GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Long-Term Care Series

Georgia, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2023

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

Georgia, USA

In-Kind Benefits

Plan details 1992-2023 * †

Public long-term care (LTC) benefits in Georgia are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In Georgia, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, semi-residential care, residential care, and some that cover a variety of care. Programs may vary in eligibility criteria.

Since 1992, Georgia's LTC system has been subject to two major policy reforms: the implementation of an integrated primary and LTC program for older adults and adults with disabilities in 1997, and the implementation of a program to cover a new adult group under the Affordable Care Act in 2022.

Key Dates

First law: 1965

Major changes since 1992: 1997, 2022

Contents

* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-1996

Overview

Long-term care (LTC) benefits in Georgia are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Georgia is administered at the state level by the Department of Medical Assistance in coordination with the Department of Human Resources, and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Georgia are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based service (HCBS) LTC programs (Community Care Services Program - CCSP).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries who have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. People covered by CCSP are able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care (ADHC) and respite care. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. Those applying for CCSP are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a waiting list prioritized by need.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility and CCSP beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

During this policy period, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 restricted most legal immigrants entering the United States after August 22, 1996 from receiving federally funded Medicaid (and some other public assistance) for at least five years after immigration.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023e)

Georgia Law for Medicaid

- Ga. Code Ann. Title 49 - Social Services, Chapter 4 - Social Services (OCGA § 49-4-1 —49-4-193, 2023)
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- Ga. Rules & Regulations Chapter 111-8, Rules of Department of Community Health - Healthcare Facility Regulation (Ga. R&R 111-8-1 —111-8-100, 2023)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Georgia Medicaid spending on beneficiaries in fiscal year 1992 was 61.78%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (61.78% in 1992), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all programs first require eligibility for Medicaid. Here we detail eligibility for Georgia Medicaid, followed by additional requirements for specific programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Georgia.

Eligibility for Medicaid in Georgia for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 1992, the monthly federal benefit amount was $422 for an individual and $633 for a couple (SSA, 2023a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1988 (GDHS, 2022).
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[2]
  - Citizenship/immigration requirements: The applicant must be a U.S. Citizen or non-citizen who meets additional eligibility requirements.[3] After 1996, the applicant must be a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023d) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount (GDCH, 2023). In 1992, this was $1,266 for an individual. Eligibility for this track is generally determined as a household of one. Couple limits only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[5]
  - Asset requirements: Resources may not exceed $2,000. Eligibility for this track is generally determined as a household of one. Couples are limited to $3,000 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for institutional benefits. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[6]

        - Asset transfer: same as eligibility track 1a.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - The applicant must be at least age 65, blind, or disabled.[4]
        - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in the CCSP program.

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
    - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to meet a specific standard. This functions similar to a deductible. The spend down amount is calculated on a monthly basis and is determined by subtracting the Medicaid Protected Income Level (PIL) from monthly net countable income. The resulting amount must be spent on qualifying medical bills and services in order to receive Medicaid coverage for the remainder of the month. PILs vary by family size. In 1992, the PIL was $317 for an individual and $375 for a couple (GDMA, 1990). Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[5]
    - Asset requirements: Resources may not exceed $2,000 for an individual and $4,000 for a couple. This standard has remained the same since 1990 (GDHS, 2022). Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[6]
        - Asset transfer: same as eligibility track 1a.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - The applicant must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Cancer State Aid (CSA): A state-funded program that extends access to services for individuals in need of cancer treatment up to 250% of the FPL who are ineligible for Medicaid due to excess income.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Community Care Services Program (CCSP)

Beyond meeting minimum level of dependence requirements, CCSP applicants must be eligible for Medicaid through eligibility track 2a (Institutional Rules).

Other community-based programs

There exist several programs that have limited enrollment or are targeted at other populations (e.g., younger populations, individuals with intellectual disabilities). Some of these programs include:

- Independent Care Waiver: Adults with physical disabilities in Georgia may be entitled to home-based care services at income and resource levels equivalent to eligibility track 2a through the Independent Care Waiver Program (ICWP).
- Hospice: Provides care services to the terminally ill.

Benefit

Home care benefit

Home Health Services

Home Health provides (CDC, 1992; GDMA, 1992):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Home Health provides up to 75 visits per year. Visits in excess of 75 can be provided through the CCSP program if authorized as medically necessary by a physician.

Nursing Facility Care

Nursing Facility Care does not provide home care during this policy period.

CCSP

CCSP provides the following services in addition to those offered under the state plan, unless otherwise noted (GDMA, 1992):

- Home health services (as described above under the state plan.)
- Personal care services:
  - Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Alternate living services (ALS): Twenty-four-hour supervision with access to medically related personal care, nursing services, physical/occupational/speech therapies, dietitians, and meal services to individuals unable to continue living independently at home —ALS homes in Georgia are non-institutional residences licensed to serve 7-24 individuals, where individuals are responsible for covering room and board.

Semi-residential care

Home Health Services, Nursing Facility Care

These programs do not provide semi-residential care during this policy period.

CCSP

CCSP provides Adult Day Health Care (ADHC) (GDMA, 1992). Referred to as adult day rehabilitation until 1994, ADHC centers provide daytime and overnight supervision, personal care assistance, and sometimes meals to recipients in a group setting.

Residential care

Home Health Services, CCSP

These programs do not provide residential care during this policy period.

Nursing Facility Care

Medicaid provides care in skilled nursing facilities (SNF), which are certified facilities providing nursing care, routine physical therapy, occupational therapy, speech pathology, room and board, and use of required equipment.

Other benefits

Georgia Medicaid provides additional state plan benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy
- Medical social services: Services provided by medical social workers intended to ease environmental, social, or situational barriers to accessing or benefiting from community-based services

CCSP

CCSP provides the following services in addition to those offered under the state plan, unless otherwise noted (GDMA, 1992; GAS, 1982):

- Medical social services: additional services beyond what is covered under the state plan
- Case Management: Services that assist the participant in developing, authorizing, and monitoring their plan of care (referred to as "Care Coordination" during this policy period)
- Personal emergency response systems (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency (referred to as Emergency Response Services (ERS) in Georgia)
- Respite: Short-term relief provided to an enrollee's caregiver in the enrollee's home/place of residence, Medicaid licensed hospital, nursing facility, or ALS facility

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Georgia Department of Medical Assistance with help from the Department of Human Resources. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

The beneficiary must be homebound and must have their need for skilled nursing or home health aide services certified as medically necessary by a physician (GDMA, 1992).

Nursing Facility Care

Individuals must require a nursing facility level of care (NFLOC) for longer than 30 days and have a physician certify continuous need for nursing facility care.

CCSP

The beneficiary must meet NFLOC, have a physician certify that their needs can be met in a home-based environment through CCSP and other available community resources, and require services for at least six months (GSHPC, 1987). However, meeting the minimum level of dependence does not guarantee admission. CCSP program applicants are placed on a waitlist if the number of applicants for the year exceeds the budget allocated to the program. Program applicants are waitlisted based on need.

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 60 days through a physician's review of the individual's plan of care, or more often if there is a change in condition (42 CFR 484.55). If a beneficiary requires more than 75 home health visits in a year, they are referred to the CCSP program for continued services.

Nursing Facility Care

NFLOC and Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition (GDCH, 2023). After admission, quarterly and annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (42 CFR 483.20).

CCSP

CCSP beneficiaries are reassessed at least annually to ensure they remain eligible, and that services remain appropriate to meet their needs.

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care

There is no age requirement.

CCSP
The individual must be at least age 65, or younger with a physical disability.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services
A physician must certify that the beneficiary's needs for home health services are medically necessary. The physician must also certify that the individual is homebound, which means that the individual is not bedridden, but has limited ability to leave the home because of their condition (GDMA, 1992).

Nursing Facility Care
Individuals must meet NFLOC in order to be admitted to a nursing facility. A Level I Pre-Admission Screening and Annual Resident Review (PASARR) must also indicate that that the resident does not have a mental disorder or intellectual disability that would warrant an alternative living environment. In later policy periods this screening is referred to as the Pre-Admission Screening and Resident Review (PASRR).

Author's note: The precise criteria used to satisfy NFLOC during this policy period could not be determined.

CCSP
CCSP applicants must meet the same NFLOC —sometimes referred to as intermediate level of care (ILOC) during this policy period —required for the other state plan LTC benefits, and have a physician certify that their needs can be met through CCSP and other available home-based program services. The individual must also require CCSP services for longer than six months due to a chronic illness or impairment (GSHPC, 1987).

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services
Individuals must have a physician's order that includes a record of an initial face-to-face assessment, written orders for a plan of care that certifies the medical necessity of services rendered, and attestation that the individual's needs can be adequately met using resources available in the community.

Nursing Facility Care
Prior to admission, a physician will certify NFLOC using a Georgia Department of Medical Assistance form 6 (DMA-6). The DMA-6 is completed by a physician who certifies NFLOC in section B, and a nurse who determines functional impairment and unmet need. See Box 1 for more on the DMA-6 form, and see GDMA (1991) for the full form.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 2 for more information on the PASRR, and Box 3 for the MDS.

