$2,215,114.60	$1,245.15	0.63%	28,603
Colquitt	1,859	$2,031,407.66	$1,092.74	0.66%	26,383
Columbia	2,747	$2,979,080.93	$1,084.49	0.97%	38,642
Cook	932	$1,065,851.99	$1,143.62	0.33%	13,624

FY 2006 PeachCare for Kids™ Distribution by County					
County	**Patients***	**Net Payments****	**Net Payment Per Patient**	**Percent of Total Population**	**Claims Paid**
Coweta	2,849	$3,843,358.40	$1,349.02	1.00%	34,832
Crawford	569	$612,012.74	$1,075.59	0.20%	7,174
Crisp	753	$944,524.37	$1,254.35	0.27%	11,859
Dade	484	$574,798.57	$1,187.60	0.17%	7,136
Dawson	922	$907,415.12	$984.18	0.33%	13,103
Decatur	1,249	$1,368,882.64	$1,095.98	0.44%	18,126
DeKalb	19,559	$18,276,432.87	$934.43	6.90%	188,079
Dodge	641	$689,820.41	$1,076.16	0.23%	9,762
Dooly	419	$435,987.86	$1,040.54	0.15%	6,270
Dougherty	2,397	$2,268,265.50	$946.29	0.85%	31,025
Douglas	4,577	$5,160,847.21	$1,127.56	1.61%	55,489
Early	460	$624,474.43	$1,357.55	0.16%	6,383
Echols	211	$249,639.08	$1,183.12	0.07%	3,170
Effingham	1,911	$2,155,312.37	$1,127.85	0.67%	26,882
Elbert	820	$816,518.72	$995.75	0.29%	10,727
Emanuel	953	$1,241,802.29	$1,303.05	0.34%	16,188
Evans	415	$497,054.02	$1,197.72	0.15%	6,384
Fannin	1,373	$1,688,091.60	$1,229.49	0.48%	21,292
Fayette	1,819	$1,670,126.73	$918.16	0.64%	18,447
Floyd	3,037	$3,680,344.52	$1,211.84	1.07%	44,043
Forsyth	3,079	$3,794,977.24	$1,232.54	1.09%	38,710
Franklin	997	$1,150,961.70	$1,154.42	0.35%	15,162
Fulton	14,796	$13,507,545.67	$912.92	5.22%	137,748
Gilmer	1,386	$1,739,829.34	$1,255.29	0.49%	21,857
Glascock	131	$183,881.30	$1,403.67	0.05%	2,012
Glynn	2,191	$2,766,640.35	$1,262.73	0.77%	29,049
Gordon	2,136	$2,413,218.84	$1,129.78	0.75%	31,624
Grady	1,100	$1,095,377.66	$995.80	0.39%	14,991
Greene	452	$424,059.83	$938.19	0.16%	4,883
Gwinnett	30,768	$34,065,630.68	$1,107.18	10.85%	361,199
Habersham	1,860	$1,802,003.41	$968.82	0.66%	25,342
Hall	7,093	$8,348,261.60	$1,176.97	2.50%	98,577
Hancock	152	$100,906.57	$663.86	0.05%	1,603
Haralson	1,268	$1,737,831.80	$1,370.53	0.45%	18,945
Harris	703	$796,415.48	$1,132.88	0.25%	9,279
Hart	926	$846,292.20	$913.92	0.33%	11,579
Heard	510	$652,206.49	$1,278.84	0.18%	7,937
Henry	5,898	$5,831,658.12	$988.75	2.08%	63,895
Houston	3,041	$3,472,007.43	$1,141.73	1.07%	39,175
Irwin	445	$513,161.46	$1,153.17	0.16%	6,183

FY 2006 PeachCare for Kids™ Distribution by County					
County	**Patients***	**Net Payments****	**Net Payment Per Patient**	**Percent of Total Population**	**Claims Paid**
Jackson	2,184	$2,368,462.58	$1,084.46	0.77%	29,862
Jasper	537	$556,033.45	$1,035.44	0.19%	6,755
Jeff Davis	845	$1,050,592.07	$1,243.30	0.30%	13,894
Jefferson	709	$742,543.82	$1,047.31	0.25%	10,025
Jenkins	363	$423,840.73	$1,167.61	0.13%	5,367
Johnson	266	$371,795.01	$1,397.73	0.09%	4,455
Jones	1,001	$1,132,094.16	$1,130.96	0.35%	13,229
Lamar	575	$503,743.37	$876.08	0.20%	6,460
Lanier	360	$395,789.02	$1,099.41	0.13%	5,422
Laurens	1,516	$1,894,943.13	$1,249.96	0.53%	23,664
Lee	1,161	$1,307,666.10	$1,126.33	0.41%	17,469
Liberty	1,250	$1,492,561.39	$1,194.05	0.44%	16,839
Lincoln	350	$409,009.98	$1,168.60	0.12%	5,053
Long	352	$441,625.39	$1,254.62	0.12%	5,420
Lowndes	3,263	$3,889,516.74	$1,192.01	1.15%	47,261
Lumpkin	1,088	$1,153,824.26	$1,060.50	0.38%	15,676
Macon	429	$479,038.99	$1,116.64	0.15%	5,907
Madison	1,234	$1,406,448.67	$1,139.75	0.44%	17,453
Marion	258	$276,396.40	$1,071.30	0.09%	3,402
McDuffie	927	$1,248,592.69	$1,346.92	0.33%	13,494
McIntosh	510	$617,884.79	$1,211.54	0.18%	7,470
Meriwether	710	$903,836.61	$1,273.01	0.25%	9,124
Miller	249	$250,544.21	$1,006.20	0.09%	3,252
Mitchell	1,046	$1,489,853.49	$1,424.33	0.37%	17,850
Monroe	776	$757,482.41	$976.14	0.27%	9,185
Montgomery	439	$584,316.01	$1,331.02	0.15%	7,018
Morgan	754	$789,879.37	$1,047.59	0.27%	9,443
Murray	2,000	$2,258,947.89	$1,129.47	0.71%	31,310
Muscogee	3,925	$4,810,150.71	$1,225.52	1.38%	49,716
Newton	3,834	$4,110,390.12	$1,072.09	1.35%	43,553
Oconee	794	$894,869.74	$1,127.04	0.28%	11,279
Oglethorpe	575	$545,670.95	$948.99	0.20%	6,966
Paulding	4,849	$5,148,419.69	$1,061.75	1.71%	57,843
Peach	770	$1,088,064.66	$1,413.07	0.27%	9,412
Pickens	1,270	$1,563,532.45	$1,231.13	0.45%	19,085
Pierce	929	$1,126,051.77	$1,212.11	0.33%	14,898
Pike	592	$712,160.76	$1,202.97	0.21%	7,731
Polk	1,736	$2,025,671.08	$1,166.86	0.61%	25,435
Pulaski	275	$334,685.78	$1,217.04	0.10%	4,117
Putnam	637	$785,887.53	$1,233.73	0.22%	8,005

