Form CMS-R-211

MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: Georgia
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: David Cook	Position/Title: Commissioner, Georgia Department of Community Health
Name:	Position/Title:
Name:	Position/Title:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, Baltimore, Maryland 21244.

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1 ☑ Obtaining coverage that meets the requirements for a separate child health program (Section 2103); OR

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX); OR

1.1.3. ☐ A combination of both of the above.

1.2 ☑ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3 ☑ Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

Effective date: September 1, 1998

Implementation date: November 1, 1998

State Plan Amendment #1: (Reinstatement policy)
Submitted: January 6, 2000
Approved: April 20, 2000
Effective: October 1, 1999

State Plan Amendment #2: (Clarification of Renewal Process)
Submitted: January 31, 2001
Approved: June 1, 2001
Effective: July 1, 2001

State Plan Amendment #3: (Increase eligibility to 235% FPL)
Submitted: February 6, 2001
Approved: June 1, 2001
Effective: July 1, 2000

Amendment #4: (Change in enrollment process to cover the month of application)
Submitted: June 15, 2001
Approved: August 31, 2001
Effective: April 1, 2001

Amendment #5: (Exempt families spending in excess of 5% of income on private coverage from the crowd-out waiting period)
Submitted: September 28, 2001
Approved: February 11, 2002
Effective: October 1, 2001

Amendment #6: (Compliance Amendment)
Submitted: July 30, 2002
Approved: January 17, 2003
Effective: August 1, 2002

Amendment #7: (Cost-sharing increase)
Submitted: July 3, 2003
Approved: September 25, 2003
Effective: July 1, 2003

Amendment #8: (Administrative policy changes)
Submitted: July 18, 2003
RESCINDED

Amendment #9: (Change to single late notice)
Submitted: February 13, 2004
Approved: Pending
Effective: January 1, 2004

Amendment #10: (Change to premiums and administrative policy changes)
Submitted: June 21, 2004
Approved: September 17, 2004
Effective: July 1, 2004

Amendment #11: (Change to premium policy, Dental benefit, and Managed Care delivery system)
Submitted: July 7, 2005
Approved: September 30, 2005
Effective: Dental Benefit effective July 1, 2005
Premium Policy effective August 1, 2005
Managed Care delivery system effective January 1, 2006

Amendment #12: (Change Dental Benefit)
Submitted: August 29, 2006
Approved: November 2, 2006
Effective: Dental Benefit effective in accordance with Georgia Families Roll out. Effective June 1, 2006 in Atlanta and Central Region; September 1, 2006 Statewide.

Amendment #13: (Adopt Enrollment Freeze)
Submitted: March 20, 2007
Approved: June 15, 2007
Effective: Close program to new enrollments effective March 11, 2007 and add CMOS Quality assessment fees as a new source of state funds effective March 20, 2007. Updated name change of Georgia Healthy Families to Georgia Families.

Amendment #14: (Implement Full Verification of Income, Citizenship and Identity and Open Enrollment)
Submitted: July 5, 2007
Approved: October 25, 2007
Effective: Require full verification of income, citizenship and identity for all PeachCare applicants and members effective July 1, 2007. Resume

enrollment in program effective July 12, 2007 until enrollment reaches 295,000 children.

Amendment #15: (Grace Period, Income, Citizenship and Identity updates)
Submitted: July 13, 2010
Approved: February 10, 2011
Effective: Grace Period Change effective July 31, 2010
Citizenship Changes effective January 1, 2010
Income documentation changes to further align with Medicaid effective June 1, 2010

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (42 CFR 457.80(a))

Of the 2,219,179 children in the state, Georgia estimates (using the Current Population Survey data from 2000) that 193,558 are without any creditable coverage. Of the 2.03 million who do have creditable coverage, 912,116 (almost half) have coverage through Georgia Medicaid. The 193,558 without coverage includes 141,489 children with income below 235% of the FPL. Of these children, 104,446 could be eligible for the Medicaid program. The other 37,043 are potentially eligible for PeachCare for Kids.

When compared to figures from the 1993-1995 period, the current data show that while the number of children in the state has grown by about 10%, the number of children without coverage has declined by about 40%. Part of this improvement is due to a decrease in the number of Medicaid eligible uninsured children from 39% to 24%, and a decrease in the number of PeachCare eligible uninsured children form 32% to 6%. The remaining uninsured children, whether eligible for PeachCare or Medicaid, will be targeted for enrollment through the state's marketing and outreach efforts.

The estimates of children with creditable coverage in the following table are based on the Current Population Survey and are submitted as requested to allow comparisons to be made between states and on a nationwide basis. The sources of the data are the Current Population Survey for the year 2000, and the combined tape 1994, 1995, 1996 (data for years 1993, 1994, 1995).

Unfortunately at this time we are unable to examine the insurance status of children in Georgia by income level, age, race, and location for the year 2000. The Census has only released a small sample of records for Georgia at this time. Due to the small sample size it is unadvisable to estimate the numbers of uninsured eligible

children within each demographic grouping. The Census is expected to release an expanded sample shortly. Upon release, these figures will be updated.

Calculations were made by William S. Custer, Ph.D. and Patricia Ketsche, Center for Risk Management and Insurance Research, Georgia State University. The sample size for some categories is very small, and the numbers should be used with caution.

Insurance Status of Children in Georgia						
Attributes of Population	**Current Medicaid Enrollees**	**Children without Creditable Coverage***				
		Total	**Eligible for Medicaid**		**Eligible for CHIP**	
TOTAL (2000)	753,114	193,558	104,446	24%	37,043	6%
TOTAL (1993,1994,1995)	759,023	320,243	124,621	39%	102,982	32%
Income Level (1993,1994,1995)						
<100%	**	112,449	112,449	100%	***	0%
100-133%	**	47,928	7,061	15%	40,867	85%
134-185%	**	56,718	5,111	9%	51,607	91%
186-200%	0	10,508	0	0%	10,508	100%
>=200%	0	92,640	0	0%	0	0%
Age (1993,1994,1995)						
0 to1	107,591	16,037	7,744	48%	***	0%
1 through 5	256,618	67,165	28,938	43%	14,901	22%
6 through 12	243,021	119,112	38,634	32%	54,199	46%
13 through 18	151,793	117,929	49,305	42%	33,882	29%
Race/Ethnicity (1993,1994,1995)						
Black, non-Hispanic	429,690	164,500	74,298	50%	54,455	33%
Hispanic	32,006	14,009	7,844	60%	3,113	22%
White, non-Hispanic	262,585	135,817	42,281	35%	43,619	32%
Other****	34,742	5,827	198	3%	1,795	31%
Location (1993,1994,1995)						
MSA	425,174	181,618	67,993	37%	53,843	30%
non-MSA	333,849	138,625	56,627	41%	49,138	35%

*The percentages of children without creditable coverage do not add to 100% in the

age, race/ethnicity and location categories because children over 200% of poverty are not included, since they were not eligible for Medicaid or for PeachCare for Kids.
**The current Medicaid information system does not have income data on non-SSI Medicaid eligibles. However, Medicaid has no enrollees at income levels above 185% of poverty
***CPS did not identify any individuals in this cell.
****Other racial/ethnic groups cannot be reported for GA from CPS due to very small sample size.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

Currently, Georgia's public child health insurance plans include PeachCare for Kids™ and the Medicaid program administered by the Georgia Department of Community Health (DCH), Division of Medical Assistance (DMA). The Department has several approaches to identifying and enrolling eligible children. These approaches are described in the following paragraphs.

PeachCare for Kids™

PeachCare for Kids' outreach effort was launched in September 1998. Outreach initiatives have included a wide array of mass-media and local grassroots efforts. PeachCare for Kids has had massive advertising, in both English and Spanish, through television, radio, newspaper, and outdoor billboard and transit advertising. In 2001 and 2002, PeachCare has teamed up with WSB Channel 2's, Atlanta's ABC affiliate, Family 2 Family Community Program. Through this partnership, PeachCare for Kids is able to participate in hundreds of family-oriented community events in the metro Atlanta area. PeachCare also benefits from the extensive public service campaigns.

In 2000, the Department created a "minigrant" program to facilitate grassroots efforts to educate targeted populations about PeachCare for Kids and Medicaid. The grantee organizations were diverse in the populations they served, including African-American, Hispanic, Asian and rural communities. An evaluation of the grantees showed a 16% increase in applications submitted over other similar counties during the same time, and a 19% increase in applications for the targeted populations.

In 2000, 2001, and 2002, the Department has teamed up with the Department of Education, Division of School Nutrition Services to distribute flyers, in English and Spanish, to each student during Back-to-School registration. The Right from the Start Medicaid (RSM) outreach staff worked

with many elementary schools to be on site promoting PeachCare for Kids and Medicaid to the parents.

PeachCare for Kids™, RSM, March of Dimes and Kmart stores partnered in 1999 and 2000 to promote PeachCare for Kids and Medicaid. In 1999, outreach workers were at each Kmart store on the Saturday before Halloween educating parents while their children shopped for costumes and treats. In 2000, the outreach workers returned to Kmarts on the Saturday before school started to talk to parents as they were getting their kids ready for the new school year.

The Department has created a simple, one-page mail-in application for PeachCare for Kids, available in English, Spanish, Vietnamese, Chinese, Korean and Somalian. The application is distributed by request through the PeachCare for Kids call center and throughout the state in many hospitals, provider offices, Department of Families and Children offices, health departments, and libraries.

In 2001, the Department launched *www.peachcare.org*, a web-based application designed to provide parents with instant access to complete the enrollment process. In its first year, applications have been received for nearly 40,000 children through the website. The site has also been successful reaching families of Medicaid-eligible children. Nearly half of all web-based applicants have been eligible for the Medicaid program. The advantages of the website are numerous. It eliminates mail delays. It provides parents with instant confirmation that the application has been received and gives parents an estimation of potential eligibility. The website also generates a list of participating primary care physicians to assist parents in the selection of a doctor for their child.

Division of Family and Children Services (DFCS)

The Department of Medical Assistance has an interagency agreement with the Department of Human Resources (DHR) to provide, through its Division of Family and Children Services (DFCS), Medicaid eligibility determinations for all Medicaid coverage groups other than SSI cash assistance. For pregnant women and children, these coverage groups include: Low Income Medicaid, Medically Needy, Right From the Start Medicaid (RSM - Georgia's poverty level Medicaid program), and the Katie Beckett Deeming Waiver programs. These programs are offered in conjunction with other entitlement programs and supportive services that are offered by DFCS. DFCS is also

responsible for Food Stamps, Temporary Assistance for Needy Families (TANF), Child Protective Services and Foster Care. The Medicaid application process is coordinated with that for cash assistance and employment related services available through TANF. Children in families seeking these services also have their Medicaid eligibility determined. The State of Georgia has 159 counties. Each county has at least one DFCS office, and some counties have multiple sites for Medicaid eligibility intake. Some workers from these local DFCS offices are assigned to Federally Qualified Health Centers (FQHCs) and Disproportionate Share Hospitals.

While the bulk of the state's Medicaid determinations are made locally at the county DFCS offices, the RSM Outreach Project is an aggressive outreach program targeted at enrolling uninsured and underinsured poverty level pregnant women and children in Medicaid and PeachCare. This project operates under a separate interagency agreement between the Department of Community Health and the Department of Human Resources. The eligibility workers who are part of this project are housed in locations other than the local DFCS offices.

Covering Kids

In 1999, the State of Georgia received a grant through The Robert Wood Johnson Foundation's *Covering Kids* initiative. Covering Kids conducted outreach for Medicaid, PeachCare for Kids and the Georgia Partnership for Caring program through schools, businesses, community-based organizations, health care and child care providers and the faith community.

Public Health Departments and Federally Qualified Health Centers

DCH also coordinates Medicaid enrollment efforts with the activities of the Division of Public Health, a part of the Department of Human Resources. Across the state, perinatal case management services and the Medicaid application process are linked. At the public health departments and federally qualified health centers, a pregnant woman can apply for Presumptive Medicaid eligibility, and begin receiving prenatal services immediately. As part of this process, the pregnant woman applies for RSM Medicaid to ensure ongoing Medicaid eligibility. When the pregnant woman applies for RSM, any children in the family are also included on the application form and the form with the children's names are routed to DFCS for a determination of their eligibility along with that of the pregnant woman.

The Division of Public Health, through its local health departments, and the federally qualified health centers administer the Special Nutritional Program for Women, Infants and Children (WIC). This program provides nutritious food to supplement the regular diet of pregnant women, breast-feeding women, infants, and children under age five who meet state income standards. Generally, on the initial visit to either of these facilities, the pregnant woman is certified for Presumptive Medicaid eligibility, applies for regular Medicaid for herself and her children, and receives WIC for herself and any children under the age of five (5).

In both the public health departments and the federally qualified health centers, outreach workers are stationed or visit on a weekly basis to process applications for regular ongoing RSM Medicaid for pregnant women and children. In addition to Medicaid certifications, they provide information on the services covered under the program and provide information on other supportive services in the communities. When appropriate they make referrals to these services as well.

Medicaid and PeachCare Participating Providers

Medicaid participating providers who treat newborn children, such as family practitioners, pediatricians and hospitals, play an integral part in enrolling uninsured children in the Medicaid and PeachCare programs. These providers have direct access to a special unit located with DCH's fiscal agent. From this unit, they can obtain a Medicaid ID number for any child under the age of one year, born to and living with a Medicaid eligible woman, who is not yet enrolled in the program. In most instances, the infant is issued a Medicaid ID number shortly after delivery. Once the number is issued, a listing is sent to DFCS for follow-up eligibility. This process has served to reduce barriers to health care for the state's infants.

Providers have been an enthusiastic supporter of PeachCare for Kids since its inception. A month before PeachCare for Kids launched statewide, DMA teamed up with the Georgia Hospital Association for a statewide outreach drive. Each of the approximately 200 hospitals in the state set up booths and housed outreach workers for families to learn about and apply for the new health care coverage program for kids. In 1999, Children's Health Care of Atlanta, the state's largest hospital for children, put its volunteers to work with a massive direct mail campaign to uninsured children who had received care in its facilities. Several other hospital systems have dedicated outreach

efforts to promote PeachCare for Kids, including billboards and fast food trayliners. In addition to large-scale efforts, many individual physicians have referred uninsured patients to www.peachcare.org and made applications available in their office.

Other State Initiatives For Special Needs Children

The following programs are some of the State's own initiatives to provide health care to special needs children. All are administered by the Department of Human Resources, three by the Division of Public Health, two by the Division of Mental Health, Mental Retardation and Substance Abuse and one by an interagency team. As mentioned previously, RSM outreach workers are stationed in many county public health departments or visit on a routine basis to process Medicaid applications. Uninsured children who present to these programs for their services are referred to outreach workers or county DFCS offices to have a Medicaid eligibility determination completed.

Division of Public Health

"Babies Can't Wait"

"Babies Can't Wait" or the Early Intervention Program is Georgia's statewide interagency service delivery system for children from birth to three years who have developmental delays or disabilities. This program guarantees that all children, regardless of their disability, have access to services that will enhance their development. Services are provided by agencies and individuals from both the public and private sectors. Some are offered at no cost. For others, state funds are available to assist families that have been determined unable to pay. Medicaid eligible children may participate in this program.

Children's Medical Services

Children's Medical Services (CMS), formerly the Crippled Children's Program, provides medical care to low income children with disabling conditions or chronic diseases. It also provides specialized health care for certain disorders, e.g., chronic lung disease, craniofacial anomalies, and cystic fibrosis. Eligibility is based on the age of the child (0-21 years), type of medical condition, Georgia residency and annual family income. Some services are covered by Medicaid and Medicaid eligible children may

participate in this program. CMS serves approximately 15,000 to 16,000 children yearly.

Regional Perinatal System

This program is administered by the Division of Public Health with funding provided by the Department of Medical Assistance. It provides medical services for pregnant women and children. The pregnant women's component provides tertiary level care to high risk pregnant women. The neonatal component provides intensive care to infants. The program also provides funds to cover unmet medical costs, including neonatal transport, for infants in families with income of up to 250% of the federal poverty level. Women and children who participate in this program have been determined to be ineligible for Medicaid.