CCSP
A telephone interview screens for potential eligibility, and places applicants on a monthly planning list based on level of impairment and unmet need. Once the program is able to admit the applicant, a face-to-face assessment determines need for services and a care coordinator determines medical eligibility, level of care, and the beneficiary's care plan. The precise criteria used to assess eligibility in the telephone screening and face-to-face assessment are not known for this policy period.

Evaluators

Evaluators vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services
A licensed physician must certify that the beneficiary requires home health services out of medical need. A registered nurse can evaluate and certify the services needed in the individual's plan of care.

Nursing Facility Care

A licensed physician must determine level of care and admission to a nursing facility. An interdisciplinary team that is made up of at least one physician, one registered nurse, and one social worker must also have determined whether care can be provided more cost-effectively in a home-based setting (Ga. Code 49-6-63). The Pre-Admission Screening and Resident Review (PASRR) is conducted by the Georgia Medical Care Foundation (GMCF), a state-approved contractor, and does not require a physician's or nurse's signature for certification (CDC, 1992).

CCSP

The initial telephone screening is conducted by agency staff and care coordinators from the individual's local Area Agency on Aging. The face-to-face evaluation and subsequent reevaluations are conducted by nurses who authorize the plan of care, and a physician must certify the need for NFLOC. The Department of Medical Assistance determines financial eligibility for Medicaid.

Benefit limitations

Can you mix LTC benefits?

All Georgia Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

Georgia did not implement an estate recovery program until 2006.

Home Health Services

Beneficiaries eligible for Medicaid and Medicare (known as dually eligible) are exempt from copayments. As of July 1, 1994, a $3 copayment applies for non-CCSP program home health visits provided to non-dual eligible beneficiaries (GDCH, 2023).

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 1992, the PNA was $30 per month.

CCSP

CCSP beneficiaries are expected to contribute any income over the SSI benefit amount to the cost of services.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 1997-2021

Policy change in 1997

In 1997, Georgia implemented a new demonstration program called Service Options Using Resources in a Community Environment (SOURCE). This program was initially piloted in Savannah, Georgia to provide case management of home and community-based LTC, and to integrate these services with primary care. In its second year, the program was expanded to four metropolitan areas (Savannah, Atlanta, Augusta, Hinesville) and was implemented statewide in 2008.

Other reforms during this period:

- (1999) Senate Bill 241 created the Georgia Department of Community Health (DCH), which consolidated the Department of Medical Assistance, Department of Public Health, State Health Planning Agency, and Health Benefits Services Division into a new entity tasked with regulating, planning, and purchasing health care in Georgia.
- (2004) Beginning in 2004, the annual maximum number of Home Health visits a beneficiary is entitled to was reduced from 75 to 50. If a beneficiary requires additional home health services, they are referred to CCSP (GDAS, 2004).
- (2006) Estate recovery, authorized under the 1993 Omnibus Budget Reconciliation Act and implemented in Georgia in 2006, allowed the DCH to place a claim against the estate of a Medicaid recipient to recover costs for lifetime long-term care services received by the Medicaid recipient.
- (2006) The Deficit Reduction Act of 2005 authorized a home equity limit of $500,000 for Medicaid applicants. Prior to 2006, in determining an applicant's assets, the value of an individual's home was usually exempt. Under the new law, a person with more than $500,000 in home equity is ineligible for nursing facility care under Medicaid. Homes occupied by a spouse or a disabled or minor child are exempt.
- (2006) Effective July 1, 2006, Georgia implemented a state-administered State Supplementary Payment (SSP) of $20 for SSI recipients residing in Medicaid-certified nursing homes.
- (2006) Effective July 1, 2006, Georgia increased its personal needs allowance (PNA) for nursing home residents from $30 to $50 (GDHR, 2007).
- (2008) The SOURCE program was expanded statewide and placed under the authority of the same federal program as CCSP, Georgia's other major program providing home- and community-based LTC. While CCSP and SOURCE maintain separate financial eligibility criteria, they now provide the same services and use the same level of care assessment criteria.
- (2011) Georgia received a grant through the Balancing Incentive Program to implement a set of structural reforms aimed at improving access to home and community-based services (HCBS). Reforms included streamlining the application process for HCBS programs and services, increasing CCSP's enrollment capacity, and expanding support for nursing home transition services.
- (2014) The Affordable Care Act (ACA) required states to extend spousal impoverishment rules to individuals receiving LTC through HCBS programs, including CCSP and SOURCE. From 2014, additional income and asset disregards applied to the community spouse of an individual receiving Medicaid HCBS.
- (2018) Effective July 1, 2018, Georgia's PNA was increased from $50 to $65 (CMS, 2018).
- (2019) Effective July 1, 2019, Georgia's PNA was increased once more from $65 to $70 (GDCH, 2019b).
- (2019) Structured Family Caregiving (SFC) was added as a program benefit to CCSP and SOURCE, providing financial and technical support to live-in family caregivers who provide at least five hours daily of personal support services to a program beneficiary.

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Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Georgia are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based service (HCBS) LTC programs (Community Care Services Program - CCSP and Services Options Using Resources in a Community Environment - SOURCE).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries who have established medical necessity, while Nursing Faciilty Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. People covered

by CCSP or SOURCE are able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care (ADHC) and respite care. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. Those applying for CCSP are not immediately guaranteed care, as the program has a strict enrollment limit. SOURCE implemented an enrollment limit in 2012 to ensure equitable access to services among HCBS programs. If the programs are at capacity, individuals are placed on a waiting list prioritized by need.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility, CCSP, and SOURCE beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

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Eligibility for Medicaid in Georgia for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 1997, the monthly federal benefit amount was $484 for an individual and $726 for a couple (SSA, 2023b). See Table 2 for historical monthly benefit amounts.
  - Asset requirements:Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1988 (GDHS, 2022).
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[7]
    - Home equity limit: Beginning in 2007, the equity interest in the individual's home may not exceed $500,000, or else they will be ineligible for LTC services. This figure increases annually with inflation beginning in 2011 (SSA, 2023a).[8]
  - Citizenship/immigration requirements: The applicant must be a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals that entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023d) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount (GDCH, 2023). In 1997, this was $1,452 for an individual. Eligibility for this track is generally determined as a household of one. Couple limits only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). See Table 2 for historical monthly benefit amounts. Additional income exceptions exist if a person is institutionalized or enrolled in CCSP or SOURCE and has a spouse residing in the community.[9]
  - Asset requirements: Resources may not exceed $2,000 for an individual. Eligibility for this track is generally determined as a household of one. Couples are limited to $3,000 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for institutional benefits. Additional asset disregards exist if a person is institutionalized or enrolled in CCSP or SOURCE and has a spouse residing in the community.[10]
    - Asset transfer & Home equity limit: same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]
    - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in the CCSP or SOURCE programs.

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to meet a specific standard. This functions similar to a deductible. The spend down amount is calculated on a monthly basis and is determined by subtracting the Medicaid Protected Income Level (PIL) from monthly net countable income. The resulting amount must be spent on qualifying medical bills and services in order to receive Medicaid coverage for the remainder of the month. PILs vary by family size and geographic area. In 1997, the PIL was $317 for an individual and $375 for a couple. This standard has remained the same since 1990 (GDHS, 2022). Additional income exceptions exist if a person is institutionalized or enrolled in CCSP or SOURCE and has a spouse residing in the community.[9]
  - Asset requirements: Resources may not exceed $2,000 for an individual and $4,000 for a couple. This standard has remained the same since 1990 (GDHS, 2022). Additional asset disregards exist if a person is institutionalized or enrolled in CCSP or SOURCE and has a spouse residing in the community.[10]
    - Asset transfer & Home equity limit: same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements

* The applicant must be at least age 65, blind, or disabled.[4]
* After 2004, this eligibility track cannot be used to qualify for receipt of nursing facility care or CCSP/SOURCE program services. Individuals can qualify for Medicaid through this track and access state plan home health services.[11]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Cancer State Aid (CSA): A state-funded program that extends access to services for individuals in need of cancer treatment up to 250% of the FPL who are ineligible for Medicaid due to excess income.
- Women's Health Medicaid (WHM): Beginning in 2000, women under age 65 who are diagnosed with breast or cervical cancer and make up to 200% of the FPL qualify for Medicaid to help pay for treatment.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Community Care Services Program (CCSP) / Service Options Using Resources in a Community Environment

Georgia has two programs with two separate eligibility tracks, each of which falls under one of the eligibility tracks described above. The SOURCE program was initially piloted in 1997 as a separate program, and was moved under the same federal program as CCSP when it reached statewide expansion in 2008:

- CCSP: Beyond meeting minimum level of dependence requirements, CCSP applicants must be eligible for Medicaid through eligibility track 2a.
- SOURCE: Beyond meeting minimum level of dependence requirements, SOURCE applicants must be eligible for Medicaid through eligibility track 1a.