FY 2006 PeachCare for Kids™ Distribution by County					
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Quitman	70	$57,113.70	$815.91	0.02%	766
Rabun	889	$1,255,586.10	$1,412.36	0.31%	15,947
Randolph	260	$308,912.34	$1,188.12	0.09%	3,573
Richmond	4,267	$4,459,170.31	$1,045.04	1.50%	53,887
Rockdale	2,797	$2,736,935.53	$978.53	0.99%	30,320
Schley	239	$333,431.41	$1,395.11	0.08%	4,464
Screven	514	$529,974.06	$1,031.08	0.18%	6,983
Seminole	379	$430,895.62	$1,136.93	0.13%	6,063
Spalding	1,707	$1,744,983.26	$1,022.25	0.60%	18,738
Stephens	1,060	$1,686,960.51	$1,591.47	0.37%	18,195
Stewart	126	$156,119.01	$1,239.04	0.04%	1,907
Sumter	922	$1,439,539.35	$1,561.32	0.33%	16,250
Talbot	196	$223,992.18	$1,142.82	0.07%	2,307
Taliaferro	54	$42,083.11	$779.32	0.02%	632
Tattnall	693	$884,095.36	$1,275.75	0.24%	10,655
Taylor	281	$518,407.64	$1,844.87	0.10%	4,761
Telfair	440	$481,295.00	$1,093.85	0.16%	5,866
Terrell	291	$303,376.58	$1,042.53	0.10%	4,046
Thomas	1,724	$1,841,000.48	$1,067.87	0.61%	21,840
Tift	1,671	$1,755,666.61	$1,050.67	0.59%	24,156
Toombs	1,231	$1,567,197.48	$1,273.11	0.43%	18,857
Towns	463	$481,144.75	$1,039.19	0.16%	6,440
Treutlen	317	$401,247.89	$1,265.77	0.11%	4,118
Troup	2,221	$2,586,973.40	$1,164.78	0.78%	29,442
Turner	444	$539,900.71	$1,215.99	0.16%	7,107
Twiggs	308	$315,676.72	$1,024.92	0.11%	3,645
Union	950	$1,113,608.92	$1,172.22	0.33%	13,475
Upson	939	$1,110,215.47	$1,182.34	0.33%	14,512
Walker	1,697	$1,881,268.20	$1,108.58	0.60%	25,006
Walton	3,128	$3,523,623.79	$1,126.48	1.10%	39,612
Ware	1,511	$1,678,958.61	$1,111.16	0.53%	21,495
Warren	197	$353,633.51	$1,795.09	0.07%	3,139
Washington	537	$516,828.57	$962.44	0.19%	7,271
Wayne	1,004	$1,048,373.14	$1,044.20	0.35%	14,310
Webster	101	$107,286.60	$1,062.24	0.04%	1,489
Wheeler	258	$352,034.41	$1,364.47	0.09%	3,882
White	1,184	$1,432,026.86	$1,209.48	0.42%	17,362
Whitfield	5,463	$5,404,777.91	$989.34	1.93%	76,753
Wilcox	295	$418,514.26	$1,418.69	0.10%	5,334
Wilkes	390	$427,538.53	$1,096.25	0.14%	5,268

FY 2006 PeachCare for Kids™ Distribution by County					
County	**Patients***	**Net Payments****	**Net Payment Per Patient**	**Percent of Total Population**	**Claims Paid**
Wilkinson	312	$317,817.82	$1,018.65	0.11%	3,653
Worth	957	$1,292,029.13	$1,350.08	0.34%	14,978
Unique Count Totals	**283,610**	**$323,263,317.39**	**$1,139.82**	**100.00**	**3,714,224**

Acronym Index: page reference indicates only one occurrence