Division of Mental Health, Mental Retardation and Substance Abuse (MH/MR/SA)

Mental Health Services for Children and Adolescents with Severe Emotional Disturbance

Currently some level of services for youth with severe emotional disturbance (SED) is available in all MH/MR/SA service areas. Public services available to the SED population include:

- Outpatient including crisis intervention, case coordination and wraparound services
- In-home crisis services (to avoid hospitalization or other out-of-home placement)
- Day Treatment (after school, evenings and some weekends)
- Respite
- Therapeutic Foster Care
- Therapeutic Group Home Care

The target population are youth with a primary diagnosis of a mental health disorder diagnosable under DSM-IV which has lasted a year or is likely to last for at least a year and causes serious functional limitations in at least two or more areas, such as risk of harm to self or others, need for assistance from multiple community agencies, behavior leading to demand for public intervention, etc. Uninsured children who present to these programs for their services are referred for a Medicaid eligibility determination, but services are provided to uninsured or underinsured children on a sliding fee scale and are

not denied due to inability to pay.

Substance Abuse Services for Adolescents

The public services available to youth with substance abuse diagnoses are: student assistance programs for early identification, day treatment, family treatment and adolescent residential treatment. These services are not currently available in all areas of the state. Uninsured children who present to these programs for their services are referred for a Medicaid eligibility determination, but services are provided to uninsured or underinsured children on a sliding fee scale and are not denied due to inability to pay.

Department of Human Resources

MATCH

The DHR Multi-Agency Team for Children (MATCH) arranges care for Georgia's children with severe emotional disturbances who need mental health treatment in residential settings. The program is administered through the Division of Family and Children Services Treatment Services Unit. The mission of MATCH is to enable children to lead the most stable and productive lives possible. More than one hundred local interagency teams operate throughout the state to identify children. The locate team reviews the child's history and response to the mental health services that have been provided. If the child's need for mental health care and safety is too great for the community to manage, then the child is referred to state MATCH.

State MATCH reviews the information from the community and makes placement decisions based upon the child's needs, recommendations from the local community, placement availability, and available funds.

MATCH services are funded through a combination of state and federal funds. The program operates within an established budget so not every child who needs help can be funded. Services are provided through a variety of private and public residential treatment providers. If the child is eligible for Medicaid, Medicaid will pay for the treatment portion of the cost of the placement, but not the room and board, educational and other costs. DHR state funds are used to pay for any uncovered cost of the placement for uninsured and underinsured youth.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

The State of Georgia has one public-private program designed to provide health care to uninsured children; however, this program does not offer "creditable coverage." The PeachCare for Kids and Medicaid program's eligibility processes have a significant role in the efforts of the program. The application process for The Georgia Partnership for Caring Program begins with the RSM Outreach Project worker.

Georgia Partnership for Caring Foundation

The Georgia Partnership for Caring Foundation (GPCF) was established in 1994 and represents a unique partnership between state government and the private sector. The mission of GPCF is to establish a free health care referral program for Georgians who cannot afford private health insurance but are not eligible for governmental medical assistance such as PeachCare for Kids, Medicaid or Medicare. Funding has been provided by grants from individuals, associations, and the Departments of Human Resources and Community Health.

The program includes the limited voluntary services of physicians, nurse practitioners, dentists, ophthalmologists, optometrists, physician's assistants, hospitals, pharmacists, pharmaceutical manufacturers, and many health provider groups and agencies. These volunteers are not paid for their services or products, but are committed to assisting Georgians obtain access to needed health care coverage. The program is available in about three-fifths of Georgia's counties. **GPCF is not insurance coverage.** It is not for emergencies or urgent care situations. Application processing time averages 1 month. As previously stated, RSM outreach workers are involved in the referral and application process for GPCF. They perform the screening function to determine that individuals who are referred to GPCF are not eligible for Medicaid. To date, over 4,300 individuals have participated in this program.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage.
(Previously 4.4.5.)
(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

As part of its effort to decrease the number of uninsured children, Georgia targets children who are under the age of nineteen (19), who have family income that is at or below 235% of the Federal Poverty Level (FPL), and who do not have other creditable health coverage. PeachCare for Kids health benefit coverage is provided to these children through a state child health insurance program that is administered by the DCH, the same agency that administers the Medicaid program.

PeachCare enrolls only eligible, targeted low-income children because marketing, outreach and eligibility determination efforts will be completely coordinated for PeachCare for Kids and Medicaid, so that those children who are eligible for Medicaid will be enrolled in Medicaid rather than PeachCare. The marketing and outreach efforts target all children at or below 235% of the FPL. RSM outreach workers have available all pertinent information for both Medicaid and PeachCare for Kids. The outreach workers have a variety of program information on both creditable and non-creditable coverage and other ways to access health care services. The order of priority for the outreach workers is first to locate uninsured children, second to determine eligibility for Medicaid, third to provide information and assistance regarding enrollment in PeachCare for Kids, fourth to provide information on the Georgia Partnership for Caring Foundation, and DHR public health care programs and services. The marketing and outreach efforts are coordinated with community based organizations and health care providers.

Applications for PeachCare for Kids contain the information necessary to determine eligibility for Medicaid as well as for PeachCare for Kids. Applications are mailed to and processed by a Third Party Administrator (TPA) at a centralized location. As part of the eligibility determination process, the TPA screens applications for Medicaid eligibility before determining eligibility for PeachCare for Kids. If a child or children on the application appear to possibly be eligible for Medicaid, the application for that child or those children is processed by RSM workers. The processing provides for investigation and verification of both the financial and non-financial requirements for the Medicaid program. If the child or children are eligible for Medicaid, Medicaid enrollment will occur, rather than eligibility determination for PeachCare for Kids. If the RSM worker finds the child or children ineligible for Medicaid, then the TPA

determines eligibility for PeachCare for Kids.

If the child or children are found to be income eligible and under age 5, they are notified of their eligibility to enroll in the Georgia Women, Infants and Children (WIC) program. Because the Georgia WIC program serves a significant number of children younger than 5 years, it is often called on to assess immunization status and screen for child health problems. Prospective participants in the WIC program must undergo a variety of nutritional screenings to determine eligibility. These include assessments of height, weight, diet, and health history.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

The PeachCare for Kids™ legislation mandates that "Any health care provider who is enrolled in the Medicaid program shall be deemed to be enrolled in the program." Therefore, the current Medicaid health assistance delivery and utilization control system is the system used for PeachCare for Kids. Service delivery is accomplished through a variety of relationships and agreements with private medical providers and state agencies.

Briefly, the current system includes a statewide primary care case management program, Georgia Better Health Care (GBHC) and a regional managed care structure, Georgia Health Families (GF). The PeachCare for Kids legislation allows the DCH to contract with licensed care management organizations (CMOs) as a condition of receiving coverage under the program. As a condition of participation, all enrolled providers in each category of service must be fully licensed and/or certified under all applicable state and federal laws to perform the services provided to participants.

Georgia Families

PeachCare for Kids™ members will be enrolled in a commercially licensed care management organization (CMO) that is contracted by DCH. Membership in Georgia Families (GF) is mandatory for all PeachCare for Kids™ members and most pregnant women and children eligible for Medicaid.

Through GF, each CMO contracts with primary care physicians, specialists and other providers to deliver and coordinate health care services for PeachCare for Kids members. The CMO receives a per member per month capitation rate for providing and coordinating members' health care services, regardless of whether the member is seen.

Five key goals of the program are to (1) improve the health care status of enrolled populations (2) Establish a "provider home" for Members through its use of assigned Primary Care Providers (PCPs) (3) Establish contractual accountability for access to, and quality of, healthcare (4) Slow the rate of growth in PeachCare costs (4) Implement an intelligent health system where members have accurate, timely knowledge of their health needs, access to the best information about how to maintain their health, knowledge of who and where to go if they have health needs, and an assurance that their health providers will be using best practices based on the most recent understanding of outcomes based medicine.

Members are given an opportunity to select a CMO in his or her area as well as a PCP within that CMO. For those who do not make a selection, a computer algorithm is used to assign a member to a CMO. Conditioned on continued eligibility, all members will be enrolled in a CMO plan for a period of twelve (12) consecutive months. The member has 90 days to change CMO plans before the continuous enrollment period or lock-in period begins.

The contracted CMOs must assure that PeachCare for Kids members are offered freedom of choice in selecting a PCP. Each contracted CMO includes in its network of PCPs physicians who routinely provide primary care services in the areas of Family Practice, General Practice, or Internal Medicine. Also, Nurse Practitioners Certified (NP-C) specializing in Family Practice or Pediatrics may enroll as PCPs. Finally, Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) may be included as PCPs.

In the event a PCP is auto-assigned, the member may change to another PCP by making a PCP selection and requesting the change. The contracted enrollment broker handles the CMO assignment functions (both self-selection and auto-assignment).

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4) (42CFR 457.490(b))

Reimbursement Limitations

The federal government allows DCH to place appropriate limits in regard to medical necessity and utilization control. Reimbursement limitations such as prior approval requirements, service limitations, non-covered procedures, and eligibility limitations are used by DCH to guarantee appropriate utilization of funds.

GF

The CMO provides assistance to Members and Providers to ensure the appropriate utilization of resources, using the following program components: prior authorization and pre- certification, prospective review, concurrent review, retrospective review, ambulatory review, second opinion, discharge planning and case management. Specifically, the CMO has written Utilization Management Policies and Procedures that:

- Include protocols and criteria for evaluating Medical Necessity, authorizing services, and detecting and addressing over-utilization and under-utilization. Such protocols and criteria comply with Federal and State laws and regulations.
- Address which services require PCP Referral; which services require Prior-Authorization and how requests for initial and continuing services are processed, and which services will be subject to concurrent, retrospective or prospective review.
- Describe mechanisms in place that ensure consistent application of review criteria for authorization decisions.
- Require that all Medical Necessity determinations be made in accordance with DCH's Medical Necessity definition.

Georgia Families also provides care coordination, case management, disease management, clinical outcome studies, and physician incentive programming. Specifically, each CMO must provide individual needs assessment and diagnostic assessments; develop individual treatment plans, as necessary, based on the needs assessment; establish treatment objectives; monitor outcomes; and maintain a

process to ensure that treatment plans are revised as necessary. The CMOs must also guarantee a strategy is in place to ensure that all Members and/or family members or guardians are involved in treatment planning.

The CMO is required to develop disease management programs for individuals with chronic conditions such as diabetes and asthma. Additionally, each CMO must have programs for at least two additional conditions including: Perinatal case management, obesity, hypertension, Sickle cell disease; or HIV/AIDS.

By looking at other State's experiences with Medicaid and SCHIP managed care, DCH expects that the GF program will save State and Federal dollars by appropriately controlling utilization, improving access to primary care services and enhancing continuity of care. Numerous studies support the theory that improving members' access to primary care and providing appropriate disease management standards reduce the rate of growth in expenditures and ultimately result in savings through reduced likelihood of hospitalization for serious illnesses, reduced number of unnecessary visits to emergency rooms for non-emergency care, and reduced visits to specialists for care that could be provided through a primary care physician.

Treatment Residential Intervention Services Utilization Controls

The DHR Multi-Agency Team for Children (MATCH) Program, which was described under Section 2.2.1, is an interagency funding mechanism and prior approval, utilization review and discharge planning process for the purchase of out-of-community residential mental health treatment for SED children and adolescents. If a child is eligible for MATCH he or she is not eligible for GF. If the child is Medicaid or PeachCare for Kids eligible, Medicaid covers the treatment portion of the cost of the placement, but not the room and board, educational and other costs. As previously described, local MATCH groups staff and coordinate care for the most difficult to serve SED youth. If all family and local resources are exhausted and the youngster has treatment needs that cannot be met, the local MATCH sends an application to the state level MATCH to be staffed for a treatment placement. The local process includes a gate-keeping function as well as a coordination function.

At the state level, applications are reviewed and given prior approval or are denied based on an evaluation system which includes an assessment score based on the child's past and current clinical and social history, diagnosis, involvement with and services from other child-serving agencies and an assessment score based on the child's behavior and functioning. If approved and placed for residential treatment,

the MATCH group (state level with local level participation) performs an on-site utilization review every six months from admission to discharge. Clinical, behavioral and functional outcomes are measured on a regular basis and are used as part of the utilization review process, along with interviews with the children and their clinicians. At the end of each utilization review an estimated discharge date is set that goes into effect unless clinical indicators change and an extension is sought and approved.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

4.1.1. ☑ **Geographic area served by the Plan:** Georgia's Title XXI plan is available statewide to children in all 159 Georgia counties

4.1.2. ☑ **Age:** The plan will be available to children 0 through 18 years of age. If the child is otherwise eligible, coverage will continue through the month of his/her nineteenth birthday.

4.1.3. ☑ **Income:** Eligible children will have family income that is at or below 235% of the federal poverty level and will not be eligible for Medicaid.

4.1.4. ☑ **Resources (including any standards relating to spend downs and disposition of resources):** There is no resource test.

4.1.5. ☑ **Residency (so long as residency requirement is not based on length of time in state):** Georgia residency is required. Residency is based on current circumstances. There is no requirement that a child must live in Georgia a specified length of time prior to application.

4.1.6. ☑ **Disability Status (so long as any standard relating to disability status does not restrict eligibility):** No child will be denied eligibility based on disability status.

4.1.7. ☑ **Access to or coverage under other health coverage:** A child will be denied eligibility if it is determined that he or she: 1) is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; or 2) is eligible for Medicaid; or 3) is a member of a family that is eligible for health benefits coverage under a State health benefit plan based on a family member's employment with a public agency in the State; or 4)

voluntarily dropped coverage under an employer plan during the past six months. (Voluntary termination of coverage does NOT include the following: employer cancellation of the entire group plan; loss of eligibility due to parent's layoff, resignation of parent from employment, employment termination; leave of absence without pay, or reduction of work hours; cancellation of a private health plan in which cost-sharing is expected to exceed 5% of the family's annual income; cancellation of an individual within a family policy due to meeting lifetime maximum of benefits; or cancellation of COBRA or an individual insurance policy. A child born during the six month waiting period would be eligible.) The CHIP application will contain questions about current and past coverage under group health plans and family member's employment with State agencies. State employment information will be verified through monthly matches with the State Merit System and the Board of Regents. In addition, as claims are paid, if the providers report coverage under other health plans, eligibility will be terminated if the coverage meets any of the four criteria listed above.

4.1.8. ☑ **Duration of eligibility:** With the approval of the PeachCare application, a child will be eligible for twelve months as long as eligibility criteria continue to be met. The family will be notified of its responsibility to report changes in income, residency or health insurance coverage. There will be monthly matches with the Medicaid MMIS to ensure that Title XXI children have not been certified for Medicaid. At the end of the twelve-month eligibility period, the family will be sent a letter detailing the information on the family's account pertinent to eligibility. The family will be required to report any changes to the information and provide verification of all sources of income at this time. Eligibility will be redetermined for another twelve-month period so long as the family provides the required documentation within the requested timeframe.

4.1.9. ☑ **Other standards (identify and describe):** Consistent with 42 CFR 457.340(b), PeachCare does not require Social Security numbers for any applicant.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 457.320(b))

4.2.1. ☑ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☑ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. ☑ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2)) (42CFR 457.350)

PeachCare for Kids utilizes the same income methodologies as are used for its Right from the Start Medicaid program (Title XIX Poverty Level Group).

DCH contracts with a Third Party Administrator (TPA) who is responsible for receiving PeachCare applications, screening for Medicaid eligibility, determining PeachCare eligibility, processing monthly premium payments and coordinating coverage between PeachCare and Medicaid for applicant children who qualify for either the Title XIX or Title XXI program.