Other community-based programs

There exist several home and community-based services HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Money Follows the Person: Provides transition support services for nursing home residents who wish to receive care in a home or community-based setting
- Independent Care Waiver: Adults with physical disabilities in Georgia entitled to home-based care services at income and resource levels equivalent to eligibility track 2a through the Independent Care Waiver Program (ICWP)
- Hospice: Provides care services to the terminally ill

Benefit

Home care benefit

Home Health Services

Home Health provides (GDHS, 1999):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Home Health provides up to 75 visits per year. Visits in excess of 75 can be provided through the CCSP or SOURCE programs if authorized as medically necessary by a physician.

Nursing Facility Care

Nursing Facility Care does not provide home care during this policy period.

CCSP/SOURCE

CCSP and SOURCE provide the following services in addition to those offered under the state plan, unless otherwise noted GDHS, 1999; hyperref[GAA2015](AA, 2015):

- Home health services: (as described above under the state plan.)
- Personal care services:

  - Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
  - In Georgia, personal care services are referred to as Personal Support Services (PSS), or as Extended Personal Support Services (PSSX) when utilized for longer periods of time or overnight as respite care. Structured Family Caregiving (SFC) was introduced in 2019 to provide social, financial, and technical support to family caregivers providing at least 5 hours daily of PSSX daily to a CCSP or SOURCE program beneficiary. See Box 4 for full details.
- Alternate living services (ALS): Twenty-four-hour supervision with access to medically related personal care, nursing services, physical/occupational/speech therapies, dietitians, and meal services to individuals unable to continue living independently at home —ALS homes in Georgia are non-institutional residences licensed to serve 7-24 individuals, where individuals are responsible for covering room and board.

Semi-residential care

Home Health Services, Nursing Facility Care

These programs do not provide semi-residential care during this policy period.

CCSP/SOURCE

The CCSP and SOURCE programs provide Adult Day Health Care (ADHC) (GDHS, 1999; GDCH, 2022a). ADHC centers provide daytime and overnight supervision, personal care assistance, and sometimes meals in a group setting.

Residential care

Home Health Services, CCSP/SOURCE

These programs do not provide residential care during this policy period.

Nursing Facility Care

Medicaid provides care in skilled nursing facilities (SNF), which are certified facilities providing nursing care, routine physical therapy, occupational therapy, speech pathology, room and board, and use of required equipment.

Other benefits

Georgia Medicaid provides additional state plan benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy
- Medical social services: Services provided by medical social workers intended to ease environmental, social, or situational barriers to accessing or benefiting from community-based services

CCSP/SOURCE

CCSP and SOURCE provide the following services in addition to those offered under the state plan, unless otherwise noted (GDHS, 1999):

- Medical social services: additional services beyond what is covered under the state plan
- Case Management: Services that assist the participant in developing, authorizing, and monitoring their plan of care (referred to as "Care Coordination" during this policy period in Georgia).
- Home delivered meals (HDM): HDM services include meals, nutrition screening, and counseling/education services available to individuals who are incapable of preparing meals due to functional or cognitive impairment
- Personal emergency response systems (PERS): Installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency (referred to as Emergency Response Services (ERS) in Georgia)
- Respite: Short-term relief provided to an enrollee's caregiver in the enrollee's home/place of residence, Medicaid licensed hospital, nursing facility, or ALS facility. Starting in 2019, respite support services are provided to CCSP/SOURCE participants through the Structured Family Caregiving (SFC) program. See Box 4 for specific services provided by SFC, as well as caregiver and care recipient qualifications.
- Community transition services: Non-recurring expenses for people who are in the process of transitioning from a nursing facility to a less institutional setting (e.g., case management, financial support for moving expenses)
- Primary Care Case Management (PCCM): PCCM is available only to SOURCE program recipients until 2015, and integrates primary medical care with care management and home- and community-based LTC.

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Georgia Department of Medical Assistance with help from the Department of Human Resources. Beginning on July 1, 1999, the Department of Medical Assistance was consolidated along with three other departments under the newly created Department of Community Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

The beneficiary must have their need for skilled nursing or home health aide services provided in a home-based setting certified as medically necessary by a physician (GDAS, 2001).

Nursing Facility Care

Individuals must require NFLOC for longer than 30 days and have a physician certify continuous need for nursing facility care.

CCSP/SOURCE

The beneficiary must meet the same NFLOC required for nursing facility placement, choose to remain in a home-based environment, and require at least one program service provided at least once per month. Applicants are screened using an assessment form that determines level of impairment and care need in a set of core ADLs and IADLs. See Table 3 for the Determination of Need (DON-R) screening form (GDAS, 1999a). By 2004, the DON-R is used as a pre-screening tool, and the participant must score at least 15 in the level of impairment column and be assessed as having unmet care needs in at least one ADL in the care needs column in order to be placed on the waitlist for program entry (GDHS, 2004).

Meeting the minimum level of dependence does not guarantee admission, and CCSP program applicants can be placed on a waitlist if the number of applicants for the year exceeds the budget allocated to the program. The SOURCE program did not have a waitlist until 2012, when it implemented one using the DON-R for greater parity among applicants to both programs in accessibility of services (GAA, 2012). Waitlisted applicants are prioritized according to need and risk of institutionalization.

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the four largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 60 days through a physician's review of the individual's plan of care, or more often if there is a change in condition (42 CFR 484.55). If a beneficiary requires more than 75 home health visits in a year, they are referred to the CCSP program for continued services. Beginning in 2004, this threshold was reduced to 50 visits per year, after which the beneficiary is referred to CCSP for continued home health services (GDAS, 2004).

Nursing Facility Care

NFLOC and Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition (GDCH, 2023). After admission, quarterly and annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (42 CFR 483.20).

CCSP/SOURCE

CCSP and SOURCE beneficiaries are reassessed at least annually to ensure they remain eligible, and that services remain appropriate to meet their needs (GDAS, 1999b).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care

There is no age requirement.

CCSP/SOURCE

The individual must be at least age 65, or younger with a physical disability.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

A physician must certify that the beneficiary's needs for home health services are medically necessary. The physician must also certify that the individual's needs can be met through available community resources in a home-based setting.

Nursing Facility Care

Individuals must meet NFLOC in order to be admitted to a nursing facility, and must have been a resident of a Medicaid certified nursing home for at least 30 days. To meet NFLOC, the individual must have a physical and/or mental impairment that requires physician-directed nursing care, monitoring, and supervision on a continuous basis (GDAS, 2001). A Level I Pre-Admission Screening and Resident Review (PASRR) must also indicate that that the resident does not have a mental disorder or intellectual disability that would warrant an alternative living environment. See Table 5 for a full list of medical, functional, and cognitive criteria to meet NFLOC in Georgia. These specific criteria are confirmed to have been in use as early as 2000.

Level I Pre-Admission Screening and Resident Review (PASRR) is indicated by answering "No" to all five questions on the PASRR. A "Yes" to one of the first three questions can still result in a Level I suitability for nursing facility care based on the evaluator's full review, and a "Yes" to question 4 or 5 may still receive approval for nursing facility care if authorized by contracted authorities or the PASRR Determination Unit. See Box 5 for the list of questions asked in the PASRR Level I screening.

Author's note: The precise criteria used to satisfy NFLOC for years 1997-2000 are not known.

CCSP/SOURCE

CCSP and SOURCE applicants receive a telephone screening that uses a Determination of Need-Revised (DON-R) assessment instrument to evaluate whether an applicant's level of impairment and unmet need for care meet potential program eligibility standards (GDAS, 1999a). See Table 3 for more on how level of impairment and unmet care needs are scored using the DON-R screening. For entry into the program, applicants for CCSP and SOURCE must meet NFLOC, and have a physician certify that their needs can be met through available home-based program services. NFLOC is certified using the Level of Care Placement Instrument (Form 5588), which uses the Minimum Data Set - Home Care (MDS-HC) to determine NFLOC and build the individual's care plan. See Box 1 for services needed and impairments recorded in Form 5588, and see Table 4 for a summary of the conditions and impairments assessed in the MDS-HC to determine NFLOC. While NFLOC is the same level of care needed for other LTC program benfits, it is often referred to as intermediate level of care (ILOC) with respect to CCSP and SOURCE eligibility during this policy period.

Evaluation of dependence

Evaluations of dependence vary depending on LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

Individuals must have a physician's order that includes a record of an initial face-to-face assessment, written orders for a plan of care that certifies the medical necessity of services rendered, and attestation that the individual's needs can be adequately met using resources available in the community.

Nursing Facility Care

Prior to admission, a physician will certify NFLOC and screen for mental illness and/or intellectual disability with Georgia Department of Medical Assistance forms 6 (DMA-6) and 613 (DMA-613) respectively. See Box 1 and Box 5 for additional information on NFLOC certification form DMA-6 and PASRR screening form DMA-613. Once NFLOC determination has been made and certified by a licensed physician on the DMA-6, the remainder of the form, which authorizes the plan of care and services needed, is filled out by a registered nurse (RN). See Box 1 for additional information on NFLOC certification form DMA-6, and see DMA, (1991) to view the full assessment form.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR), which is conducted using form DMA-613, and periodic assessments using the Minimum Data Set (MDS). See Box 2 for more information on the PASRR, Box 5 for a summary of the DMA-613 form, and Box 3 for more information on the MDS.

Finally, within 14 days of nursing facility admission, as well as in quarterly and annual intervals, nursing facility staff are federally required to complete a Minimum Data Set (MDS) 3.0. The MDS is a standardized assessment tool that measures health status in nursing facility residents. It is completed within 14 days of admission to build the resident's initial plan of care, every three months to monitor for changes in condition, and is annually approved by a physician to certify continued need for care. To view the full assessment, see (link). See Table 4 for an overview of the full MDS 3.0 assessment. In general, the assessment collects information in the following domains (CMS & state sources):

- Functional status
- Cognitive status
- Psychosocial functioning
- Geriatric syndromes

All individuals seeking nursing facility care must be given information on home- and community-based service options upon admission to the nursing facility, as well as during annual MDS assessments (GDCH 2023b).

CCSP/SOURCE

A telephone interview screens for potential eligibility. CCSP program applicants are then placed on a monthly planning list based on level of impairment and need. See Table 3 for the screening form. Once the program is able to admit the applicant, a face-to-face assessment determines the services that will comprise the individual's care plan, a care coordinator determines medical eligibility, and the Division of Family and Children Services determines financial eligibility for Medicaid.

Starting in 2012, the SOURCE program also implemented a waitlist for greater parity in access among potential program beneficiaries applying for LTC benefits from the two programs (GAA, 2012).

Evaluators

Evaluators vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

A licensed physician, or certain categories of physician-supervised staff (e.g., nurse practitioner, certified midwife, physician assistant), must certify an individual's eligibility for home health benefits based on a face-to-face assessment, which must occur within 90 days prior to or 30 days after the start of care (GDCH, 2023e). A licensed physician must certify that the beneficiary requires home health services out of medical need, and a registered nurse can evaluate and certify the services needed in the individual's plan of care. The physician may not have a financial relationship with the home health agency being referred to for services ((GDCH, 2023e)).

Nursing Facility Care

A licensed physician must determine level of care and admission to a nursing facility. An interdisciplinary team that is made up of at least one physician, one registered nurse, and one social worker must also have determined whether care can be provided more cost-effectively in a home-based setting (Ga. Code 49-6-63). Pre-Admission Screening and Resident Review (PASRR) can be conducted by a state-approved contractor and does not require a physician's or nurse's signature for certification (GDCH, 2023f).

CCSP/SOURCE

The initial telephone screening is conducted by the applicant's local Area Agency on Aging Community Care Assessment team. The face-to-face evaluation and subsequent reevaluations are conducted by nurses, who ultimately certify the level of care and services required. A physician must authorize the need for NFLOC (GDCH, 2023). Care services can be ordered by care coordinators, but a licensed physician, nurse practitioner, or physician's assistant must certify their approval.

Benefit limitations

Can you mix LTC benefits?

All Georgia Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

In 2006, Georgia implemented a Medicaid Estate Recovery program as required by federal law. Medicaid estate recovery allows the Medicaid agency to file a claim against the estate of a Medicaid recipient after their death. Estate recovery applies to those Medicaid recipients who have received nursing facility care or CCSP/SOURCE program services at any time on or after August 31, 1993, and who were 55 years of age or older at the time of provision of the service. Starting in 2018, the state will waive its claim against the first $25,000 of the beneficiary's estate. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (Ga. R&R 111-3-8-.04, 42 USC 1396p(b)(1)).

Home Health Services

Beneficiaries eligible for both Medicaid and Medicare (known as dually eligible) are exempt from copayments. A $3 copayment applies for non-CCSP/SOURCE program home health visits provided to non-dual eligible beneficiaries.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 1997, the PNA was $30 per month.

CCSP/SOURCE

CCSP beneficiaries are expected to contribute any income over the SSI benefit amount to the cost of services. There are no user charges for SOURCE services during this policy period.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 3: Policy enacted 2022-2023

Policy change in 2022

In 2022, Georgia received approval to create a new Medicaid eligibility track for adults between 19-64 years of age with income below the poverty line who were not otherwise eligible for Medicaid. People eligible for Medicaid under this eligibility track must satisfy a work requirement and are required to pay insurance premiums if earning above an established threshold, making this eligibility track significantly less applicable to older adults seeking to qualify for LTC services. This program was originally approved in 2020, with the work requirements and premiums rescinded in 2021 (along with similar requirements in six other states) after CMS determined that they posed a significant barrier to the program's ability to provide coverage during the ongoing COVID-19 pandemic. The state government of Georgia sued and the program was reinstated by a federal judge in August 2022, and implemented on July 1, 2023. This new eligibility track provides access to the same benefits available under the existing state plan.

Other reforms during this period:

- (2022) Assistive technology was added as a program benefit to the CCSP and SOURCE programs.

Overview

Long-term care (LTC) benefits in Georgia are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Georgia is administered at the state level by the Department of Community Health in coordination with the Department of Human Services, and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Georgia are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based service (HCBS) LTC programs (Community Care Services Program - CCSP and Services Options Using Resources in a Community Environment - SOURCE).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries who have established medical necessity, while Nursing Faciilty Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. People covered by CCSP or SOURCE are able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care (ADHC) and respite care. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. Those applying for CCSP and SOURCE are not immediately guaranteed care, as the programs have strict enrollment limits. If the program is at capacity, individuals are placed on a waiting list prioritized by need.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility, CCSP, and SOURCE beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023e)

Georgia Law for Medicaid

- Ga. Code Ann. Title 49 - Social Services, Chapter 4 - Social Services (OCGA § 49-4-1 —49-4-193, 2023)
- Ga. Code Ann. Title 49 - Social Services, Chapter 6 - Services for the Aging (OCGA § 49-6-1 —49-6-92, 2023)
- Ga. Rules & Regulations Chapter 111-3, Rules of Department of Community Health - Medical Assistance (Ga. R&R 111-3-6 —111-3-14, 2023)
- Ga. Rules & Regulations Chapter 111-8, Rules of Department of Community Health - Healthcare Facility Regulation (Ga. R&R 111-8-1 —111-8-100, 2023)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Georgia Medicaid spending on beneficiaries in fiscal year 2022 was 73.05%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (73.05% in 2022), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all programs first require eligibility for Medicaid. Here we detail eligibility for Georgia Medicaid, followed by additional requirements for specific programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Georgia.

Eligibility for Medicaid in Georgia for people needing LTC services is primarily attained by satisfying at least one of 4 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2022, the monthly federal benefit amount was $841 for an individual and $1,261 for a couple (SSA, 2023b). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1988 (GDHS, 2022).
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[14]
    - Home equity limit: The equity interest in the individual's home may not exceed $636,000, or else they will be ineligible for LTC services (GDCH, 2023). This figure increases annually with inflation (SSA, 2023a).[10]
  - Citizenship/immigration requirements: The applicant must be a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals that entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023d) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[6]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount (GDCH, 2023). In 2022, this was $2,523 for an individual. Eligibility for this track is generally determined as a household of one. Couple limits only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). See Table 2 for historical monthly benefit amounts. Additional income disregards exist if a person is institutionalized or enrolled in CCSP or SOURCE and has a spouse residing in the community.[12]
  - Asset requirements: Resources may not exceed $2,000. Eligibility for this track is generally determined as a household of one. Couples are limited to $3,000 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for institutional benefits. Additional asset disregards exist if a person is institutionalized or enrolled in CCSP or SOURCE and has a spouse residing in the community.[13]
    - Asset transfer & Home equity limit: same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[6]
    - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in the CCSP or SOURCE programs.
- 2c. Affordable Care Act (ACA) expansion adults
  In Georgia this eligibility track is called Georgia Pathways to Coverage, and has key differences from other states, including a work requirement that makes this track significantly less applicable to older adults seeking to qualify for LTC.[14]
  - Income requirements: Income may not exceed 100% of the FPL. In 2022, this was $1,132.50 for an individual and $1,526 for a household of two.
  - Asset requirements: There is no asset test for this population.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - Applicants must be aged 19-62, ineligible for Medicare, ineligible for other Medicaid eligibility tracks, and not incarcerated in a public institution.
    - Applicants must report work or other qualified activities unless they are exempt.[16]

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to meet a specific standard. This functions similar to a deductible. The spend down amount is calculated on a monthly basis and is determined by subtracting the Medicaid Protected Income Level (PIL) from monthly net countable income. The resulting amount must be spent on qualifying medical bills and services in order to receive Medicaid coverage for the remainder of the month. PILs vary by family size and geographic area. In 2022, the PIL was $317 for an individual and $375 for a couple. This standard has remained the same since 1990 (GDHS, 2022). Additional income disregards exist if a person is institutionalized or enrolled in CCSP or SOURCE and has a spouse residing in the community.[11]
  - Asset requirements: Resources may not exceed $2,000 for an individual and $4,000 for a couple. This standard has remained the same since 1990 (GDHS, 2022). Additional asset disregards exist if a person is institutionalized or enrolled in CCSP or SOURCE and has a spouse residing in the community.[12]
    - Asset transfer & Home equity limit: same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[6]
    - After 2004, this eligibility track cannot be used to qualify for receipt of nursing facility care or CCSP/SOURCE program services. Individuals can qualify for Medicaid through this track and access state plan home health services.[11]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Cancer State Aid (CSA): A state-funded program that extends access to services for individuals in need of cancer treatment up to 250% of the FPL who are ineligible for Medicaid due to excess income.
- Women's Health Medicaid (WHM): Beginning in 2000, women under age 65 who are diagnosed with breast or cervical cancer and make up to 200% of the FPL qualify for Medicaid to help pay for treatment.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become

eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Nursing Facility Care
There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

CCSP/SOURCE
Georgia's Elderly & Disabled Waiver Program combines two programs with two separate eligibility tracks, each of which falls under one of the eligibility tracks described above:

- Community Care Services Program (CCSP): same financial, asset, and citizenship/residency requirements as eligibility track 2a.
- Service Options Using Resources in a Community Environment (SOURCE): same financial, asset, and citizenship/residency requirements as eligibility track 1a.