Customer Service is a major component of the functions required of the Third Party Administrator. The TPA's telephone customer service staff is expected to furnish PeachCare applications upon request, provide assistance to potential applicants who may have questions about the program in general or who may need assistance in the completion of the form. The following process is used to establish eligibility and continuing enrollment:

APPLICATION

PeachCare for Kids has a single-page mail-in application form and a web-based enrollment process that is available for families to quickly and easily apply for health care coverage for their children. Both the mail-in and web-based applications can be used to enroll children in either Medicaid or PeachCare for Kids, depending on each child's eligibility. The PeachCare application gathers information about the applicant children and their parents. Requested information includes:

- Documentation of amount, frequency and source of earned and unearned income
- Amount, frequency and source of child care expenses
- Health insurance status of family members
- Current address
- U. S. Citizen/Lawful Alien Status of children

VERIFICATION OF INCOME, CITIZENSHIP/LEGAL RESIDENCY AND IDENTITY

Beginning July 1, 2007, all PeachCare applicants are required to provide verification of income, citizenship/legal residency and identity. The application

directs families to send in the most recent proof of all earned and unearned income sources. The following documentation is requested:

A. **Earned Income** - money anyone in the household received from providing a service.
   - Weekly pay – (4) weeks of pay stubs (one week after the other)
   - Bi-Weekly pay – (2) pay stubs received every other week (one after the other)
   - Semi-Monthly – (2) pay stubs received two times a month (one after the other)
   - Monthly – (2) pay stubs received one time a month (one month after another)
   - Yearly – Federal Tax Form
   - Paid in cash-letter from Employer provided by an Officer of the Company. Must be provided on Company letterhead.

   Self-employment documents:
   - business ledger/receipts
   - tax forms- 1040, 1040A, 1040EZ
   - bank deposits
   - applicant/recipient's signed statement if neither of the above is available.

   NOTE: Assume that any deductions taken on a tax return or business record is allowable by the Internal Revenue Service.

   Document the case record as to why federal income tax returns or business records were not used if the A/R's statement was accepted as verification.

B. **Unearned Income –**money anyone in the household received from any agencies, parents or relatives, friends, or any other sources.
   a. SSI or SSA – Current year or most recent award letter
   b. Unemployment check – (4) weeks of pay stubs (one week after the other) or award letter
   c. Workman's Compensation – letter from insurance company stating amount received and how often received, provide contact name and number
   d. Child Support (paid through court) – court papers or letter stating amount of income received and how often it is received.
   e. Contributions – written statement from the person who gives you money. Provide name, address, and contact number. Provide amount received and how often received
   f. Child Support (paid directly to custodial parent) – written statement from

the parent who pays the child support to the applicant/recipient-. Provide the name, address, and contact number. Provide amount received and how often received.

g. Other Unearned Income – letter from the source stating amount received and how often received. Provide name, address, and contact number or (4) weeks of pay stubs (one week after the other)

C. **Citizenship/Identity/Legal Residency**

Georgia follows the DRA provisions regarding citizenship/nationality and as of January 1, 2010, has updated its process to comply with section 211 of CHIPRA. PeachCare for Kids applicants must declare their citizenship or alien status and provide documentation, as described in CFR 435.407, that verify they are in an eligible status to receive benefits. As required in CHIPRA section 211, the State will not deny, delay, reduce, or terminate benefits while the documentation is gathered during a reasonable opportunity period. If an applicant is determined to be eligible for PeachCare for Kids, but citizenship documentation is still outstanding, the State will continue to provide PeachCare for Kids benefits until the end of the reasonable opportunity period.

For determining deemed newborn status, the TPA performs a data match with Georgia's MMIS files to determine whether the applicant's mother was Medicaid eligible per the date of the child's birth. If citizenship cannot be verified through data match with vital records or MMIS records, the applicant is then required to submit a form of acceptable documentation as outlined in CFR 435.407.

The following groups of individuals are exempt from the requirements:

- Individuals receiving SSI benefits under title XVI of the Act.
- Individuals entitled to or enrolled in any part of Medicare.
- Individuals receiving disability insurance benefits under section 223 of the Act or monthly benefits under section 202 of the Act, based on the individual's disability (as defined in section 223(d) of the Act).
- Individuals who are in foster care and who are assisted under Title IV-B of the Act, and individuals who are recipients of foster care maintenance or adoption assistance payments under Title IV–E of the Act.

Types of acceptable documentary evidence of citizenship.

For purposes of this section, the term "citizenship" includes status as a "national of the United States" as defined by section 101(a)(22) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(22)) to include both citizens of the United States and non-citizen nationals of the United States.

(a) Primary evidence of citizenship and identity. The following evidence must be accepted as satisfactory documentary evidence of both identity and citizenship:

(1) A U.S. passport. The Department of State issues this. A U.S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation .Note: Spouses and children were sometimes included on one passport through 1980. U.S. passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented. Exception: Do not accept any passport as evidence of U.S. citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.

(2) A Certificate of Naturalization (DHS Forms N–550 or N–570.) Department of Homeland Security issues for naturalization.

(3) A Certificate of U.S. Citizenship (DHS Forms N–560 or N–561.) Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.

(4) A valid State-issued driver's license, but only if the State issuing the license requires proof of U.S. citizenship before issuance of such license or obtains a social security number from the applicant and verifies before certification that such number is valid and assigned to the applicant who is a citizen. (This provision is not effective until such time as a State makes providing evidence of citizenship a condition of issuing a driver's license and evidence that the license holder is a citizen is included on the license or in a system of records available to the Medicaid agency. The State must ensure that the process complies with this statutory provision in section 6036 of the Deficit Reduction Act of 2005. CMS will monitor compliance of States implementing this provision.).

(5) A Tribal document issued by a federally recognized Indian tribe evidencing membership, enrollment in, or affiliation with such Tribe is satisfactory documentary evidence of an individual’s U.S. citizenship or nationality.

(b) Secondary evidence of citizenship. If primary evidence from the list in paragraph (a) of this section is unavailable, an applicant or recipient should provide satisfactory documentary evidence of citizenship from the list specified in this section to establish citizenship and satisfactory documentary evidence from paragraph (e) of this section to establish identity, in accordance with the rules specified in this section.

(1) A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986 (NMI local time)). A State, at its option, may use a cross match with a State vital statistics agency to document a birth record. The birth record document may be issued by the State,

Commonwealth, Territory, or local jurisdiction. It must have been recorded before the person was 5 years of age. A delayed birth record document that is recorded at or after 5 years of age is considered fourth level evidence of citizenship. (Note: If the document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. Collective naturalization occurred on certain dates listed for each of the territories.) The following will establish U.S. citizenship for collectively naturalized individuals:

(2) A Certification of Report of Birth (DS–1350). The Department of State issues a DS–1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth, based on the information shown on the FS–240. When the birth was recorded as a Consular Report of Birth (FS–240), certified copies of the Certification of Report of Birth Abroad (DS–1350) can be issued by the Department of State in Washington, DC. The DS–1350 contains the same information as that on the current version of Consular Report of Birth FS–240. The DS–1350 is not issued outside the U.S.

(3) A Report of Birth Abroad of a U.S. Citizen (Form FS–240). The Department of State consular office prepares and issues this. A Consular Report of Birth can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside the U.S. to U.S. military personnel usually have one of these.

(4) A Certification of birth issued by the Department of State (Form FS–545 or DS–1350). Before November 1, 1990, Department of State consulates also issued Form FS–545 along with the prior version of the FS–240. In 1990, U.S. consulates ceased to issue Form FS–545. Treat an FS–545 the same as the DS–1350.

(5) A U.S. Citizen I.D. card. (This form was issued until the 1980s by INS. Although no longer issued, holders of this document may still use it consistent with the provisions of section 1903(x) of the Act.) INS issued the I–179 from 1960 until 1973. It revised the form and renumbered it as Form I–197. INS issued the I–197 from 1973 until April 7, 1983. INS issued Form I–179 and I–197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.

(6) A Northern Mariana Identification Card (I–873). (Issued by the DHS to a collectively naturalized citizen of the United States who was born in the Northern Mariana Islands before November 4, 1986.) The former Immigration and Naturalization Service (INS) issued the I–873 to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986. The card is no longer issued, but those previously issued are still valid.

(7) A final adoption decree showing the child's name and U.S. place of birth. The adoption decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized and the State in which the child was born will not release a birth certificate prior to final adoption, a statement from a State approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.

(8) Evidence of U.S. Civil Service employment before June 1, 1976. The document must show employment by the U.S. government before June 1, 1976. Individuals employed by the U.S. Civil Service prior to June 1, 1976 had to be U.S. citizens.

(9) U.S. Military Record showing a U.S. place of birth. The document must show a U.S. place of birth (for example a DD–214 or similar official document showing a U.S. place of birth.)

(10) A data verification with the Systematic Alien Verification for Entitlements (SAVE) Program for naturalized citizens. A State may conduct a verification with SAVE to determine if an individual is a naturalized citizen, provided that such verification is conducted consistent with the terms of a Memorandum of Understanding or other agreement with the Department of Homeland Security (DHS) authorizing verification of claims to U.S. citizenship through SAVE, including but not limited to provision of the individual's alien registration number if required by DHS.

(11) Child Citizenship Act. Adopted or biological children born outside the United States may establish citizenship obtained automatically under section 320 of the Immigration and Nationality Act (8 U.S.C. 1431), as amended by the Child Citizenship Act of 2000 (Pub. L. 106–395, enacted on October 30, 2000). The State must obtain documentary evidence that verifies that at any time on or after February 27, 2001, the following conditions have been met:

(i) At least one parent of the child is a United States citizen by either birth or naturalization (as verified under the requirements of this Part);

(ii) The child is under the age of 18;

(iii) The child is residing in the United States in the legal and physical custody of the U.S. citizen parent;

(iv) The child was admitted to the United States for lawful permanent residence (as verified under the requirements of 8 U.S.C. 1641 pertaining to verification of qualified alien status); and

(v) If adopted, the child satisfies the requirements of section 101(b) (1) of the Immigration and Nationality Act (8 U.S.C. 1101(b) (1) pertaining to international

adoptions (admission for lawful permanent residence as IR–3 (child adopted outside the United States)), or as IR–4 (child coming to the United States to be adopted) with final adoption having subsequently occurred).

(c) Third level evidence of citizenship. Third level evidence of U.S. citizenship is documentary evidence of satisfactory reliability that is used when both primary and secondary evidence is unavailable. Third level evidence may be used only when the applicant or recipient alleges being born in the U.S. A second document from paragraph (e) of this section to establish identity must also be presented:

(1) Extract of a hospital record on hospital letterhead established at the time of the person's birth that was created 5 years before the initial application date and that indicates a U.S. place of birth. (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.) Do not accept a souvenir “birth certificate” issued by the hospital.

(2) Life, health, or other insurance record showing a U.S. place of birth that was created at least 5 years before the initial application date that indicates a U.S. place of birth. (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.) Life or health insurance records may show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.

(3) Religious record recorded in the U.S. within 3 months of birth showing the birth occurred in the U.S. and showing either the date of the birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization. CAUTION: In questionable cases (for example, where the child's religious record was recorded near a U.S. international border and the child may have been born outside the U.S.), the State must verify the religious record and/or document that the mother was in the U.S. at the time of birth.

(4) Early school record showing a U.S. place of birth. The school record must show the name of the child, the date of admission to the school, the date of birth, a U.S. place of birth, and the name(s) and place(s) of birth of the applicant's parents.

(d) Fourth level evidence of citizenship. Fourth level evidence of citizenship is documentary evidence of the lowest reliability. Fourth level evidence should only be used in the rarest of circumstances. This level of evidence is used only when primary, secondary and third level evidence is unavailable. With the exception of the affidavit process described in paragraph (d) (5) of this section, the applicant may only use fourth level evidence of citizenship if alleging a U.S. place of birth. In addition, a second document establishing identity must be presented as described in paragraph (e) of this section.

(1) Federal or State census record showing U.S. citizenship or a U.S. place of birth. (Generally for persons born 1900 through 1950.) The census record must also show the applicant's age. Note: Census records from 1900 through 1950 contain certain citizenship information. To secure this information the applicant, recipient or State should complete a Form BC–600, Application for Search of Census Records for Proof of Age. Add in the remarks portion “U.S. citizenship data requested.” Also add that the purpose is for PeachCare for Kids™ eligibility. This form requires a fee.

(2) One of the following documents that show a U.S. place of birth and was created at least 5 years before the application for PeachCare for Kids™ (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.) This document must be one of the following and show a U.S. place of birth:

(i) A delayed U.S. public birth record that is recorded more than 5 years after the person's birth.

(ii) Statement signed by the physician or midwife who was in attendance at the time of birth.

(3) Institutional admission papers from a nursing facility, skilled care facility or other institution created at least 5 years before the initial application date that indicates a U.S. place of birth. Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.

(4) Medical (clinic, doctor, or hospital) record created at least 5 years before the initial application date that indicates a U.S. place of birth. (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.)

Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. (Note: An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.)

(5) Written affidavit. Affidavits should ONLY be used in rare circumstances. If the documentation requirement needs to be met through affidavits, the following rules apply:

(i) There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship (the two affidavits could be combined in a joint affidavit).

(ii) At least one of the individuals making the affidavit cannot be related to the applicant or recipient. Neither of the two individuals can be the applicant or recipient.

(iii) In order for the affidavit to be acceptable the persons making them must be able to provide proof of their own citizenship and identity.

(iv) If the individual(s) making the affidavit has (have) information which explains why documentary evidence establishing the applicant's claim or citizenship does not exist or cannot be readily obtained, the affidavit should contain this information as well.

(v) The State must obtain a separate affidavit from the applicant/recipient or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained.

(vi) The affidavits must be signed under penalty of perjury and need not be notarized.

(e) Evidence of identity. The following documents may be accepted as proof of identity and must accompany a document establishing citizenship from the groups of documentary evidence of citizenship in the groups in paragraphs (b) through (d) of this section.

(1) Identity documents described in 8 CFR 274a.2 (b) (1) (v) (B) (1).

(i) Driver's license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color.

(ii) School identification card with a photograph of the individual.

(iii) U.S. military card or draft record.

(iv) Identification card issued by the Federal, State, or local government with the same information included on drivers' licenses.

(v) Military dependent's identification card.

(vi) U.S. Coast Guard Merchant Mariner card.

Note to paragraph (e) (1): Exception: Do not accept a voter's registration card or Canadian driver's license as listed in 8 CFR 274a.2 (b) (1) (v) (B) (1). CMS does not view these as reliable for identity.

(2) The TPA may use a cross match with a Federal or State governmental, public assistance, law enforcement or corrections agency's data system to establish identity if the agency establishes and certifies true identity of individuals. Such agencies may include child support, corrections, including juvenile detention, motor vehicle, or child protective services.

(3) The TPA may also accept three or more documents that together reasonably corroborate the identity of an individual provided such documents have not been used

to establish the individual's citizenship and the individual submitted second or third tier evidence of citizenship. The State must first ensure that no other evidence of identity is available to the individual prior to accepting such documents. Such documents must at a minimum contain the individual's name, plus any additional information establishing the individual's identity. All documents used must contain consistent identifying information. These documents include employer identification cards, high school and college diplomas from accredited institutions (including general education and high school equivalency diplomas), marriage certificates, divorce decrees and property deeds/titles.

(f) Special identity rules for children. For children under 16, a clinic, doctor, hospital or school record may be accepted for purposes of establishing identity. School records may include nursery or daycare records and report cards. If the State accepts such records, it must verify them with the issuing school. If none of the above documents in the preceding groups are available, an affidavit may be used. An affidavit is only acceptable if it is signed under penalty of perjury by a parent, guardian or caretaker relative (as defined in the regulations at 45 CFR 233.90(c) (v) stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided. The affidavit is not required to be notarized. The state may accept an identity affidavit on behalf of a child under the age of 18 in instances when school ID cards and drivers' licenses are not available to the individual in that area until that age.

For Peachcare for Kids™ applicants, the affidavit requirement can be met when the parent attests to the to the child’s identity under penalty of perjury when the application is signed and submitted or certified when the information is entered online.

(g) Special identity rules for disabled individuals in institutional care facilities. The State may accept an identity affidavit signed under penalty of perjury by a residential care facility director or administrator on behalf of an institutionalized individual in the facility. States should first pursue all other means of verifying identity prior to accepting an affidavit. The affidavit is not required to be notarized.

(h) Special populations needing assistance. The state must assist individuals to secure satisfactory documentary evidence of citizenship when because of incapacity of mind or body the individual would be unable to comply with the requirement to present satisfactory documentary evidence of citizenship in a timely manner and the individual lacks a representative to assist him or her.

(i) Documentary evidence. (1) All documents must be either originals or copies certified by the issuing agency. Uncertified copies, including notarized copies, shall not be accepted.

(2) States must maintain copies of citizenship and identification documents in the case record or electronic data base and make these copies available for compliance audits.