Other community-based programs
There exist several home and community-based services HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Money Follows the Person: Provides transition support services for nursing home residents who wish to receive care in a home or community-based setting
- Independent Care Waiver: Adults with physical disabilities in Georgia may be entitled to home-based care services at income and resource levels equivalent to eligibility track 2a through the Independent Care Waiver Program (ICWP).
- Program of All-Inclusive Care for the Elderly (PACE)
- Hospice: Provides care services to the terminally ill.

Benefit

Home care benefit

Home Health Services
Home Health provides:

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Home Health provides up to 50 visits per year. Visits in excess of 50 can be provided through the CCSP or SOURCE programs if authorized as medically necessary by a physician.

Nursing Facility Care
Nursing Facility Care does not provide home care during this policy period.

CCSP/SOURCE
CCSP and SOURCE provide the following services in addition to those offered under the state plan, unless otherwise noted:

- Home health services: (as described above under the state plan.)
- Personal care services:
  - Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
  - In Georgia, personal care services are referred to as Personal Support Services (PSS), or as Extended Personal Support Services (PSSX) when utilized for longer periods of time or overnight as respite care. Structured Family Caregiving (SFC) was introduced in 2019 to provide social, financial, and technical support to family caregivers providing at least 5 hours daily of PSSX daily to a CCSP or SOURCE program beneficiary. See Box 4 for full details.
- Alternate living services (ALS): Twenty-four-hour supervision with access to medically related personal care, nursing services, physical/occupational/speech therapies, dietitians, and meal services to individuals unable to continue living independently at home —ALS homes in Georgia are non-institutional residences licensed to serve 7-24 individuals, where individuals are responsible for covering room and board

Semi-residential care

Home Health Services, Nursing Facility Care

These programs do not provide semi-residential care during this policy period.

CCSP/SOURCE

The CCSP and SOURCE programs provide Adult Day Health Care (ADHC) (GDHS, 1999; GDCH, 2022a). ADHC centers provide daytime and overnight supervision, personal care assistance, and sometimes meals in a group setting.

Residential care

Home Health Services, CCSP/SOURCE

These programs do not provide residential care during this policy period.

Nursing Facility Care

Medicaid provides care in skilled nursing facilities (SNF), which are certified facilities providing nursing care, routine physical therapy, occupational therapy, speech pathology, room and board, and use of required equipment.

Other benefits

Georgia Medicaid provides additional state plan benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy
- Medical social services: Services provided by medical social workers intended to ease environmental, social, or situational barriers to accessing or benefiting from community-based services

CCSP/SOURCE

CCSP and SOURCE provide the following services in addition to those offered under the state plan, unless otherwise noted:

- Medical social services: additional services beyond what is covered under the state plan
- Case Management: Services that assist the participant in developing, authorizing, and monitoring their plan of care
- Home delivered meals (HDM): HDM services include meals, nutrition screening, and counseling/education services available to individuals who are incapable of preparing meals due to functional or cognitive impairment
- Personal emergency response systems (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency (referred to as Emergency Response Services (ERS) in Georgia)
- Respite: Short-term relief provided to an enrollee's caregiver in the enrollee's home/place of residence, Medicaid licensed hospital, nursing facility, or ALS facility. In Georgia, respite support services are provided to CCSP/SOURCE participants through the Structured Family Caregiving (SFC) program. See Box 4 for specific services provided by SFC, as well as caregiver and care recipient qualifications.
- Community transition services: Non-recurring expenses for people who are in the process of transitioning from a nursing facility to a less institutional setting (e.g., case management, financial support for moving expenses)
- Enhanced Case Management: Integrates primary medical care with care management and home- and community-based LTC
- Assistive technology: Adaptive equipment that improves functional capabilities, such as home automation, computer accessibility software and hardware, telecare device

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Georgia Department of Community Health with help from the Department of Human Services. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

The beneficiary must have their need for skilled nursing or home health aide services provided in a home-based setting certified as medically necessary by a physician (GDCH, 2023e).

Nursing Facility Care

Individuals must require NFLOC for longer than 30 days and have a physician certify a continuous need for nursing facility care (GDCH, 2023c).

CCSP/SOURCE

The beneficiary must meet the same NFLOC required for nursing facility placement, choose to remain in a home-based environment, and require at least one program service provided at least once per month. However, meeting the minimum level of dependence does not guarantee admission. CCSP and SOURCE program applicants can be placed on a waitlist if the number of applicants for the year exceeds the budgets allocated to those programs. Applicants are screened using an assessment form that determines level impairment and care need in a set of core ADLs and IADLs. See Table 3 for the Determination of Need (DON-R) screening form (GDHS, 2023). The participant must score at least 15 in the level of impairment column and be assessed as having unmet care needs in at least one ADL in the care needs column in order to be placed on the waitlist for program entry. Scores are also used to rank waitlisted applicants according to need and risk of institutionalization.

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the four largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 60 days through a physician's review of the individual's plan of care, or more often if there is a change in condition (42 CFR 484.55, GDCH 2023e). If a beneficiary requires more than 50 home health visits in a year, they are referred to the CCSP program for continued services.

Nursing Facility Care

NFLOC and Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition (GDCH, 2023a). After admission, quarterly and annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (GDCH, 2023a).

CCSP/SOURCE

Comprehensive care plans are reviewed and updated every three months or with a change in condition (GDCH, 2023b). The Member's Care Plan is rewritten at least once per year (GDCH, 2023). For individuals in Alternative Living Services (ALS) homes, face-to-face supervisory visits are required twice a month to monitor for changes in condition (GDCH, 2023b). Provisional levels of care can be issued temporarily for 1-6 months at the discretion of the Department of Community Health for individuals being transferred between agencies or locations, or for those whose level of care is expiring without approved renewal (GDCH, 2022b).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care

There is no age requirement.

CCSP/SOURCE

The individual must be at least age 65, or younger with a physical disability.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

A physician must certify that the beneficiary's needs for home health services are medically necessary, which is defined using the Statement of Medical Necessity form according to one or more of the following criteria:

1. The patient's illness, injury, or disability makes going to a physician's office or outpatient setting a medical hardship. Examples include a patient in severe pain, a patient for whom leaving the home is likely to cause an exacerbation of their condition, a patient who experiences shortness of breath that significantly hinders travel, or a patient who requires ambulance transportation.
2. The patient's condition is so fragile or unstable that leaving the home is physician certified to be undesirable or detrimental. Examples include a patient with heart disease who must avoid all stress and physical activity, a patient with a medical condition that requires protection from exposure to infections, and a patient who has just had surgery and is experiencing weakness and pain.
3. Going to a physician's office, clinic, or outpatient setting for a service would interfere with the effectiveness of the service. Examples include a patient living in an area where travel to outpatient therapy would require an hour or more of travel, a patient who needs a service repeated daily or so frequently as to make it difficult to accommodate in a clinic or outpatient setting, a patient who due to their injury/illness/disability has demonstrated inability to comply with physician's office visits for needed services.

The individual must also have an absence of significant others or family members able to provide the services.

Nursing Facility Care

Individuals must meet NFLOC in order to be admitted to a nursing facility, and must have been a resident of a Medicaid certified nursing home for at least 30 days (GDCH, 2023c). NFLOC is met if the individual has a stable medical condition requiring intermittent skilled nursing services under the direction of a licensed physician, as well as either a mental or a functional impairment that would prevent self-execution of the required nursing care. See Table 5 for the specific medical, cognitive, and functional criteria used to determine NFLOC. A Level I Pre-Admission Screening and Resident Review (PASRR) must also indicate that that the resident does not have a mental disorder or intellectual disability that would warrant an alternative living environment. See Table 5 for a full list of medical, functional, and cognitive criteria to meet NFLOC in Georgia.