(3) States may permit applicants and recipients to submit such documentary evidence without appearing in person at a PeachCare for Kids™ office. States may accept original documents in person, by mail, or by a guardian or authorized representative.

(4) If documents are determined to be inconsistent with pre-existing information, are counterfeit, or altered, States should investigate for potential fraud and abuse, including but not limited to, referral to the appropriate State and Federal law enforcement agencies.

(5) Presentation of documentary evidence of citizenship is a one time activity; once a person's citizenship is documented and recorded in a State database subsequent changes in eligibility should not require repeating the documentation of citizenship unless later evidence raises a question of the person's citizenship. The State need only check its databases to verify that the individual already established citizenship.

(j) Record retention. The State must retain documents in accordance with 45 CFR 74.53.

(k) Reasonable opportunity to present satisfactory documentary evidence of citizenship. Eligible individuals who declare to be U.S. citizens or nationals must be provided a reasonable opportunity to present satisfactory documentation of citizenship or nationality and must be enrolled in coverage pending the reasonable opportunity to document that claim. New applicants are asked to provide citizenship verification after the application is received if they are not exempt from providing documents or there is no data match or other acceptable verification on file. (See §435.930 and §435.911.) Applicants are given up to 90 days to provide documents and their eligibility may be extended as long as they are making a good faith effort to comply. If an individual has not provided satisfactory documentation of citizenship by the end of the reasonable opportunity period, and any extension period, States may terminate that individual's eligibility for Medicaid or CHIP benefits in accordance with Medicaid rules at 42 CFR 435.919 and 42 CFR 431 Subpart E (regarding timely notice and opportunity for a fair hearing).

APPLICATION PROCESSING

Upon receipt of the PeachCare application, the TPA screens the application for potential Medicaid eligibility. Potentially Medicaid eligible cases will be referred to Medicaid once income has been verified. The TPA provides the State Eligibility Specialist with an electronic file of the application for eligibility determination. Since the income verification requirements for PeachCare for Kids are the same as in Medicaid, families will not have to go through the process again unless they report a change in income. The State Eligibility Specialists reports back the eligibility and enrollment status for all referred children. If a child comes back to the TPA as not

Medicaid eligible, the account will not be required to go through income verification. The case will be updated using information provided by the State Eligibility Specialist. For children who are not Medicaid eligible, the TPA determines if net family income (gross income minus disregards) is at or below the 235% federal poverty level; the child is covered by a group health plan (either currently or in the past six months); the child is eligible for health benefits through a family member's employment with a state agency; and if the child is a U.S. citizen or lawfully admitted alien. The TPA is also required to use customer service personnel to follow up on incomplete or unclear information found in the application.

The TPA checks Medicaid's information system for enrollment in the Medicaid program and conducts matches with the State Health Benefit Plan and Board of Regents for enrollment in or eligibility for state-sponsored health benefit plans. If a child is determined to be ineligible for PeachCare for Kids™, the family receives a written notice describing the reason for ineligibility. The notice specifies the reason for the denial (e.g. excess income, age over eighteen years etc.) The notice also specifies the applicant's opportunity to request a reconsideration of the decision and related procedures to accomplish this. This may include submission of additional or clarifying information to allow a review of the application decision. If the applicant is not satisfied with the final decision of the TPA, the case is sent to the Department of Community Health for further review.

If a child is found to be eligible for the PeachCare for Kids™ program, the family receives a PeachCare handbook that describes the program's benefits, instructions on how to submit premium payments and a number to contact the TPA to report changes. The family is also contacted by the Georgia Families (GF) enrollment broker and receives a new enrollment package that explains the GF program and choices about CMO plans in the Member's service region. The enrollment broker also provides information regarding how to access services through the GF CMO selected by, or assigned to the family.

CONTINUING ENROLLMENT

At the time of application approval, the family receives information requiring them to report changes in their income, place of residence or household size to the TPA. If a family reports a decrease in income, verification of all income is required. If the family remains PeachCare eligible and is within 90 days of their annual renewal, the income verification process will be held until that time. The verification request for renewal is sent two months prior to the renewal month. If these changes result in ineligibility, the TPA reviews the account information for potential eligibility for the Medicaid program. If the child is potentially Medicaid eligible, the account information is sent immediately to the State Medicaid staff for review, just as the new applications are handled.

If the child is screened as ineligible for Medicaid and PeachCare for Kids™ based on the information provided, the TPA sends the member a notice of termination and closes the case. The notice specifies the reason for termination (e.g. excess income, etc.) The notice also specifies the applicant's opportunity to request a reconsideration of the decision and related procedures to submit any necessary documentation.

As long as the family continues to meet all eligibility requirements and continues to pay the monthly premium as required, the child(ren) may be eligible for coverage for twelve (12) months.

PREMIUM COLLECTION and REINSTATEMENT PROCESS

• Premiums: Premiums are not required for children ages 0 through 5 years. For children ages 6 through 18, the premiums are detailed in the table below.

FPL	One Child	Family Cap
100-150%	$10.00	$15.00
151-160%	$20.00	$40.00
161-170%	$22.00	$44.00
171-180%	$24.00	$48.00
181-190%	$26.00	$52.00
191-200%	$28.00	$56.00
201-210%	$29.00	$58.00
211-220%	$31.00	$62.00
221-230%	$33.00	$66.00
231-235%	$35.00	$70.00

- The applicant must submit one (1) month's premium, if required, with the application for it to be complete. Once determined eligible, enrollment becomes effective the first day of month the application is determined complete.
- When the applicant is enrolled, the TPA sends a coupon payment book (or other payment mechanism) to the member for use in making regular premium payments. Members may send in premiums for multiple months.
- The first two months' coverage will be funded with state/federal funds. The premium received with the application will be applied to the third month's coverage. With this model, the collection process will be one month ahead of coverage and a member has 45 days after being late with a payment to submit it before coverage is terminated.
- If payments are late, the notification/cancellation process will begin. A letter will be sent before cancellation occurs.

An example follows:

Date	Event
January 6th	Applicant submits complete application.
January 15th	Eligibility is determined.
January 1st	New applicant is enrolled, if eligible. Child is eligible to receive benefits effective January 1st. State/federal dollars fund January's coverage.
February 1st or March 1st.	Child is enrolled in a Care Management Organization (CMO). State/federal dollars fund January and February's coverage.
March 1st	Premium submitted with application is applied to March's coverage. April premium is due.

RENEWAL PROCESS

Sixty days prior to a member's annual anniversary date, PeachCare for Kids™ sends a letter to the family detailing enrollment-related information on the account, including demographic information, children enrolled, and premiums required. Families are notified of the requirement to send in the appropriate verification documents. All families will be required to provide income verification at the annual renewal. A form detailing the required documentation will be sent with the renewal notice. After 3 weeks, a reminder notice will be sent. If a family makes an effort to comply with the verification process prior to the renewal date but needs additional time to provide the necessary documents, a thirty (30) day grace period will be granted. In circumstances where there is intent to comply, an additional (30) days of coverage can be granted manually by a supervisor with the TPA.

Children who remain eligible after the 12-month renewal period will continue coverage. If a change in income or household composition is reported, the account will be reprocessed, similar to a new application with the children being screened for potential Medicaid eligibility, referred if appropriate and then evaluated for continued eligibility for PeachCare.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

☐ Check here if this section does not apply to your state.

Due to a lack of funding, effective March 11, 2007, DCH closed PeachCare for Kids to new enrollment. Receipt of federal funds from FFY2004 and FFY2005 redistribution and supplemental appropriations, provided sufficient resources to open enrollment. On June 14, 2007, a public notice was issued announcing the Department's intent to resume enrollment. Upon DCH Board approval, enrollment resumed effective July 12, 2007. However, enrollment is limited to 295,000 children. The enrollment limit will be reassessed based on the availability of federal funding once SCHIP is reauthorized.

While the cap is in place, enrollment will be monitored weekly. Children will only be activated for coverage when the number of active children is under the cap (295,000). Once the cap is reached, no pending accounts whether they are new or reinstatements will be activated to receive coverage. In the chance occurrence that the cap is reached during the processing of a family group, all eligible children will be given coverage. The eligibility system will include notes and updated correspondence that will be "turned on" if the cap is reached. Public notice on the enrollment cap was issued.

In the event that the enrollment cap of 295,000 children is reached before adequate FFY08 is available and enrollment must be closed again, the following procedures will be in place:

- All correspondence, as well as the PeachCare for Kids website, will be updated to indicate the capped enrollment status and explain what it will mean for members and potential members.

- Members whose participation in the program is suspended for failure to timely pay premiums or for failure to provide required income verification will be precluded from re-enrollment during any closed enrollment period.. These members will receive additional notice by direct mail informing them of their review rights as required by governing regulations.

- Members enrolled and/or determined eligible prior to any closed enrollment period will not be impacted by this particular change so long as they continue to pay premiums timely and comply with any requests for information, including income, citizenship and identity verification.

- Members who are suspended during a closed enrollment period will be able to re-instate their accounts once enrollment is open so long as they bring their account into balance. They will not be required to submit a new application. These accounts will be given a special designation in the eligibility system as “pending closed enrollment.”

- All individuals who submit an application during a closed enrollment period will receive a notice stating that PeachCare for Kids is in closed enrollment but that they will be notified once the program is open to new enrollment.

- PeachCare will continue to accept applications during any closed enrollment period. The TPA would enter them into the system and continue to screen for potential Medicaid eligibility. Upon re-opening of enrollment, applications would continue processing based on date of application or reinstatement request.

Applications received during any enrollment freeze will be retained based on original date of receipt. For children referred to Medicaid, the original date of receipt will be the date the application was received by PeachCare for Kids.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))

PeachCare for Kids utilizes the same income methodologies as are used for its Right from the Start Medicaid program (Title XIX Poverty Level Group), ensuring that there are no gaps or overlap in income eligibility for PeachCare for Kids and Medicaid based on income sources or income disregards.

Upon receipt of the completed application, including verification of income, citizenship and identity, the TPA screens the application for potential Medicaid eligibility. If the child is potentially Medicaid eligible based on verified income, the TPA will route the application to centralized Right from the Start Medicaid (RSM) staff for a determination of Medicaid eligibility. The child's application is entered into SUCCESS, the state's eligibility system for Medicaid, Food Stamps, and TANF. The RSM staff notifies the TPA of the outcome of all applications. The denial reasons and any additional income information are included for the TPA to reevaluate the application for potential eligibility for PeachCare for Kids. If it is determined that the income is within the PeachCare eligibility guidelines, the TPA will enroll the child in PeachCare for Kids without requiring the parent to complete an additional application.

Prior to enrollment, each child who is screened for potential PeachCare eligibility is checked against the Medicaid information system for enrollment in Medicaid. The record of each child is also checked with the State Health Benefit plan and Board of Regents for enrollment of the child or a parent in the state health insurance plan

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

Upon receipt of the application, the TPA screens the application for potential Medicaid eligibility. This process will continue during the PeachCare enrollment freeze. If the child is potentially Medicaid eligible based on reported income, the TPA will route the application to centralized Right from the Start Medicaid (RSM) staff for a determination of Medicaid eligibility. The child's application is entered into SUCCESS, the state's eligibility system for Medicaid, Food Stamps, and TANF. The RSM staff notifies the TPA of the outcome of all applications. The denial reasons and any additional income information are included for the TPA to reevaluate the application for potential eligibility for PeachCare for Kids. If it is determined that the income is within the PeachCare eligibility guidelines, the TPA will enroll the child in PeachCare for Kids without requiring the parent to complete an additional application.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

Since the inception of PeachCare for Kids DCH has worked closely with DFCS to promote the program. The PeachCare for Kids application requests all of the information necessary to determine Medicaid eligibility for a child. DFCS offices use this application for parents who are only seeking coverage for their children. If the children are determined to be ineligible for Medicaid, the caseworker mails the application to PeachCare for processing, without requiring the family to complete an additional form or application.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

4.4.4.1. ☑ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

A child will be denied eligibility if it is determined that he or she: 1) is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; or 2) is eligible for Medicaid; or 3) is a member of a family that is eligible for health benefits coverage under a State health benefit plan based on a family member's

employment with a public agency in the State; or 4) voluntarily dropped coverage under an employer plan during the past six months. (Voluntary termination of coverage does NOT include the following: employer cancellation of the entire group plan; loss of eligibility due to parent's layoff, resignation of parent from employment, employment termination; leave of absence without pay, or reduction of work hours; cancellation of a private health plan in which cost-sharing is expected to exceed 5% of the family's annual income; cancellation of an individual within a family policy due to meeting lifetime maximum of benefits; or cancellation of COBRA or an individual insurance policy. A child born during the six month waiting period would be eligible.) The PeachCare application contains questions about current and past coverage under group health plans and family member's employment with State agencies. The application also contains questions about current and past coverage under group health plans. In addition to self-declaration of other coverage, providers report coverage under other health plans and PeachCare enrollment is terminated if the other coverage meets any of the four criteria listed above.

Children who are currently insured, regardless of the amount of cost-sharing required by their policy will be ineligible for PeachCare for Kids. PeachCare also requires children to be uninsured for six months prior to being eligible to enroll, with exceptions for non-voluntary cancellations of coverage. The application asks parents to report if their children have cancelled insurance within the previous six months and provides an opportunity to report the reason the insurance is cancelled. Once a month, these applications are manually reviewed by PeachCare for Kids staff to determine if the reason given meets one of the exceptions defined in Georgia's state plan (such as change in employment, employer dropped coverage, etc.)

At this time, the application does not ask the parent to report the cost sharing required under their previous private policy. A letter is generated to request such information before a determination of the 5% of household income can be made.

To calculate the cost sharing imposed on a household and the

5% threshold, the enrollment system for PeachCare will have to be modified. With this information stored on the system, PeachCare for Kids will be able to monitor on an ongoing basis the number of letters sent, the number of families providing the information about their previous coverage, and the number of children who are exempted from the waiting period.

Once the revision has been made to collect this data on the application, PeachCare will continue to monitor the number of applications requesting to be exempted from the six-month wait due to the cost of their previous insurance and the number of children who are ultimately exempted.

The average percentage of children who had reported canceling private insurance due to excessive costs was 5.06% of the new eligibles for the 1st Federal Fiscal Quarter in 2002. If there are two consecutive quarters in which the percentage of new eligible who report losing coverage due to cost exceeds 7.5%, the Department of Community Health will increase the cost-sharing threshold from 5% to 7.5% before an exemption from the six-month wait is granted.

4.4.4.2. ☑ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

See 4.4.4.1

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4.4.4.3. ☐ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

N/A

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))

There are no federally-recognized tribes in Georgia. Recognizing that a member of a tribe may re-locate to the State, CHIP will exempt children who are members of federally-recognized tribes from the cost-sharing requirements as stipulated in Section 2103(e)(1)(A). Children who identify themselves as American Indian or Native Alaskan on the CHIP application will be notified that, upon receipt of documentation of tribal membership, they will no longer be required to submit monthly premiums. Any premiums paid after October 1, 1999 will be reimbursed within 45 days of receipt of documentation of tribal membership.

The materials sent to all new enrollees will include information on the cost-sharing exemption for members of federally-recognized American Indian or Native Alaskan tribes to ensure that those not indicating race on the application will be notified of this exemption.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90)

PeachCare for Kids Outreach Through RSM Outreach

Outreach efforts are completely coordinated for PeachCare for Kids and Medicaid, so that those children who are eligible for Medicaid will be reached and enrolled in Medicaid and those children eligible for PeachCare can be reached and enrolled in PeachCare. The outreach efforts target all children at or below 235% of the FPL. To build on and enhance our outreach efforts, Georgia utilizes our nationally recognized RSM outreach strategies for PeachCare for Kids. With over 143 representatives statewide, RSM outreach workers have been specifically trained in doing outreach for PeachCare for Kids. RSM outreach workers have available all pertinent information for both Medicaid and PeachCare for Kids. The outreach workers also have a variety of program information on both creditable and non-creditable coverage and other ways to access health care services. The order of priority for the outreach workers are first to locate uninsured children, second to determine eligibility for Medicaid, third to provide information and assistance regarding enrollment in PeachCare for Kids, fourth to provide information on the Georgia Partnership for Caring Foundation and DHR public health care programs and services. The outreach efforts are also coordinated with community-based organizations, health care providers, GF CMO plans and the enrollment broker.