Level I Pre-Admission Screening and Resident Review (PASRR) is indicated by answering "No" to all five questions on the PASRR. A "Yes" to one of the first three questions can still result in a Level I suitability for nursing facility care based on the evaluator's full review, and a "Yes" to question 4 or 5 may still receive approval for nursing facility care if authorized by contracted authorities or the PASRR Determination Unit. See Box 5 for the list of questions asked in the PASRR Level I screening.

CCSP/SOURCE

CCSP and SOURCE applicants receive a telephone screening that uses a Determination of Need-Revised (DON-R) assessment instrument to evaluate whether an applicant's level of impairment and unmet need for care meet potential program eligibility standards. The applicant must obtain a level of impairment score of at least 15 on the DON-R assessment, and must have an unmet care need in at least one ADL (GDHS, 2023). See Table 3 for more on how level of impairment and unmet care needs are scored using the DON-R screening. For entry into the program, applicants for CCSP and SOURCE must meet NFLOC, and have a physician certify that their needs can be met through available home-based program services. NFLOC is certified using the Level of Care Placement Instrument (Form 5588) which uses the Minimum Data Set - Home Care (MDS-HC) to determine NFLOC and build the individual's care plan. See Box 1 for services needed and impairments recorded in Form 5588, and see Table 4 for a summary of the conditions and impairments assessed in the MDS-HC to determine NFLOC. While NFLOC is the same level of care needed for other LTC program benfits, it is often referred to as intermediate level of care (ILOC) with respect to CCSP and SOURCE eligibility during this policy period.

Evaluation of dependence

Evaluations of dependence vary depending on LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

Individuals must have a physician's order that includes a record of an initial face-to-face assessment, written orders for a plan of care that certifies the medical necessity of services rendered, and documented medical need for home health services. After the

initial assessment, reauthorizations do not require face-to-face meeting unless there is a change in condition (GDCH, 2023).

Nursing Facility Care

Prior to admission, a physician will certify NFLOC and screen for mental illness and/or intellectual disability with Georgia Department of Medical Assistance forms 6 (DMA-6) and 613 (DMA-613) respectively. Once NFLOC determination has been made and certified by a licensed physician on the DMA-6, the remainder of the form, which authorizes the plan of care and services needed, is completed by a registered nurse (RN). See Box 1 for additional information on NFLOC certification form DMA-6, and see DMA (1991) to view the full assessment form.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR), which is conducted using form DMA-613, and periodic assessments using the Minimum Data Set (MDS). See Box 2 for more information on the PASRR, Box 5 for a summary of the DMA-613 form, and Box 3 for more information on the MDS.

Finally, within 14 days of nursing facility admission, as well as in quarterly and annual intervals, nursing facility staff are federally required to complete a Minimum Data Set (MDS) 3.0. The MDS is a standardized assessment tool that measures health status in nursing facility residents. It is completed within 14 days of admission to build the resident's initial plan of care, every three months to monitor for changes in condition, and is annually approved by a physician to certify continued need for care. For 2023, see Table 4 for an overview of the full MDS 3.0 assessment. In general, the assessment collects information in the following domains (GDCH, 2010):

- Functional status
- Cognitive status
- Psychosocial functioning
- Geriatric syndromes

All individuals seeking nursing facility care must be given information on HCBS options upon admission to the nursing facility, as well as during annual MDS assessments (GDCH 2023b).

CCSP/SOURCE

Individuals are referred to qualified CCSP/SOURCE service provider agencies by care coordinators, who receive referrals for potential program participants from the state plan Home Health Services program as well as directly from new and potentially eligible program applicants. Once contacted with a referral, provider agencies have 24 hours to follow up with care coordinators to arrange a face-to-face evaluation in the individual's place of residence within three business days. A screening specialist from the local Area Agency on Aging Community Care Assessment team also conducts a pre-screening telephone call that uses the DON-R assessment to determine the applicant's level of impairment and unmet need for care. A registered nurse then conducts the face-to-face evaluation, and within three business days of the evaluation must notify the care coordinator of their decision to accept or refuse the referral based on a version of the DMA-6 form (renamed form 5588 for CCSP and SOURCE level of care evaluations). A nurse conducts regular face-to-face reassessments, and must document and certify the following with signature and date of visit:

- Evaluation of health status (including change in condition)
- Evaluation of quality of care rendered (including individuals' satisfaction)
- Results of care being rendered
- Planned interventions, follow-up for any problems identified
- Needed revisions to individual's care plan
- Date of previous supervisory visit

Evaluators

Evaluators vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

A licensed physician, or certain categories of physician-supervised staff (e.g., nurse practitioner, certified midwife, physician assistant), must certify an individual's eligibility for home health benefits based on a face-to-face assessment, which must occur within 90 days prior to or 30 days after the start of care (GDCH, 2023e). A licensed physician must certify that the beneficiary requires home health services out of medical need, and a registered nurse can evaluate and certify the services needed in the individual's plan of care. The physician may not have a financial relationship with the home health agency being referred to for services ((GDCH, 2023e)).

Nursing Facility Care

A licensed physician must determine level of care and admission to a nursing facility. An interdisciplinary team that is made up

of at least one physician, one registered nurse, and one social worker must also have determined whether care can be provided more cost-effectively in a home-based setting (Ga. Code 49-6-63). Pre-Admission Screening and Resident Review (PASRR) can be conducted by a state-approved contractor and does not require a physician's or nurse's signature for certification (GDCH, 2023f).

CCSP/SOURCE

The initial telephone screening is conducted by the applicant's local Area Agency on Aging Community Care Assessment team. The face-to-face evaluation and subsequent reevaluations are conducted by nurses, who ultimately certify the level of care and services required. A physician must authorize the need for NFLOC (GDCH, 2023). Care services can be ordered by care coordinators, but a licensed physician, nurse practitioner, or physician's assistant must certify their approval.

Benefit limitations

Can you mix LTC benefits?

All Georgia Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, Georgia enforces Estate Recovery. The acceptance of Medicaid in Georgia creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for nursing facility care or CCSP/SOURCE program services after the recipient reached 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient valued at more than $25,000. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (Ga. R&R 111-3-8-.04, 42 USC 1396p(b)(1)).

There exist additional user charges that apply only to beneficiaries eligible for Medicaid through eligibility track 2c:

- Copayments for certain services
- Monthly premium of $7 (for beneficiaries with income between 50-84% FPL), or $11 (for beneficiaries with income between 85-100% FPL)
- $3 (for beneficiaries with income between 50-84% FPL), or $5 (for beneficiaries with income between 85-100% FPL) tobacco premium surcharge if beneficiary self-attests to using tobacco

See Table 6 for a list of services and their corresponding copayment amounts.

Home Health Services

Beneficiaries eligible for both Medicaid and Medicare (known as dually eligible) are exempt from copayments. A $3 copayment applies for non-CCSP/SOURCE program home health visits provided to non-dual eligible beneficiaries. (GDCH, 2023e).

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 2022, the PNA was $70 per month.

CCSP/SOURCE

CCSP beneficiaries are expected to contribute any income over the SSI benefit amount to the cost of services. There are no user charges for SOURCE services during this policy period.

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: Georgia Federal Medical Assistance Percentage (FMAP) for Medicaid

Fiscal Year	FMAP
1992	61.78%
1993	62.08
1994	62.47
1995	62.23
1996	61.90
1997	61.52
1998	60.84
1999	60.47
2000	59.88
2001	59.67
2002	59.00
2003	61.08
2004	61.81
2005	60.44
2006	60.60
2007	61.97
2008	63.10
2009	73.93
2010	74.96
2011	70.76
2012	66.16
2013	65.56
2014	65.93
2015	66.94
2016	67.55
2017	67.89
2018	68.50
2019	67.62
2020	71.95
2021	73.23
2022	73.05
2023	71.00
2024	66.27

Source: US DHHS (2022)

Notes: FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period (H.R. 6201). The enhanced FMAP decreased from 6.2 to 5 percentage points from April to June 2023, 2.5 percentage points from June to September 2023, and 1.5 percentage points from October to December 2023.

Table 2: Historical Georgia Medicaid Income Limits

Year	SSI (Individual)	SSI (Couple)	300% SSI (Individual)	300% SSI (Couple)	100% FPL (Individual)	100% FPL (Couple)
1992	$422	$633	$1,266	$1899		
1993	434	652	1,302	1,956		
1994	446	669	1,338	2,007		
1995	458	687	1,374	2,061		
1996	470	705	1,410	2,115		
1997	484	726	1,452	2,178		
1998	494	741	1,482	2,223		
1999	500	751	1,500	2,253		
2000	513	769	1,539	2,307		
2001	531	796	1,593	2,388		
2002	545	817	1,635	2,451		
2003	552	829	1,656	2,487		
2004	564	846	1,692	2,538		
2005	579	869	1,737	2,607		
2006	603	904	1,809	2,712		
2007	623	934	1,869	2,802		
2008	637	956	1,911	2,868		
2009	674	1,011	2,022	3,033		
2010	674	1,011	2,022	3,033		
2011	674	1,011	2,022	3,033		
2012	698	1,048	2,094	3,144		
2013	710	1,066	2,130	3,198		
2014	721	1,082	2,163	3,246		
2015	733	1,100	2,199	3,300		
2016	733	1,100	2,199	3,300		
2017	735	1,103	2,205	3,309		
2018	750	1,125	2,250	3,375		
2019	771	1,157	2,313	3,471		
2020	783	1,175	2,349	3,525		
2021	794	1,191	2,382	3,573		
2022	841	1,261	2,523	3,783	1,133	1,526
2023	914	1,371	2,742	4,113	1,215	1,643

Source: SSA (2023)

Notes: Supplemental Security Income (SSI) and federal poverty level (FPL) amounts for individuals and couples are monthly.