RSM Outreach Project

The Right From the Start Medicaid (RSM) Project began in July 1993 as Georgia's response to the high infant mortality rate and to improve health care access for all children and pregnant women.

The Department of Community Health (DCH) and the Department of Human Resources (DHR) entered into an agreement to place eligibility workers in community settings. The agreement provides for 143 eligibility workers. This staffs currently have offices in health departments, hospitals, clinics, day care

centers, schools, community action agencies and other locations in the community. A major feature of the program is the availability of staff during non-traditional work hours so that clients may apply for RSM without having to lose time from their jobs or from school. Non-traditional hours are defined as any time other than 8 a.m. to 5 p.m. Monday through Friday.

Outreach staffs are housed throughout Georgia and, although not housed in all 159 counties, provide Medicaid enrollment information and access to the Medicaid application process in every county. This involvement with potential Medicaid clients on a local level greatly enhances Georgia's outreach efforts. Outreach staff also actively pursue collaboration with other agencies and groups in their communities in order to maximize involvement at the local level and to educate other agencies in the basics of Medicaid eligibility and the availability of Medicaid services and to provide for mutual referral systems. Most of the local RSM project staff has partnerships with the county health departments, local schools, pregnancy centers, battered women's shelters, Head Start programs and the health care community in their areas.

Workers and supervisory staff make presentations regularly to community groups, medical providers and employers. RSM project staffs often participate in health fairs and other local activities in order to reach potential Medicaid clients. Staffs have utilized creative techniques for distributing information to the public. Medicaid flyers have been sent home with school age children and workers have visited day care centers to pass out brochures. Employer contacts have resulted in opportunities to distribute literature through personnel offices and at employee forums, and to accept applications at job sites.

Simplified PeachCare for Kids Application

PeachCare for Kids has developed a simplified paper and web-based application in both English and Spanish for use by families who apply for the PeachCare for Kids program. The paper application is a one page, two-sided form designed to be submitted to PeachCare by mail. (Attachment 1)

The web-based application is available on-line at *www.peachcare.org*. It was created to allow parents to apply quickly and easily at local libraries, community centers, hospitals and in their homes. When an application is submitted online, a cover form with the application confirmation number will be generated. Parents will be instructed to print out this form and

attach required documents for income and/or citizenship and identity verification to then be mailed or faxed to the TPA. Both applications are designed to gather information needed to determine eligibility for both PeachCare and Medicaid. Marketing and Public Awareness

Advertising Campaign

The PeachCare for Kids outreach campaign includes television, radio, outdoor and transit advertising. The advertising campaign follows the theme, "Now You Can Afford Peace of Mind," addressing the practical and the emotional needs of potential PeachCare families. Creatively, advertising is intended to evoke the heroism of the working-class parent, recognizing their love and dedication to their child. The radio commercial, "Vicky," tells the story of a father and his daughter, and the TV commercial, "Emma," spotlights a mother and her son.

Outreach Publications

PeachCare for Kids published informational brochures in both English and Spanish to educate and encourage enrollment. The brochures give a brief description of benefits available through PeachCare and a summary of PeachCare eligibility requirements. The brochures are distributed at outreach activities throughout the state and are available at doctor's offices, DFACS, Department of Labor career centers, health departments, community centers, and daycare centers.

Outreach Video

The Georgia Department of Community Health produced a short promotional video, which details the benefits of PeachCare to parents and community outreach workers. It features two women talking about their experience with the program. The video explains how to apply, premiums, benefits and accessing services. For bilingual viewers, it is available with Spanish subtitles. The video is especially designed for broadcast in hospital and physician waiting rooms, health departments, and community health fairs.

Back-to-School Outreach

To enhance back to school outreach activities, PeachCare for Kids partners with the Georgia Department of Education to distribute a program flyer to every child in the public school system. Through this effort, nearly every

parent of a school-age child in the state receives information about PeachCare for Kids. To date, we distribute over 1.6 million brochures at the beginning of each school year.

Community Outreach Mini-grants

In 1999, the Georgia Department of Community Health created a minigrant program, "Improving Health Care Access: Innovations in Medicaid and PeachCare for Kids Outreach, to assist local efforts to raise awareness of both PeachCare and Medicaid programs among hard-to-reach populations. Twenty-four community organizations were awarded grants to conduct grassroots outreach activities specifically designed for their communities.

The minigrant outreach program had a positive impact on the number of applications submitted to PeachCare for Kids and Medicaid. The grantees were responsible for producing between 30,000 and 40,000 new applications between October 1999 and June 2000.

An evaluation performed by the Health Policy Center at Georgia State University looked at various differences by race and county size, as part of our goal was to reach the underserved hard-to-reach population. The evaluation found:

- An increase of 16% in new applications compared to non-outreach counties;
- An increase of 18% in smaller counties (fewer than 42,000 people);
- An increase of 11% in larger counties (more than 90,000 people); and
- An increase of 19% in minority applications.

The activity level of the grantees produced the following results:

- 427,315 pieces of PeachCare for Kids informational materials were distributed;
- 445 PeachCare for Kids presentations were conducted; and
- 6,000 families were assisted with applications.

Local Media Partnerships

PeachCare for Kids became one of five partner organizations in Georgia's largest and most comprehensive community service campaign, WSB-TV's Family 2 Family Project. WSB-TV, the highest ranked television station in the

state and has established partnerships with community and family organizations throughout Georgia to address family issues. As part of its partnership, PeachCare participates in several major events such as the Baby & Kid Expo, CPR Saturday trainings by the American Red Cross, the Susan B. Komen Foundation's Race for the Cure, the Salute 2 America Fourth of July parade, and Give Kids a Boost. PeachCare brochures are also always on display in the other Family 2 Family sponsor locations, including Haverty's Furniture, Verizon Wireless, Promina Health Systems, and Southtrust Bank.

The news and advertising exposure on one of Georgia's most popular television stations, community event participation across northern Georgia, and exclusive program opportunities will continue to help us reach even more eligible families.

Georgia Families

The Georgia Families Care Management Organizations (CMOs)

The CMO plans are permitted to perform the following marketing activities:

- Distribute general information through mass media (i.e. newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, and other media outlets);
- Make telephone calls, mailings and home visits only to Members currently enrolled in the Contractor's plan, for the sole purpose of educating them about services offered by or available through the Contractor;
- Distribute brochures and display posters at Provider offices and clinics that inform patients that the clinic or Provider is part of the CMO plan's Provider network, provided that all CMO plans in which the Provider participates have an equal opportunity to be represented; and
- Activities that benefit the entire community such as health fairs or other health education and promotion activities.

If the CMO performs an allowable activity, the CMO shall conduct these activities in the entire Service Region. The State must approve all CMO marketing materials prior to their use. All materials are in compliance with the information requirements in 42 CFR 438.10.

The GF Enrollment Broker (EB)

The GF EB conducts an outreach and educational campaign to promote community awareness of GF and inform Potential Members about the managed care benefits available, including preventive care and Health Check services. The EB ensures that outreach activities reach non-English speaking populations, populations with hearing impairments, and populations with vision impairments.

Outreach Materials

The EB develops print ads, public service announcements, post card mailings and other outreach materials targeted to GF eligible populations in each Service Region.

The outreach materials are designed to be understandable to GF eligible populations and written at a 5th grade reading level.

The outreach materials are also available in Spanish and as determined by DCH, other non-English prevalent languages spoken by five percent (5%) of the Medicaid population in a Service Region.

Collaboration with Others

The EB regularly collaborates with other State agencies and community-based advocacy and service groups that are involved in programs and activities targeted at GF eligible population.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) (42CFR 457.410(a))

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1)) (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. See instructions.

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☑ Secretary-Approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

6.1.4.1. ☐ Coverage the same as Medicaid State plan

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. ☑ Coverage that includes benchmark coverage plus additional coverage

The BlueChoice Health Care Plan, the state's HMO with the largest enrollment, is the benchmark plan. The benefit plan for PeachCare for Kids is the benchmark coverage with added services to bring the coverage to equal a Medicaid look-alike, with the exceptions of non-emergency transportation, targeted case management, services solely for persons over age 19, and some services that to be needed require a level of disability that would qualify the child for Medicaid.

6.1.4.5. ☐ Coverage that is the same as defined by "existing comprehensive state-based coverage"

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. ☐ Other (Describe)

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

These services are the same as the services in the Georgia Medicaid Plan with the exceptions of non-emergency transportation, targeted case management, services solely for persons over age 19, and some services that to be needed require a level of disability that would qualify the child for Medicaid. All these services are subject to the same limitations and prior approvals as they are in the Georgia Medicaid Plan.

6.2.1. ☑ Inpatient services (Section 2110(a)(1))

Inpatient services include medical and surgical services delivered during a hospital stay. Inpatient services are covered in full. See 6.2.10 for coverage for psychiatric hospital services. Prior approval is needed for some services.

6.2.2. ☑ Outpatient services (Section 2110(a)(2))

Outpatient services include outpatient surgery, clinic services and emergency room care. Outpatient services are covered in full. Prior approval is needed for some services.

6.2.3. ☑ Physician services (Section 2110(a)(3))

Physician services include services provided by a participating physician for the diagnosis and treatment of an illness or an injury. Physician services are covered in full. Prior approval is needed for some services.

6.2.4. ☑ Surgical services (Section 2110(a)(4))

Surgical services are covered in full. See 6.2.1 for inpatient surgical services and 6.2.2 for outpatient surgical services. Prior approval is needed for certain procedures.

6.2.5. ☑ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

See 6.2.2 above.

6.2.6. ☑ Prescription drugs (Section 2110(a)(6))

Prescribed drugs (from participating rebate manufacturers) and supplies approved by DMA and dispensed by an enrolled pharmacist are covered in full. Some drugs require prior approval or have therapy limitations. Prescriptions or refills are limited to six per month per enrollee. There are procedures in place that allow a member to receive medically necessary prescriptions in excess of six (6) per month.

6.2.7. ☑ Over-the-counter medications (Section 2110(a)(7))

The following non-prescription drugs are covered up to a maximum allowable cost: Multi-vitamins and multiple vitamins with iron, enteric coated aspirin, diphenhydramine, insulin, NIX, iron, meclizine, insulin syringes, insulin delivery unit systems (NOVO pen for example) and urine test strips. No other over-the-counter medications are covered.

6.2.8. ☑ Laboratory and radiological services (Section 2110(a)(8))

Radiology services are covered in a hospital setting or in a physician's office only. Note: laboratory and radiological services are covered as two separate services.

6.2.9. ☑ Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))

These services are covered in full. This includes Childbirth Education Services, a series of 8 classes regarding the birth experience and tools to prepare for a healthier pregnancy, birth and postpartum period.

6.2.10. ☑ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

Inpatient mental health services are covered only for short-term acute care in general acute care hospitals up to 30 days per admission.

Services furnished in a state-operated mental hospital are not covered. Services furnished in an Institution for Mental Disease (IMD) are not covered. Residential or other 24-hour therapeutically planned structural services are covered only through the DHR MATCH Program. (See Sections 2.2.1. and 3.2.) Psychotherapy is limited to 10 hours per calendar month.

6.2.11. ☑ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)

Outpatient mental health services are covered through: Community Mental Health Centers, subject to limitations specified in DHR standards

6.2.12. ☑ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

Durable medical equipment and supplies prescribed by a physician are covered. Prior approval is required for custom molded shoes and for repairs to certain prosthetic devices. Hearing aids are allowed every three years without prior approval. Medical necessity for hearing aids must be approved by Children's Medical Services. This prior approval is based upon the completion of a hearing evaluation by the prescribing physician or other licensed practitioner. Medical equipment purchases and one-way mileage for delivery in excess of $200.00 require prior approval. See Vision Care under 6.2.28 for eyeglasses.

6.2.13. ☐ Disposable medical supplies (Section 2110(a)(13))

6.2.14. ☑ Home and community-based health care services (See instructions) (Section 2110(a)(14))

Home health services, ordered by a physician and provided in the enrollee's home, including part-time nursing services, physical, speech and occupational therapy, and home health aide services are covered for 75 visits per calendar year. Home health services

exceeding 75 visits per calendar year may be covered when requested by a physician and determined to be medically necessary by DMA.

6.2.15. ☑ Nursing care services (See instructions) (Section 2110(a)(15))

Nursing care services are covered as follows. The Nurse Practitioner Services Program reimburses for a broad range of medical services provided by participating Pediatric, Family, Adult, and OB/GYN Nurse Practitioners, as well as Certified Registered Nurse Anesthetists (CRNA). Nurse Midwife services are also covered and include primary care services in addition to obstetrical care.

6.2.16. ☑ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)

6.2.17. ☑ Dental services (Section 2110(a)(17))

Dental and oral surgical services are covered as follows: 2 visits (initial or periodic) for dental exams/screens and 2 emergency exams during office hours and two emergency exams after office hours per calendar year are allowed; 2 cleanings per calendar year; 1 restorative (filling) procedure per tooth per restoration; the maximum number of surfaces covered is four (4); sealants for first and second permanent molars only; orthodontic services with prior approval.

6.2.18. ☑ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

Inpatient substance abuse treatment services are covered only for short-term acute care in general acute care hospitals up to 30 days per admission. Services furnished in a state-operated mental hospital are not covered. Services furnished in an Institution for Mental Disease (IMD) are not covered.

6.2.19. ☑ Outpatient substance abuse treatment services (Section 2110(a)(19))

Outpatient substance abuse treatment services are covered through

Community Mental Health Centers, subject to limitations specified in DHR standards. Outpatient short term acute care and substance abuse treatment services are covered in general acute care hospitals.

6.2.20. ☐ Case management services (Section 2110(a)(20))

6.2.21. ☐ Care coordination services (Section 2110(a)(21))

6.2.22. ☑ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

Physical, occupational and speech pathology therapy are covered as follows: 1 hour per day up to 10 hours per calendar month for physical therapy; 1 hour per day up to 10 hours per calendar month for occupational therapy; 1 session per day up to 10 sessions per month for individual speech therapy. With prior approval these limits may be exceeded. See also Children's Intervention Services below.

6.2.23. ☑ Hospice care (Section 2110(a)(23))

Covered under a plan of care when provided by an enrolled hospice provider.

6.2.24. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))

6.2.25. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.26. ☑ Medical transportation (Section 2110(a)(26))

Emergency ambulance services are covered for an enrollee whose life and/or health are in danger. Non-emergency transportation is not covered.

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))

6.2.28. ☑ Any other health care services or items specified by the

Secretary and not included under this section (Section 2110(a)(28))

Health Check: Regular physical examinations (screening), health tests, immunizations and treatment for diagnosed problems are covered. Screening requirements are based on the recommendations for preventive pediatric health care adopted by the American Academy of Pediatrics. Treatment is covered within the limitations on covered services.

Vision Care: Services including eyeglasses, refractions, dispensing fees, and other refractive services are covered. Medically necessary diagnostic services are also covered. Limitations are: 1 refractive exam, optical device, fitting, and dispensing fee within a calendar year; additional such services require prior approval. Prior approval is also required for other services including but not limited to: contact lenses, trifocal lenses, oversized frames, hi-index and polycarbonate lenses.

Children's Intervention Services: Services covered for children from birth through 18 years of age are audiology, nursing, nutrition, occupational therapy, physical therapy, social work, speech-language pathology and developmental therapy instruction. Written prior approval is required for medically necessary Children's Intervention Services once the annual service limitations listed in the *Policy and Procedure Manual* have been reached. Individualized Family Service Plan is required to document medical necessity for amount, duration and scope of services. Note that children 18 years of age are not covered under these program services.

Family Planning: Covered services include initial and annual examinations, follow-up, brief and comprehensive visits, pregnancy testing, birth control supplies, and infertility assessment.

Pregnancy-Related Services: Covered services help reduce infant mortality by providing home visits that assess the mother and child and teach the mother about specific subjects that will reduce infant mortality.

Podiatry: Services covered are diagnosis, medical, surgical, mechanical, manipulative and electrical treatment of ailments of the

foot or leg as authorized within the Georgia statute governing podiatric services.

Physicians Assistant Services: Covered services are limited to primary care services and anesthesiologist's assistant services authorized in the basic primary care job description, approved by the Georgia Composite State Board of Medical Examiners.

End Stage Renal Disease (ESRD) Dialysis: Services and procedures designed to promote and maintain the functioning of the kidney and related organs are covered when provided by a provider enrolled in the ESRD program. Acute renal dialysis services are covered under other programs.

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

6.3.1. ☑ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: ***Previously 8.6***

6.4 Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: (Section 2105(c)(2) and(3)) (42 CFR 457.1005 and 457.1010)

6.4.1. ☐ Cost Effective Coverage. Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above.; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

6.4.2. ☐ Purchase of Family Coverage. Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

Section 7. Quality and Appropriateness of Care

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495(a))

Will the state utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☑ Quality standards
7.1.2. ☑ Performance measurement
7.1.3. ☑ Information strategies
7.1.4. ☑ Quality improvement strategies

The monitoring for 7.1.1-7.1.4 is detailed in Section 7.2 and in Section 9 "Strategic Objectives and Performance Goals and Plan Administration."

7.2. Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42CFR 457.495)

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

To encourage utilization of primary and preventive care, PeachCare for Kids does not have any co-payments for services. Additionally, premiums are not required for children under the age of six, ensuring that all children up to the age of six in households with incomes up to 235% of the federal poverty level have access to care without any cost to the family.

PeachCare for Kids sends each child a birthday postcard each year that wishes them a healthy year and reminds their parents of the well-child care available through PeachCare.

PeachCare for Kids monitors the members' appropriate Early Periodic Screening, Diagnostic and Testing (EPSDT) utilization. Each CMO must provide quarterly reports to DCH documenting the number of initial newborn visits, the number of members who received all scheduled EPSDT services on the periodicity schedule, the number of members who received any dental services, number of members that received an initial health visit and screening within 90 days of enrollment, the number of diagnostic and treatment services, including referrals, and the number and rate of lead screening for children.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

All members are enrolled in Georgia Families (GF), a managed care program. GF PCPs are required to have care accessible to their members 24 hours a day.

Members are informed in member handbooks mailed to each family upon enrollment, "If your child is in an emergency situation, call 911 or go immediately to the nearest hospital emergency room. You do not need prior approval from your child's doctor if your child has a serious or disabling illness or injury. Be sure to call your doctor if your child has a serious or disabling illness or injury. Be sure to call your doctor as soon as you can after your child has received care."

The Georgia Health Policy Center (GHPC), Georgia State University, has done an annual evaluation of the claims submitted for services received by PeachCare for Kids members. The results of the survey are shared with DCH staff and analyzed to monitor access, utilization and trends in utilization as the program matures. The GHPC has also conducted the Consumer Assessment of Health Plan Satisfaction (CAHPS) survey on behalf of PeachCare for Kids. This survey assesses the parents' perceptions about the availability and quality of care their children have received.

Additionally, each CMO is required to provide quarterly timely access reports that monitor the time lapsed between a Member's initial request for an office appointment and the date of the appointment. The CMOs are also required to submit a Provider Network Adequacy and Capacity Report that demonstrates that the Contractor offers an appropriate range of preventive, Primary Care and specialty services that is adequate for the anticipated number of enrollees for the service are and that its network of providers is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. Additionally, on an ad hoc basis DCH can request of each CMO a report of the availability of certain services and the coverage and authorization of services.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

The Georgia Health Policy Center (GHPC), Georgia State University, has done an annual evaluation of the claims submitted for services received by PeachCare for Kids members. The results of the survey are shared with DCH staff and analyzed to monitor access, utilization and trends in utilization as the program matures. The GHPC also conducts the Consumer Assessment of Health Plan Satisfaction (CAHPS) survey on behalf of PeachCare for Kids. This survey assesses the parents' perceptions about the availability and quality of care their children have received, including access to specialist care. Through these evaluations, PeachCare monitors access to specialist care for all members, including those with special or chronic conditions.

All children enrolled in PeachCare for Kids are assigned a CMO and primary care provider (PCP) through GF. The PCP's role is to assess, treat, and coordinate specialty care for the PeachCare members under their care.

PeachCare for Kids members who are identified as in need of special health care services by receiving care through MATCH, CMS or Georgia Pediatric Program (GAPP) are excluded from GF and covered under PeachCare for Kids on a fee for service basis.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

As mentioned earlier, each CMO has written Utilization Management Policies and Procedures that have been reviewed and approved by DCH. Also, on a monthly basis CMO will provide to DCH a report of the availability of certain services and the coverage and authorization of services.

The CMO must submit Prior Authorization and Pre-Certification Reports that summarize all requests in the preceding month for Prior Authorization and Pre-Certification. The Report includes, at a minimum, the following information:

- Total number of requests for Prior Authorization and Pre-Certification requested by type of service;
- Total number of requests for Prior Authorization and Pre-Certification processed within fourteen (14) Calendar Days for standard Service Authorizations;
- Total number of requests for extension of the fourteen (14) Calendar Days for standard Service Authorizations;
- Total number of requests for Prior Authorization and Pre-Certification processed within twenty-four (24) hours for expedited Service Authorizations;
- Total number of requests for the extension of the twenty-four (24) hours for expedited Service Authorizations;
- Total number of requests for authorization processed within thirty (30) Calendar Days for determination for services that have been delivered;
- Total number of requests approved by type of service; and
- Total number of requests denied by type of service.

Section 8. Cost Sharing and Payment (Section 2103(e))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.**

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505)

8.1.1. ☑ YES
8.1.2. ☐ NO, skip to question 8.8.

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1 Premiums: Premiums are not required for children ages 0 through 5 years. For children ages 6 through 18, the premiums are detailed in the table below.

FPL	One Child	Family Cap
100-150%	$10.00	$15.00
151-160%	$20.00	$40.00
161-170%	$22.00	$44.00
171-180%	$24.00	$48.00
181-190%	$26.00	$52.00
191-200%	$28.00	$56.00
201-210%	$29.00	$58.00
211-220%	$31.00	$62.00
221-230%	$33.00	$66.00
231-235%	$35.00	$70.00

8.2.2. Deductibles: None

8.2.3. Coinsurance or co-payments: None

8.2.4. Other: None

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)((1)(B)) (42CFR 457.505(b))

PeachCare for Kids publicizes the cost sharing requirements in its brochures, applications, website, mass media campaigns and other outreach materials. If a parent applies for a child and does not include a premium payment with the application, if applicable, a letter is sent indicating that a payment must be received for the children to be enrolled in the program. The letter includes the specific amount due, depending on the number of children over 6 in the household, and the due date for premium payments for enrollment to be initiated and maintained monthly.

The Board of Community Health, a nine-person board appointed by the Governor, governs the Department of Community Health. The board meets regularly on a monthly basis and is open to the public. The FY 04-05 cost sharing changes were presented to and approved by the board on May 12, 2004.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. ☑ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

8.4.2. ☑ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3 ☑ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

8.5. Describe how the state will ensure that the annual aggregate cost sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

For a family with only one child enrolled age 6 or older, the maximum a family could have to pay is $420. This is the maximum per child premium of $35 times 12 months. Since there are no deductibles, coinsurance, co-payments or other cost sharing methods, the annual aggregate cost sharing is the maximum family premium annually. In order for $420 to exceed 5 percent of a family's annual income, the family's annual income would have to be below $8,400. Uninsured children in a family with annual income below $8,400 would be eligible for Medicaid rather than PeachCare for Kids™, if they met the other eligibility criteria in addition to income criteria.

For a family with 2 or more enrolled children age 6 and older, the maximum a family could have to pay is $840 annually. This is the maximum family premium of $70 times 12 months. Since there are no deductibles, coinsurance, co-payments or other cost sharing methods, the annual aggregate cost sharing is the maximum family premium annually. In order for $840 to exceed 5 percent of a family's annual income, the family's annual income would have to be below $16,800. Uninsured children in a family with annual income below $16,800 are below 150% FPL and would either be eligible for Medicaid or would have a maximum premium of $15 per household per month for enrollment in PeachCare for Kids™, if they met the other eligibility criteria in addition to income criteria.

Therefore, with such a low cost-sharing requirement, PeachCare ensures that the aggregate cost sharing for a family never exceeds 5 percent of a family's annual income.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

PeachCare for Kids notifies enrolled American Indian and Alaska Native families of the cost sharing exclusion by letter. The letter instructs families to mail their official tribal documentation to PeachCare for review. Once the documentation is reviewed, a letter is sent to families to confirm receipt. This letter also notifies the families that they are no longer required to pay a monthly premium. If official tribal documentation is not submitted, families must continue to make premium payments.

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- ☑ **State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, co-payments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))**
- ☑ **The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))**
- ☑ **In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))**
- ☑ **The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))**

Premiums are due the first of the month, prior to the month of coverage. If a premium payment is not received on the first, a late letter is sent to the family approximately four days after the late premium was due informing them that if payment is not received by the end of the month, they will be given 45 days of grace period before the coverage termination process begins, with coverage being canceled at the end of the 2nd month of the grace period. This notification also explains their option to opt out of receiving coverage for the grace period months. If the family does not pay the past due premium at the end of the month that it is due, the grace period begins the following month. The State will send a notice no later than the 8th of the first grace period month, informing the family that failure to make a premium by the 15th of the 2nd grace period month will initiate the termination process and coverage will ultimately be terminated at the end of the 2nd grace period month. A call campaign is launched on the 15th of the first grace period month to inform parents of the past due premium payments. If the premium is not paid by the 15th of the 2nd grace period month, then the coverage termination process begins and is ultimately terminated by the end of the 2nd grace period month. Payments received after the 15th day of the 2nd grace period month will not stop the termination process. Once coverage is terminated due to non-payment of premium, the family is ineligible to reinstate for

the following month. Families who are canceled due to non-payment of premium are notified by mail and informed of their right to a review of the termination.

In the case that a premium payment is made during the grace period, but there is still an outstanding premium(s), the payment would apply to the first missed premium payment. The grace period would then start again based on the date of the second missed premium payment such that a family always has a grace period starting at the first of the month of a new coverage period and ending 45 days later.

For example, on January first the premium is due for February coverage. If a family missed the January 1st due date, a letter is sent to the family on approximately January 4th informing them that their payment is due and that if payment is not received by the end of January, the grace period will begin on February 1st and last until March 15th, after which the coverage termination process will begin. If the family does not pay the January 1st premium due for February coverage by the 15th of March, the family's coverage is terminated at the end of March. In this case, the family would be ineligible for coverage during the month of April**,** unless the family opts out of February coverage by January 31.

In the case where a family missed the January 1st and the February 1st premium, but made a single premium payment by February 15th , the payment would apply to the January missed payment and the family would be offered a new premium grace period starting on March 1st and requiring payment by April 15th before coverage is terminated. In the case where a family missed the January 1st premium, the February 1st premium, but made a single premium payment by March 15th**,** the February 1st premium due for March coverage would be required by April 15, after which coverage would end April 30. This cycle will continue for each new month of coverage and each grace period, where premium payments are late. Any late premium payments will always apply to the earliest premiums due.

If the family requests a review of the termination due to a claim of reduced income that disrupts their ability to pay the premium, coverage is extended to the child during the appeal process.

If the family reports a reduction in income during the cancellation period, as well as any other time, the application is screened for potential Medicaid eligibility. If it appears that the child is eligible for Medicaid, the application will be referred to Right from the Start Medicaid for a full determination. If it appears that the child still

qualifies for PeachCare for Kids™, but at a lower premium amount, the family will be notified of the new premium requirement and will be issued a new coupon book.

Prior to August 1, 2005 a Member who was cancelled for late/non-payment of premium was ineligible to reinstate for a period of three (3) months. PeachCare for Kids™ enrollees and the public at large were made aware of the policy change from a three-month period to a one-month period in a variety of methods. Those enrollees that were in a 3-month waiting period were notified via a letter that they were eligible for reinstatement effective August 1, 2005. All other members were notified of changes in correspondence mailed to households, the Frequently Asked Questions posted on our website (www.peachcare.org), and call center customer service representatives.

During closed enrollment, there will be no reinstatement period. Any family cancelled for late/non-payment of premium will be ineligible to reinstate so long as PeachCare enrollment is closed. All effected families will be notified of this change in policy by a mailing. It will be reiterated in the final notice letter that will also inform them of their right to seek a review within 30 days of receipt of the notice and to continue services during the review period.

8.8 The state assures that it has made the following findings with respect to ~~the payment~~the payment aspects of its plan: (Section 2103(e))

8.8.1. ☑ No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☑ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (*Previously 8.4.5)*)

8.8.3. ☑ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.
(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☑ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. ☑ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. ☑ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

The six strategic objectives of PeachCare for Kids are to:

1. Increase insurance coverage among Georgia's low income children
2. Increase the percentage of low-income children with a regular source of care.
3. Promote utilization of Health Check (EPSDT) services.
4. Decrease unnecessary use of emergency departments for non-emergency services.
5. Minimize preventable hospitalizations.
6. Promote the appropriate use of health care services by children with asthma (as defined by national standards).

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

Objective 1: Increase insurance coverage of Georgia's low-income children.

Performance goals:

1.1 Enroll 75% of uninsured, non-Medicaid eligible children with family income below 235% of the federal poverty level.
Measure: Percent of eligible children enrolled.

1.2 Employ marketing and outreach techniques that encourage parents of eligible, low-income children to enroll their children in PeachCare for Kids.
Measure: Percent of eligible children enrolled and survey data of applicant families.

Baseline and Target Improvement Levels: Within one year, Georgia exceeded our two-year enrollment goal of 60,000 children, as indicated in our original state plan. For the upcoming fiscal year, we have set the goal of enrolling 85% of the estimated eligibles (169,142 children enrolled on June 30, 2003).

Objective 2: Increase the percentage of low-income children with a regular source of care.

Performance goals:

2.1 Over time, decrease the percent of children matched to a PCP through auto assignment.
Measure: Percent of children who selected PCP on enrollment.

2.2 Encourage use of PCP through health plan policies and education.
Measure: Percent of enrolled children who seek care from their assigned PCP.

2.3 Maximize the number of enrollees who stay with their PCP for 12 months.
Measure: Percent of enrollees who stay with their PCP at least one year.

Baseline and Target Improvement Levels: As of November 30, 1999, there were 17,120 children who were matched to a PCP through auto assignment, and 41,713 (71%) who chose their own PCP. Our target improvement level is 80% by the end of federal fiscal year 2005.

Objective 3: Promote utilization of Health Check (EPSDT) services to achieve

targets set by the Centers for Medicare and Medicaid Services and GF. These are 80% for screening and 90% for immunizations.

Performance goals:

3.1 Assess how many children receive recommended well visits and screenings.
Measure: Percent of enrolled children receiving each screening on or about the recommended schedule.

3.2 Assess how many children receive immunizations.
Measure: Percent of enrolled children receiving each immunization on or about the recommended schedule.

3.3 Increase provider and patient compliance with use of primary and preventive services by feeding back information to providers and health plans about their rates of screening for the enrolled population.
Measure: Percent of PCP panels with improved screening rates in subsequent years.

Baseline and Target Improvement Level: From claims data for fiscal year 2000, 41% of all children enrolled 10 to 12 months had an EPSDT visit. Of the children ages 1 to 5, 55% had an EPSDT visit. Georgia's goal is to increase this to 80% by the end of federal fiscal year 2005. With enhancements in our fiscal management system and the reporting provided by GF CMO plans, we anticipate being able to track services among children who have EPSDT services as their coverage changes among Medicaid and PeachCare for Kids. This will allow us to evaluate more children with 10 to 12 months of coverage and have a more complete picture of the percentage of children who are receiving these services, either through PeachCare exclusively or intermittent coverage through the Medicaid program.

Objective 4: Decrease unnecessary use of emergency departments for non-emergency services. A non-emergency service is one that does not meet the prudent layperson definition of emergency.

Performance goals:

4.1 Reduce the number of ED visits for non-emergency services.
Measure: Rate of non-emergency ED visits per year for the population enrolled.

Baseline and Target Improvement Level: From claims data for fiscal year 2000, 66% of visits to emergency departments met the criteria for an emergency. Georgia's goal is to increase the percentage of emergency department visits for diagnoses

considered to be medical emergencies to 70% by the end of federal fiscal year 2005.

Objective 5: Reduce preventable hospitalizations.