Box 1: DMA-6 Form (1992-2023) and CCSP/SOURCE Level of Care Placement Instrument (Form 5588, 2010-2023)

The DMA-6 form contains the following sections:

- Section A: Identifying Information
- Section B: Physician's Examination Report and Recommendation
  - Certification of nursing facility level of care: Nursing Facility or Intermediate Care for Mentally Retarded (ICF/MR)
  - Physician's diagnoses: Primary, secondary, and other
  - Treatment plan: (attached)
- Section C: Evaluation of Nursing Care Needed
  - Diet: Regular, Diabetic, Formula, Low sodium, Tube feeding, Other
  - Bowel: Continent, Occasionally incontinent, Incontinent, Colostomy
  - Overall Condition: Improving, Stable, Fluctuating, Deteriorating, Critical, Terminal
  - Restorative Potential: Good, Fair, Poor, Questionable, None
  - Mental and Behavioral Status: Agitated, Confused, Cooperative, Depressed, Forgetful, Alert, Noisy, Nonresponsive, Vacillating, Violent, Wanders, Withdrawn, Dependent, Independent, Anxious, Well adjusted, Disoriented, Inappropriate reaction
  - Decubiti: Yes, No, Infected, On Admission, Surgery (date)
  - Bladder: Continent, Occasionally incontinent, Incontinent, Catheter
  - Hours out of bed: Per day (), Intake, Output, IV, Bedfast, Catheter care, Colostomy care, Sterile dressings, Suctioning
  - Frequency/week of occupational, physical, speech therapies (received and needed)
  - Impairments (scored as: 1 - severe, 2 - moderate, 3 - mild, 4 - none)
    - Sight
    - Hearing
    - Speech
    - Limited Motion
    - Paralysis
  - Activities of Daily Living (ADLs) (scored as: 1 - dependent, 2 - needs assistance, 3 - independent, and 4 - N/A)
    - Eats
    - Wheelchair
    - Transfers
    - Bath
    - Ambulation
    - Dressing

Source: GDMA (1991), GDCH (2010)
Notes: The same form has been adapted for use in authorizing home and community-based services (HCBS) for state plan benefits as well as HCBS waiver programs.

Box 2: Preadmission Screening and Resident Review (PASARR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASARR). The purpose of the PASARR is to rpevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level I screening), and a final determination. All applicants of Medicaid-certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASARR evaluation.

Source: 42 CFR 483.100-138

Box 3: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: MDS (2023)

Box 4: Structured Family Caregiving (2019-present)

SFC provides financial, social, and technical support to family caregivers who live with and provide care to a CCSP or SOURCE program beneficiary requiring assistance with ADLs or IADLs.

To qualify, the care recipient must:

- Be an adult at least 18 years of age
- Be enrolled in either CCSP or SOURCE
- Require at least 5 hours daily of personal support services
- Live with a family member who is able to provide at least 5 hours of personal support services daily

To qualify as a caregiver under the SFC program, the caregiver must be:

- At least 18 years of age
- Living in the home of the CCSP or SOURCE member care recipient
- Related to the care recipient by blood or by marriage, but cannot be a spouse or legal guardian
- Willing to work with a health coach, submit daily notes, and support care recipient by providing ADL and IADL support as needed
- Unable to work in or outside of the home due to caregiving responsibilities. A caregiver is ineligible if they:
  - Work from home or are self employed
  - Are enrolled in school
  - Are raising minors
  - Have engagement in extensive personal hobbies

The SFC is designed to support family members who live with and provide 24-hour care for an elderly or disabled family member. Support comes in the form of access to a health coach and annual trainings, as well as a daily stipend that is set by SFC provider agencies, but that cannot be lower than 60% of the Medicaid reimbursement rate for Medicaid personal support services. In 2023, the SFC stipend is set at a minimum of USD 59.53 per day.

Source: GDCH (2019a), GDCH (2019c), GDCH, (2023)

Table 3: Determination of Need, Revised (DON-R) Form Responses (1999-2023)

ADL/IADL	Determination of Need: Level of Impairment	Determination of Need: Unmet Need for Care
ADLs (1-6)		
1. Eating	0 1 2 3	0 1 2 3
2. Bathing	0 1 2 3	0 1 2 3
3. Grooming	0 1 2 3	0 1 2 3
4. Dressing	0 1 2 3	0 1 2 3
5. Transferring	0 1 2 3	0 1 2 3
6. Continence	0 1 2 3	0 1 2 3
IADLs (7-15)		
7. Managing money	0 1 2 3	0 1 2 3
8. Telephoning	0 1 2 3	0 1 2 3
9. Preparing meals	0 1 2 3	0 1 2 3
10. Laundry	0 1 2 3	0 1 2 3
11. Housework	0 1 2 3	0 1 2 3
12. Outside work	0 1 2 3	0 1 2 3
13. Routine health	0 1 2 3	0 1 2 3
14. Special health	0 1 2 3	0 1 2 3
15. Living alone	0 1 2 3	0 1 2 3
Total Level of Impairment Score:	[must score at least 15]	
Total Unmet Need Score:		[no strict cutoff; make the case for unmet care need in at least one ADL]
Total DON Score:		
Scale:	0: Performs all of activity 1: Performs most of activity 2: Cannot perform most of activity 3: Cannot perform activity	0: Needs currently being met 1: Needs being met most of the time 2: Needs not being met most of the time 3: Needs seldom/never met

Source: GDCH (2023)

Box 5: Pre-Admission Screening and Resident Review (Form DMA-613) (2004-2023)

The DMA-613 Form screens potential nursing home residents using the following questions:

1. Does the individual have a primary diagnosis of Dementia?
2. Is there current and accurate data found in the patient record to indicate that there is a severe physical illness that is so severe that the patient could not be expected to benefit from specialized services?
3. Does the individual have a terminal illness which includes a medical prognosis that his/her life expectancy is 6 months or less?
4. Does the individual have a primary diagnosis of serious mental illness or mental disorder?
5. The individual has a diagnosis of intellectual disability or developmental disability prior to age 18 or a related condition.

Source: GDMA (2004)

Table 4: Minimum Data Set for Home Care (MDS-HC): Assessment Sections

Section	Intent
A: Identification Information	Documents the resident's living arrangement and time since last hospital stay, capturing the level of support available to and needed by the program applicant in their current environment.
C: Cognition	Determines the individual's decision making, memory, awareness, and changes in mental status.
D: Communication and Vision	Assesses the individual's hearing, vision, ability to understand others, and ability to make oneself understood.
E: Mood and Behavior	Screens for indicators of depression, anxiety, or sad mood, and monitors self-reported mood and behavioral symptoms such as wandering, verbal or physical abuse, and socially inappropriate or disruptive behavior.
F: Psychosocial Wellbeing	Monitors social relationships, loneliness, social activity, and major life stressors.
G: Functional Status	Assesses the need for assistance with ADLs, IADLs, walking, and activity level, and determines the potential for improvement in physical function.
H: Continence	Gathers information on bowel and bladder continence as well as the use of bowel and bladder appliances.
I: Disease Diagnoses	Tracks status and diagnoses for musculoskeletal, neurological, cardiac or pulmonary, psychiatric, infectious (pneumonia, UTI), and chronic (diabetes, cancer) diseases.
J: Health Conditions	Documents health conditions that impact the resident's functional status and quality of life. Tracks falls, balance, sleep problems, cardiac/pulmonary issues, gastrointestinal status, psychiatric and neurological issues, fatigue, shortness of breath, self-reported health, and tobacco or alcohol use.
K: Oral and Nutritional Status	Assesses nutritional issues as well as conditions that could affect the resident's ability to maintain adequate nutrition and hydration.
L: Skin Conditions	Document the risk, presence, appearance, and change of pressure ulcers as well as other skin ulcers, wounds or lesions. Also identifies foot problems that can affect ambulation.
M: Medications	Records the dosage and frequency of administration of prescribed medications.
N: Treatment and Procedures	Tracks preventive screenings, treatment programs, home-based care services received, and hospital or physician visits.
P: Social Supports	Records informal care received from up to two informal helpers, and strength of family relationship.
Q: Environmental Assessment	Documents safety and accessibility of home and neighborhood environment.
R: Discharge Potential and Overall Status	Documents improvement and progress toward care goals, as well as deterioration in status if more than 3 ADLs or IADLs were recorded as having deteriorated in section G.

Source: (GDCH, 2010)
Notes: Sections omitted from this table are purely administrative (e.g., identification information).