Performance goals:

5.1 Reduce preventable hospitalizations.
Measure: Percentage of hospitalizations for preventable diagnoses.

Baseline and Target Improvement Level: From claims data for fiscal year 2000, 32% of hospitalizations were for diagnoses which could be considered preventable. Georgia's goal is to decrease the percentage of preventable hospitalizations to 25% by the end of federal fiscal year 2005.

Objective 6: Promote the appropriate use of health care services by children with asthma (as defined by standards of the National Heart Lung and Blood Institute of the National Institutes of Health).

Performance goals:

6.1 Assess the number of children whose asthma is managed through appropriate outpatient care.
Measure: Percent of children seeing PCP within two weeks of ER or hospital visit.

Baseline and Target Improvement Level: From claims data for fiscal year 2000, 93% of children had a follow-up visit within 2 weeks of a visit to an emergency department or a hospitalization. Georgia's goal is to increase the percentage of children who have a follow-up visit within 2 weeks of a visit to an emergency department or a hospitalization due to asthma to 95% by 2005.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

- **9.3.1. ☐ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.**
- **9.3.2. ☑ The reduction in the percentage of uninsured children.**
- **9.3.3. ☑ The increase in the percentage of children with a usual source of care.**
- **9.3.4. ☑ The extent to which outcome measures show progress on one or more of the health problems identified by the state.**
- **9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.**
- **9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.**
- **9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:**
  - **9.3.7.1. ☐ Immunizations**
  - **9.3.7.2. ☐ Well child care**
  - **9.3.7.3. ☐ Adolescent well visits**
  - **9.3.7.4. ☐ Satisfaction with care**
  - **9.3.7.5. ☐ Mental health**
  - **9.3.7.6. ☐ Dental care**
  - **9.3.7.7. ☐ Other, please list:**
- **9.3.8. ☐ Performance measures for special targeted populations.**

9.4. ☑ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

9.5. ☑ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

PeachCare for Kids™ will comply with the annual assessment by submitting a report, utilizing the Framework for Annual Evaluation developed by the National Academy for State Health Policy in conjunction with state SCHIP staff and CMS. This report will be completed by PeachCare staff. Independent evaluators will be responsible for measuring PeachCare's progress in meeting the performance measures defined in Section 9 "Strategic Objectives and Performance Goals and Administration" and for nationally-mandated measures when they become available.

9.6. ☑ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)

9.7. ☑ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)

- **9.8.1. ☑ Section 1902(a)(4)(C) (relating to conflict of interest standards)**
- **9.8.2. ☑ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)**
- **9.8.3. ☑ Section 1903(w) (relating to limitations on provider donations and taxes)**
- **9.8.4. ☑ Section 1132 (relating to periods within which claims must be filed)**

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

Initial Public Involvement

In 1996, the Georgia Coalition for Health was asked by the Governor to examine approaches for reforming Medicaid in Georgia. The Coalition sponsored extensive research on the views of the stakeholders in the state's Medicaid system – healthcare providers, Medicaid members and Georgia citizens. Three separate but complementary processes—focus groups, community forums and community dialogues—offered the opportunity for about 6,000 Georgians to express their views.

This unique process of obtaining stakeholder input served as a foundation for convening people with varied perspectives and expectations, raising awareness about those perspectives, identifying areas of agreement and disagreement, and working together to find solutions to difficult problems.

Georgia Health Decisions was commissioned by the Coalition to conduct research to learn what changes citizens would support in the state's Medicaid program. Citizen input was gathered through focus groups in all areas of the state, with almost 500 people participating. Focus group participants were randomly chosen to represent all socio-economic segments of Georgia's population. Eleven focus groups were composed of Medicaid members, and six others were made up of healthcare providers. Further, Georgia Health Decisions conducted 200 open community forums throughout the state in which 5,000 Georgians had the opportunity to express their concerns about Medicaid reform.

In addition, the Georgia Health Policy Center engaged 14 communities across Georgia in Medicaid community dialogues. The objectives of the dialogues were to ensure a process for obtaining input from Medicaid consumers and health care providers around the state; to clarify an understanding of the issues related to Medicaid reform and the ramifications of those issues; and, to identify examples of system disincentives that could be corrected by changes in policy.

The consumers and advocates participating in the dialogues were identified by a coalition of consumers and advocates incorporated under the name Healthcare for a Lifetime. This group represents the four primary populations that receive Medicaid: low income Mothers and children, older people, people with physical disabilities, and people with mental retardation, mental illness, or those with substance abuse

problems. The providers were selected by the Healthcare Providers Council and included representation from hospitals, physicians, nursing, dentistry, nursing homes, home health, pharmacy, public health, community health and others. County Commissioners as well as members of the legislature were also invited to attend. Overall, 443 consumers and advocates and 234 providers participated for a total of 677 statewide participants. The meetings were open to the public and at every Dialogue there were observers who did not participate in the discussions yet had the advantage of moving among groups and hearing all four conversations.

These statewide, public conversations on Medicaid contributed to dispelling barriers between consumers and providers; the process also indicated where consumers, advocates and providers stand on major issues and where they are willing to negotiate. The main themes identified through the process are summarized below. These themes served as a reference and defining force for developing general Medicaid reform recommendations and many are reflected in Georgia's proposal for implementing the Title XXI program.

Citizens

The citizens, both Medicaid members and members of the general public, expressed a wide variety of views, but agreed on a few basic themes.

- Vulnerable people should be protected. Citizens generally believe in the concept of a health care safety net and are willing to pay taxes to provide health care to people who need help.

- Only truly needy individuals should qualify for Medicaid. Citizens want to make sure that eligibility is strictly defined and enforced to stop abuse.

- Nothing should be free. Citizens want all adult Medicaid members to make some financial contribution toward their care, generally favoring a sliding scale based on income. They believe welfare recipients should work. They also want to make sure that families contribute to the cost of caring for disabled children and, perhaps, elderly parents.

- Health care should be accessible to all Georgians. Citizens worry about rising health care costs and their own ability to get affordable coverage, even if they now have health benefits, they worry about losing them. People are also concerned about the uninsured and would like to broaden Medicaid reform to also offer affordable coverage for this group.

Medicaid Members

In the community dialogues, Medicaid members generally shared the opinions of the general population, as described above, but also expressed some specific concerns.

- Medicaid costs should not be cut by reducing eligibility, since not enough truly needy people are covered today.

- There should be no stigma attached to receiving Medicaid, and any managed care plans used in the program should serve both Medicaid members and non-Medicaid patients.

- Prevention and education should be integral components of any benefits package.

Providers

In addition to participating in the focus groups and community dialogues, many health care providers were interviewed for a separate study as part of a detailed analysis of the current health care delivery system in Georgia. Key findings from that research are summarized below:

- The delivery system is in rapid transition. Organized health plans are widespread in the state, displacing traditional fee-for-service reimbursement plans. Hospitals and other providers are restructuring, merging and forming networks to compete with insurer-sponsored managed care organizations.

- A quick-budget-fix approach to Medicaid reform could harm public health and actually raise costs in the long run. Providers would support a serious, well-reasoned reform effort, developed through a fair process that listens to providers' concerns, and includes realistic transition periods.

- Any reform plan should include performance standards, outcome measures, accountability, competition, and choice (for both members and providers). Providers should be able to at least break even financially if they participate in Medicaid, and a small profit would be appropriate as recompense for taking risk.

- Providers who have traditionally served the Medicaid population with demonstrated quality should be included in a managed care or any other delivery system.

About six months after this public input process was completed, the Georgia Coalition for Health Board, concerned about the effects of Medicaid reform on uninsured children, asked the Health Policy Center to study mechanisms for providing coverage to this target population. In response to this charge, the Policy Center applied for (and was subsequently awarded) a Robert Wood Johnson Foundation grant to replicate the Florida Healthy Kids program. The Coalition also allocated funding to the Center to conduct preliminary planning activities so that Georgia could position itself for implementing the Healthy Kids program as well as the impending federal children's health insurance legislation.

From May through December 1997, the Center established several advisory committees with representation from key agencies and organizations around the state. (It should also be noted that, according to the reviewers from the Robert Wood Johnson Foundation, one of the most impressive components of the initial grant and the subsequent planning efforts was the inclusive process for obtaining input from affected stakeholders into the design of the program.) The committee structure included a primary broad-based Children's Health Insurance Advisory Committee and four subcommittees, each governed by specific charges that addressed the major programmatic issues of benefits package, eligibility criteria, program design, and local collaboration. There were a total of 40 individuals on the full advisory committee and four subcommittees, however, these meetings were open to and attended by several additional visitors and observers. There were about 25 meetings of the full advisory group and the subcommittees between April and December. Membership on these groups was comprised of representatives from the following agencies and organizations:

- Association of County Commissioners of Georgia
- Augusta/Richmond County Community Partnership
- Caring Program for Children
- Chatham-Savannah Youth Futures Authority
- Child Psychologist
- Children's Hospitals (Egleston, Hughes-Spalding, Scottish Rite)
- Council on Maternal and Infant Health
- Department of Education
- Department of Medical Assistance (Division of Maternal and Child Health, Eligibility and Quality Control, and Strategic Planning)
- Division of Family and Children Services
- Division of Mental Health/Mental Retardation/Substance Abuse
- Division of Public Health (Division Director, Child and Adolescent Health Unit, Gwinnett County Health District, DeKalb County Board of Health)
- Georgia Academy of Family Physicians

- Georgia Association for Primary Health Care
- Georgia Chapter/American Academy of Pediatrics
- Georgia Dental Association
- Georgia Partnership for Caring
- Georgia Policy Council for Children and Families
- Georgians for Children
- Governor's Office of Planning and Budget
- Healthy Mothers, Healthy Babies Coalition of Georgia
- March of Dimes
- Office of the Commissioner of Insurance
- Tanner Medical Center
- The Family Connection
- United Healthcare
- Wachovia Bank of Georgia Compensation and Benefits Branch
- West Georgia Medical Center

In addition, separate group meetings were held with child advocates, health plan representatives, and public health district officers to explain the program and obtain input about specific components of the program design for CHIP. During December, January, February and March, several legislative hearings were held in both the Senate and House of Representatives. The hearings focused on the Governor's proposal for implementing Title XXI in Georgia. At these hearings, child advocates, state agencies, pediatricians and other health care providers provided testimony.

Public Notice

At the regular meeting of the Board of Medical Assistance on April 8, 1998, DMA staff provided a public briefing for the Board on the status of the Georgia CHIP planning process. Again, at the regular meeting of the Board on May 13, 1998, the DMA presented detailed information to the Board and the public about the proposed Georgia CHIP, and gave opportunity for public comment. The May meeting had been extensively publicized with a notice mailed to a large mailing list of stakeholders in Medicaid and CHIP, in addition to regularly published meeting notices.

Ongoing Public Involvement

The House Appropriations Committee created the Medical Assistance Study Committee in June, 1997. It was charged with conducting a comprehensive study of the Medicaid system in Georgia. The rationale was for a core group of people on

the Appropriations Committee to learn as much as possible about the complexities of the budget item known as Medicaid.

Identifying problems and finding opportunities in Georgia's Medicaid system were main challenges of the committee. To meet these, a series of hearings were conducted around the state, sixteen (16) in all. They began in the summer and ended in the fall of 1997. Georgia is comprised of one hundred fifty-nine counties, urban and rural. Input was gathered from big metropolitan areas, such as Atlanta and Savannah, and small rural areas, such as Greensboro and Moultrie, to name a few. Providers and their respective associations, professional health care associations, community groups, patient advocates, Medicaid recipients, and interested citizens were invited to share their concerns with the committee.

Through the hearings, the Committee identified significant findings in fifteen different areas ranging from reimbursement to providers to health care for those with disabilities. Along with the findings, recommendations were made to DMA. A copy of the Committee's report is on file with DMA. Members of the Committee took lead roles in drafting the Georgia CHIP legislation. The Medical Assistance Study Committee has since become a standing committee of the House Appropriations Committee, which is now known as the DCH Subcommittee of the House Appropriations Committee.

The Department of Community Health is governed by a nine-person board appointed by the Governor. The Board has an active role in developing and approving DCH's proposed budget, setting priorities for the Department and working with DCH to affect policy and process to improve the health care delivered to its membership. During the budget development process, DCH holds public forums throughout the state for public input. The DCH has additional advisory committees. The Physician Advisory Committee provides a forum for health care providers and advocates to improve the health care delivery to Medicaid and PeachCare for Kids members.

Georgia Families

In February 2003, the State issued a request for information seeking comprehensive proposals to redesign the Medicaid program to improve quality and provider accountability while achieving budget predictability and cost containment. Over 42 responses were received. For the next several months, meetings were held with providers, consumer groups, insurance representatives and other stakeholders to design a new program.

In October 2003, a diverse team of stakeholders, including senior executives from healthcare provider organizations and advocacy groups, assembled for several days to discuss state strategies to promote quality healthcare, enhanced access, shared member and provider responsibility, improved efficiency, and better cost management.

In August 2004, the State announced that it would implement a mandatory managed care program using Care Management Organizations. From September 2004 through October 2004, the State held stakeholder sessions with physician and hospital providers, senior associations, children and family coalitions, and others to ensure participation and input from all groups affected by the new mandatory managed care program.

Upon implementation of the program, the State will continue to utilize providers from the various medical advisory committees, recipients involved in NET advisory committees, staff liaisons to advocacy groups that include both providers and recipients, and member satisfaction survey.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR . 457.125. (Section 2107(c)) (42CFR 457.120(c))

There are no nationally recognized American Indian tribes or organizations in the state of Georgia. PeachCare for Kids, however, does not charge cost-sharing to enrolled members who are members of federally-recognized American Indian or Alaskan Native tribes.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in. 457.65(b) through (d).

On February 8, DCH announced that it would quit enrolling new members in PeachCare for Kids effective March 11, 2007. State code allows for these changes to be made administratively, but public notice was provided in compliance with state laws. A public notice with comment period was published in regional newspapers, posted on the Department of Community Health's website and made available for review at each county Department of Family and Children Services office. A widely attended public hearing was held on February 23, 2007. Current members, including those "locked-out" of coverage, will be notified by direct mail. The Department also issued a press

release and is communicating with providers and stakeholders on the change. On March 8, 2007, the Board of Community Health approved the implementation of the closed enrollment period.

Upon receipt of additional federal funds, DCH issued a public notice announcing that enrollment would resume effective July 12, 2007, pending Board approval. The public notice further stated that in order to ensure that the funding adequately supports the cost of health care for members through September 30, 2007, enrollment will be limited to 295,000 children. The enrollment limit will be reassessed upon passage of SCHIP reauthorization legislation. Public comments were accepted for 30 days and a public hearing was held on June 27, 2007.

The following documents are enclosed in Attachment 2:

- Public Notices
- Letter to PeachCare Families
- Message to Providers
- DCH Press Release

To reflect the new verification requirements, the PeachCare for Kids™ website, applications and all correspondence were updated to inform members of the required documentation. The information required has always been information that the Department could seek from individuals in order to determine eligibility and was requested as deemed necessary. This is clearly stated in the PeachCare application. A new application was used beginning July 1, 2007 which requested that applicants send in their proof of income with the application. Furthermore, a public notice was issued on August 24, 2007. Per state policies, the public notice was published in newspapers across the state, on the DCH web and in all DFCS offices. The public notice is enclosed in Attachment 3.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42CFR 457.140)

Planned use of funds, including --

- Projected amount to be spent on health services;
- Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
- Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-Federal plan expenditures, including any requirements for cost sharing by enrollees.

SCHIP Budget			
STATE: GEORGIA	**Current FFY Budget**	**Budget Change For Requested SPA 30 Day Grace Period**	**Current Budget + SPA Budget Change**
Federal Fiscal Year	**FFY 2011**	**FFY 2011**	**FFY 2011**
State's FMAP rate	75.73		75.73
Benefit Costs			
Insurance payments			
Managed care	$ 313,816,114	$ 11,241,511	$ 325,057,625
Fee for Service	$ 20,671,324	-	$ 20,671,324
Total Benefit Costs	$ 334,487,438	$ 11,241,511	$ 345,728,949
(Offsetting beneficiary cost sharing payments)	$ (26,070,811)	$ 907,882	$ (25,162,929)
Net Benefit Costs	$ 308,416,627	$ 12,149,393	$ 320,566,020
Total Administration Costs	$ 27,058,088	-	$ 27,058,088
Federal Share	$ 254,055,001.37	$ 9,200,735.32	$ 263,255,736.69
State Share	$ 81,419,713.24	$ 2,948,657.68	$ 84,368,370.92
TOTAL COSTS OF APPROVED SCHIP PLAN	$ 335,474,715	12,149,393	$ 347,624,108

Assumptions:
Enrollment

- The calculations for projecting the enrollment in the PeachCare for Georgia plan include the use of historical enrollment data and trending formulas within Excel.

Suspensions

- October 2010 – September 2011 suspensions (Grace Period members) are projected based on similar suspension activity in 2009-2010.

PMPM

- We used $128.65 PMPM for October 2010 – June 2011 and used $132.25 PMPM for July – September 2011.

Premium Paid

- This amount represents the average premium paid by PeachCare members.

Other

- The cost driver for this budget request is the number of Grace Period members. This group of members impacts the funds required to keep them in the program and also impacts the amount of revenue DCH collects.

Calculations:

$11,241,511 Total Benefit Cost Increase

- Per month, two different sets of members need to be considered when calculating the impact of the expanded grace period. Each month starting with October 2010, the projected suspended members for that month should be included with an adjusted number from the prior month. The prior month adjusted number is added each month because the expansion of the grace period will now cover parts of two months.
- Each month's total of Grace Period First Month and Grace Period Second Month is multiplied by the PMPM for the federal fiscal year in which the month falls.

The sum of all the PMPM calculations for October 2010-Septmber 2011 totals $11,251,511.

Decrease in Offsetting beneficiary cost sharing payments by $907,882

- As detailed above, the same monthly total of Grace Period First Month and Grace Period Second Month are multiplied by $10.45 which represents the average premium payment made by PeachCare members. This calculation shows the loss or revenues from the grace period members.
- The sum of the each FFY 2011 months' Grace Period Total multiplied by the premium rate equals the $907,882.

Explanation of Expenditures

1. Benefit Expenditures
   This line item reflects the reimbursements to providers for the provision of health care services to the PeachCare members. The State assures that benefit expenditures do not include any cost sharing payments, including premiums.

2. Administrative Expenditures
   This line item includes costs associated with enrolling children in the PeachCare for Kids program.

Explanation of Revenues

3. Federal Share
   This line item reflects a portion of funds, which have been allocated to Georgia under Title XXI. It is calculated by reducing total expenditures by the amount estimated for premium collections and multiplied by the federal financial participation rate for Georgia's Title XXI program.

4. State Share
   This line item reflects a portion of the funds, which have been allocated specifically to the Georgia Department of Community Health by the Georgia General Assembly.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. ☑ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☑ The state assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. ☑ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. Program Integrity (Section 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue to Section 12.**

11.1 ☑ **The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) ***The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)***

- **11.2.1. ☑ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)**
- **11.2.2. ☑ Section 1124 (relating to disclosure of ownership and related information)**
- **11.2.3. ☑ Section 1126 (relating to disclosure of information about certain convicted individuals)**
- **11.2.4. ☑ Section 1128A (relating to civil monetary penalties)**
- **11.2.5. ☑ Section 1128B (relating to criminal penalties for certain additional charges)**
- **11.2.6. ☑ Section 1128E (relating to the National health care fraud and abuse data collection program)**

Section 12. Applicant and enrollee protections (Sections 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**.

Eligibility and Enrollment Matters

12.1 Please describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120.

Upon denial of eligibility, a parent will be notified by mail of the reason for the denial and the process to notify PeachCare for Kids if the parent believes the denial is in error. Parents will first be directed to call the toll-free number and report additional information or clarify information on the applicant's account. The information or clarification will be input into the TPA eligibility system and a review of eligibility will be initiated. If the information provided does not result in the child being eligible, the parent will be notified of the reason the denial was upheld. If the parent would like additional reconsideration of the decision, the request will be directed to a senior supervisor and/or the account manager of the TPA. The management level will review if the determination made by the TPA system and supported by the staff is correct based on state and federal policy. If the supervisory level does not overturn the denial, the parent will once again be informed of the decision. If the parent continues to dispute the denial, the supervisory staff will inform the parent that they may submit a request in writing to the PeachCare for Kids, to be reviewed by state-level PeachCare for Kids staff.

Receipts of requests for review will be acknowledged in writing within 10 days, including notification that that member will receive a decision within 30 days. PeachCare for Kids will review requests for reconsiderations of denials. If PeachCare disagrees with the decision of the TPA, the child will be enrolled in PeachCare for Kids retroactive to the first day of the month in which the complete application, including any additional information affecting the outcome of PeachCare's decision, is received. If PeachCare for Kids agrees with the decision to deny eligibility, a letter will be sent to the parent detailing the reason for denial. If the parent elects to dispute the decision, the parent will have the option of having the decision reviewed by the Formal Appeals Committee for the State Health Benefit Plan. The member will have 30 days from the issuance of the letter to submit a request for a formal appeal. Formal appeals will be held within 45 days of request, allowing both

parties adequate time to prepare documentation and schedule of the appeal, either in person or through written communication.
The decision of the Formal Appeals Committee will be the final recourse available to the member. If at any level of dispute, the appropriate party determines the child is eligible for enrollment in PeachCare for Kids, the enrollment will become effective retroactive to the first day of the month in which the complete application, including any additional information affecting the outcome of PeachCare's decision, is received.

The State assures that in the review process, enrollees have the opportunity to fully participate in the review process; decisions are made in writing; and impartial reviews are conducted in a reasonable amount of time and consideration is given for the need for expedited review when there is an immediate need for health services.

Members whose coverage is cancelled due to closed enrollment will follow all of the same procedures for review as detailed in this section, including having the right to continue services pending completion of a review.

Health Services Matters

12.2 Please describe the review process for health services matters that complies with 42 CFR 457.1120.

Upon denial of covered benefits, a parent will notify the Care Management Organization if the parent believes that the service should be covered. The information provided by the parent in the phone call will initiate a review. The contracted CMO will research the situation, including reviewing the medical policy, the claims system and any documentation submitted by the physician, if applicable. The CMO will ensure that all reviews are conducted by a health care professional with appropriate clinical expertise, as determined by DCH, in treating the Member's Condition. If the initial review does not result in a change in the decision to deny a service, the parent will be notified of the reason the denial was upheld. If the parent would like additional reconsideration of the decision, the parent may submit a request in writing to the PeachCare for Kids, to be reviewed by DCH management staff, including the policy director of the service area and the Chief of the Division of Medicaid Services or his designee. If this decision of this review is maintain the denial of service, a letter will be sent to the parent detailing the reason for denial. If the parent elects to dispute the decision, the parent will have the option of having the decision reviewed by the Formal Appeals Committee for the State Health Benefit Plan. The decision of the Formal Appeals Committee will be the final recourse available to the member. In reference to the Formal Appeals level, the State assures:

- Enrollees receive timely written notice of any determinations that include the reasons for the determination, an explanation of applicable rights to review, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review.
- Enrollees have the opportunity for an independent, external review of a delay, denial, reduction, suspension, termination of health services, failure to approve, or provide payment for health services in a timely manner. The independent review is available at the Formal Appeals level.
- Decisions are written when reviewed by the CMO, DCH and the Formal Appeals Committee.
- Enrollees have the opportunity to represent themselves or have representatives in the process at the Formal Appeals level.
- Enrollees have the opportunity to timely review of their files and other

applicable information relevant to the review of the decision. While this is assured at each level of review, members will be notified of the timeframes for the appeals process once an appeal is filed with the Formal Appeals Committee.

- Enrollees have the opportunity to fully participate in the review process, whether the review is conducted in person or in writing.
- Reviews that are not expedited due to an enrollee's medical condition will be completed within 90 calendar days of the date a request is made consistent with 42 CFR §457.1160(b)(1).
- Reviews that are expedited due to an enrollee's medical condition are completed within 72 hours of the receipt of the request consistent with 42 CFR §457.1160(b)(2).

Consistent with 42 CFR §457.1130(c), DCH and its Agents are not required to provide an opportunity for review of medical or eligibility matters if the sole basis for the decision is a provision in the State Plan or in Federal or State law requiring an automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all applicants or enrollees without regard to their individual circumstances.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR ¸ 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

N/A

Attachment 1

PeachCare for Kids Application

Attachment 2:

PeachCare for Kids Closed Enrollment Public Information

PUBLIC NOTICE

Pursuant to 42 CFR § 457.65, the Georgia Department of Community Health is required to give public notice of any state plan amendment that limits or restricts eligibility in the State Children's Health Insurance Program, known as the Georgia's PeachCare for Kids Program.

PEACHCARE FOR KIDS

Pursuant to Title XXI of the Social Security Act, the PeachCare Program is a jointly funded state and federal insurance program for low-income children. Effective **March 11, 2007**, the Department will discontinue enrollment in the PeachCare for Kids Program.

- Any new applications received or postmarked after **March 11, 2007** will not be processed for PeachCare eligibility.

- Members whose participation in the program is suspended for failure to timely pay premiums or for failure to provide required income verification will also be affected by this change and will be precluded from re-enrollment. These members will receive additional notice by direct mail as required by governing regulations.

- Members enrolled and/or determined eligible prior to **March 11, 2007** will not be impacted by this particular proposed change.

This change serves as an effort to sustain the PeachCare for Kids Program so that low-income children currently enrolled in the program may continue to receive low-cost health insurance.

This public notice is available for review at each county Department of Family and Children Services office and will also be published in regional newspapers and on the Georgia Department of Community Health's website. An opportunity for public comment will be held on **February 23, 2007,** 10:00 a.m.-12:00 p.m., at the Floyd Room of the Twin Towers Building, 20th Floor, West Tower, 200 Piedmont Avenue, Atlanta Georgia. Individuals who are disabled and need assistance to participate during the meeting should call (404) 656-4479. Citizens wishing to comment in writing on the proposed changes should do so before **March 2, 2007** to the Board of Community Health, P.O. Box 38406, Atlanta, Georgia 30334.

Submitted comments will be available for review by the public at the Department of Community Health, Monday through Friday, 9:00 a.m. to 4:30 p.m., in Room 4074, 2 Peachtree Street, NW, Atlanta, Georgia 30303.

Comments from written and public testimony will be summarized and provided to the Board of Community Health prior to the **March 8, 2007** Board meeting. The Board will vote on the proposed change at the March meeting which will be held 10:30 a.m. at the Floyd Room of the Twin Towers Building, 20th Floor, West Tower, 200 Piedmont Avenue, Atlanta, Georgia.

NOTICE IS HEREBY GIVEN THIS 8TH DAY OF FEBRUARY, 2007
Rhonda M. Medows, M.D., Commissioner

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Rhonda M. Medows, MD, Commissioner Sonny Perdue, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

From: Commissioner Dr. Rhonda Medows, M.D.
Date: February 20, 2007
Re: PeachCare for Kids Enrollment Freeze

It was with a heavy heart that I announced we will stop accepting new applications to enroll in the PeachCare for Kids (PKC) program effective March 11, 2007. This freeze will then be in effect until further notice.

While we are no longer accepting new enrollees, I am writing to you as parents and guardians of children already enrolled in PKC to inform you that you should not be alarmed by this notification. This is NOT a notice announcing that the program is ending. As long as PKC has money to operate, **your children will receive care** under the terms of their current enrollment.

As a parent, I understand the importance of providing quality health care to your children, and I have notified providers that the enrollment freeze **does not impact the health care services** of current PKC members. Providers will continue to render health care services to current PKC members.

However, if you are required to pay a PCK premium, it is crucial that you make your monthly payment on time or your child(ren)'s coverage will be at risk. After March 11, 2007, any family whose participation in the program is cancelled for failure to pay premiums will no longer be re-enrolled during this period.

PCK, Georgia's State Children's Health Insurance Program, is a partnership between the state and federal government to provide comprehensive health care program for uninsured children living in Georgia. The state has committed its share of the funds; however, the program has a $131 million federal funding shortfall for Federal Fiscal Year 2007.

We continue to work with members of Congress, the members of our State Legislature and the Governor' office to resolve the funding needs of this very important program.

For additional information on the PeachCare for Kids program, please access http://www.dch.ga.gov.

If you have any questions or concerns, please feel free to call **1-877-GAPEACH (1-877-427-3224)**

To: Providers of PeachCare for Kids Health Care Services

From: Commissioner Dr. Rhonda Medows, M.D.

Date: February 16, 2006

Re: PeachCare for Kids Enrollment Freeze

It was with a heavy heart that I announced we will stop accepting new applications to enroll in the PeachCare for Kids (PKC) program effective March 11, 2007. This freeze will then be in effect until further notice.

While we are no longer accepting new enrollees, I am writing to inform you that the enrollment freeze does not affect the rendering of services to current PKC members. This is NOT a notice announcing that the program is ending. As long as PCK has money to operate, **members of PCK will receive care** under the terms of their current enrollment.

PCK, Georgia's State Children's Health Insurance Program, is a partnership between the state and federal government to provide comprehensive health care program for uninsured children living in Georgia. The state has committed its share of the funds; however, the program has a $131 million federal funding shortfall for Federal Fiscal Year 2007.

We continue to work with members of Congress, the members of our State Legislature and the Governor' office to resolve the funding needs of this very important program.

For additional information on the PeachCare for Kids program, please access http://www.dch.ga.gov.

If you have any questions or concerns, please feel free to call **1-800-766-4456**.

Equal Opportunity Employer

Rhonda M. Medows, MD, Commissioner
2 Peachtree Street, NW
Atlanta, GA 30303-3159
Sonny Perdue, Governor www.dch.georgia.gov

FOR IMMEDIATE RELEASE CONTACT:

February 8, 2007 Dena' Brummer
404-463-5391

PeachCare for Kids Enrollment Closes to New Members

Children currently enrolled continue to receive care

ATLANTA – Today, Georgia Department of Community Health Commissioner Dr. Rhonda Medows informed the Board of Community Health that PeachCare for Kids (PCK) will no longer accept new enrollees to the program as of March 11, 2007.

"We have seen this important program grow to cover over 270,000 children. It is a way for hard working parents to try to provide health care for their children," Dr. Medows said. "We continue to wait for an act of Congress to occur so that we can provide care for the children currently enrolled in the program through October 2007."

PCK, Georgia's State Children's Health Insurance Program (SCHIP), is a partnership between the state and federal government to provide comprehensive health care program for uninsured children living in Georgia. The state has reserved its share of the funds needed; however, the program has a $131 million federal funding shortfall for Federal Fiscal Year 2007.

The announcement comes as the state is actively urging Congress to allot funds for the SCHIP shortfall that Georgia and 14 other states face. State projections show that PCK will run out of operating funds sometime in March 2007.

A public notice has been filed to cease the allowance of new members to the PCK program. Effective March 11, 2007, only those currently enrolled in the PCK program may continue to receive services via the state.

"Parents and guardians of children already enrolled in PCK should not be alarmed by this notification," Dr. Medows said. "As long as the PCK has money to operate, your children will receive care under the terms of their current enrollment. We remain hopeful that Congress will fulfill its commitment to the SCHIP program."
For more information about the PeachCare for Kids program, please access http://www.dch.ga.gov

ATTACHMENT 2

PUBLIC NOTICE

Pursuant to 42 CFR § 457.65, the Georgia Department of Community Health is required to give public notice of any state plan amendment that limits or restricts eligibility in the State Children's Health Insurance Program, known as the Georgia's PeachCare for Kids™ Program.

PEACHCARE FOR KIDS

Pursuant to Title XXI of the Social Security Act, PeachCare for Kids™ is a jointly funded state and federal insurance program for low-income children. Effective July 1, 2007, the Department has modified its procedures for validating eligibility for the Program.

Income and citizenship information are a condition of eligibility for PeachCare for Kids™. This information has been accepted through self-declaration or upon request of documentation. To ensure appropriate enrollment in the program, effective July 1, 2007, the Department is requiring proof of income and citizenship status to determine eligibility.

Verification documents will be required for new applications received after July 1, 2007 and for all renewing accounts annually. Additionally, documentation may be sought at any time when changes in income are reported.

This public notice is available for review at each county Department of Family and Children Services office and will also be published in regional newspapers and on the Georgia Department of Community Health's website. Citizens wishing to comment in writing on the proposed changes should do so before September 26, 2007, to the Board of Community Health, P.O. Box 38406, Atlanta, Georgia 30334.