Table 5: Nursing Facility Level of Care Criteria (2001-present)

Column A: Medical Status	Column B: Mental Status[1]	Column C: Functional Status
1. Requires monitoring and overall management of a medical condition(s) under the direction of a licensed physician.	1. Documented short or long-term memory deficits with etiologic diagnosis. Cognitive loss addressed on MDS/care plan for continued placement.	1. Transfer and locomotion performance of the resident requires limited/extensive assistance by staff through help or one-person physical assist.
2. Nutritional management, which may include therapeutic diets or maintenance of hydration status.	2. Documented moderately or severely impaired cognitive skills with etiologic diagnosis for daily decision making. Cognitive loss addressed on MDS/care plan for continued placement.	2. Assistance with feeding. Continuous stand-by supervision, encouragement, or cueing required and set up of meals.
3. Maintenance and preventative skin care and treatment of skin conditions, such as cuts, abrasions, or healing decubiti.	3. Problem behavior, i.e. wandering, verbal abuse, physically and/or socially disruptive or inappropriate behavior requiring appropriate supervision or intervention.	3. Requires direct assistance of another person to maintain continence.
4. Catheter care such as catheter change and irrigation.	4. Undetermined cognitive patterns which cannot be assessed by a mental status exam, for example, due to aphasia.	4. Documented communication deficits in making self understood or understanding others. Deficits must be addressed in medical record with etiologic diagnosis addressed on MDS/care plan for continued placement.
5. Therapy services such as oxygen therapy, physical therapy, speech therapy, occupational therapy.		5. Direct stand-by supervision or cueing with one-person physical assistance from staff to complete dressing and personal hygiene. (If this is the only evaluation of care identified, another deficit in functional status is required).
6. Restorative nursing services such as range of motion exercises and bowel and bladder training.		
7. Monitoring of vital signs and laboratory studies or weights.		
8. Management and administration of medications including injections.		

Source: GDAS (2001)

Notes: Number 1 along with one other condition must exist from Column A (Medical Status), in addition to one from either Column B (Mental Status) or Column C (Functional Status), is needed to satisfy Nursing Facility Level of Care (NFLOC). If number 5 is selected from Column C, one more functional deficit must be selected from that column to qualify for NFLOC.

[1] The mental status must be such that the cognitive loss is more than occasional forgetfulness.

Table 6: Cost sharing for Georgia Pathways to Coverage Eligible Medicaid Beneficiaries (2023-present)

Service	Copay
Inpatient Hospitalization	$12.50 for entire stay
Outpatient Hospital Visit	$3.00 per visit
Non-emergency use of the emergency room	$30.00 per visit
Primary Care	$0 per visit
Specialist	$2 per visit
Durable Medical Equipment (DME)	$3.00 / $1.00 for rentals and supplies
Pharmacy - Copayment varies based on the cost to the state.	$10.00 or less: $0.50
	$10.01-$25.00: $1.00
	$25.01-$50.00: $2.00
	$50.01 or more: $3.00

Source: CMS (2023)

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Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1115 Waiver: Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations.

1915(c) Home and Community-Based Services (HCBS) Waiver: Allows states to waive certain federal requirements and provide HCBS to people who otherwise would have to access longoterm care in an institutional setting.

Activities of Daily Living (ADLs): Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility).

Adult Day Health Care (ADHC): A community-based long-term care benefit that provides comprehensive health care services in a congregate day setting. Services include nursing, case management, clinical management, medical, diagnostic, social, rehabilitative, recreational and personal care services on a routine or daily basis. Services are provided according to the assessed needs of the beneficiary. In Georgia this benefit is referred to as Adult Day Health (ADH) and has in the past been referred to as Adult Day Rehabilitation.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act (ACA) made a number of changes to Medicaid, most notably the expansion of eligibility to adults with incomes up to 133 percent of the federal poverty level (FPL). Originally a requirement, the June 2012 Supreme Court ruling in National Federation of Independent Business v. Sebelius effectively made the Medicaid expansion an option. To date, over three-quarters of states have opted to expand.

Alternative Living Services (ALS): Personal care homes providing 24-hour supervision, medically oriented personal care, nursing supervision, and health-related support services in a residential setting other than the individual's home. The service is provided in licensed personal care homes to individuals who are no longer able to remain independent in their residential homes, but whose care plan does not require residence in a nursing facility.

Area Agency on Aging (AAA): Georgia is divided into 12 regions, each with a corresponding Area Agency on Aging (AAA) that is contracted through the Division of Aging Services to administer a range of HCBS, including both Medicaid and non-Medicaid HCBS, to elderly adults residing in their geographic areas. AAAs contract care coordinators as well as providers to administer Georgia's CCSP waiver program, conduct intake screenings, and manage waitlists of program applicants to ensure open slots are allocated according to greatest need.

Balancing Incentive Program: The State Balancing Incentive Payments Program, or Balancing Incentive Program (BIP), was established under section 10202 of the Affordable Care Act (ACA) as a grant program funding structural reform to increase access to non-institutional LTC services through a targeted FMAP increase of 2-5 percent, calculated based on the proportion of state Medicaid spending on non-institutional LTC in fiscal year 2009.

Care management: CCSP/SOURCE program benefit called Primary Care Case Management (PCCM) that provides service management for the enrollee. A care coordinator will develop an individual plan of service, assist with access to benefits, and provide overall case management for a program beneficiary. PCCM started as a benefit provided to SOURCE program beneficiaries only and became available to both CCSP and SOURCE program beneficiaries when the two programs merged in 2008.

Community Spouse Resource Allowance (CSRA): Upper limit on countable assets for a spouse residing in the community if their spouse is institutionalized or requires home and community-based long-term care.

Community Care Services Program (CCSP): A program that has provided a range of home and community-based services designed

to delay or prevent nursing home placement for elderly and disabled Georgians since 1982. Services include care management, home health services, adult day health, alternative living services, respite care, personal support services, and home delivered meals.

CCSP/SOURCE: Georgia's two major programs providing home and community-based services to the elderly and disabled. CCSP and SOURCE initially began as two separate programs, and were combined under the same federal program in 2008

Deficit Reduction Act of 2005: Authorized a home equity limit of $500,000 in order to qualify for Medicaid benefits and extended the look-back period for asset transfers from 3 to 5 years. The 2005 DRA also authorized a number of other measures impacting state LTC programs such as Money Follows the Person demonstrations, where states receive grants in the form of an enhanced FMAP for the first 12 months for each person transitioned back to their communities, as well as the option to include home and community-based services as state plan benefits without having to apply for a 1915(c) waiver.

Department of Community Health: Responsible for purchasing, planning, and regulating health care in Georgia, including administering the state health plan as well as waiver home and community-based service programs.

Department of Human Resources: Until it was reorganized as the Department of Human Services in 2009, the DHR supported the Department of Medical Assistance and Department of Community Health in connecting individuals and families in need with economic and social support services.

Department of Human Services: Works to support the Department of Community Health in connecting individuals and families in need with economic and social support services.

Department of Medical Assistance: Until it was reorganized as the Department of Community Health in 1999, the state agency responsible for administering Medicaid programs including state plan benefits and home and community-based service programs.

Department of Medical Assistance Form 276: Standardized form used to determine Medical Necessity in order to be eligible for Home Health Services under the State Medicaid Plan.

Department of Medical Assistance Form 6 (DMA-6): Standardized form used to authorize nursing facility level of care across each of Georgia Medicaid's long-term care programs

Department of Medical Assistance Form 613 (DMA-613): Standardized form used to conduct federally mandated Pre-Admission Screening and Resident Reviews for nursing facility residents. The PASRR screens for mental illness or intellectual disabilities that may warrant placement in specialized intermediate care facility for individuals with intellectual disabilities, rather than skilled nursing facilities.

Determination of Need-Revised (DON-R): A screening assessment conducted by telephone to determine potential program eligibility for the CCSP home and community-based service program.

Division of Family and Children Services: Division within the Department of Human Services responsible for administering a number of social assistance programs, including determining financial eligibility for Medicaid.

Eligibility Track 1a. Supplemental Security Income (SSI) Recipients: Mandatory coverage group under Medicaid that automatically guarantees Medicaid coverage to individuals that receive SSI, a federal cash assistance benefit for aged, blind, and disabled individuals with limited means.

Eligibility Track 2a. Institutional Rules: Optional coverage group under Medicaid that allows for expanded income limits, up to 300 percent of the federal poverty level, for individuals that are in an institution or who medically qualify for placement in an institution and are instead receiving home and community-based services (HCBS). Federal terminology separates the institutional and HCBS populations into two coverage groups: Individuals receiving HCBS under Institutional Rules, and Institutional Individuals Eligible under a Special Income Level. This is because some states do not extend this income limit to both coverage groups. For ease, we have combined the two groups under a single track, as regardless of whether it applies only to institutional care or extends to HCBS, the eligibility track uses institutional standards, e.g., institutional income/asset limits including spousal impoverishment disregards, as well as dependence requirements (NFLOC). It will be clearly noted in policy documents when a state does not extend this income limit to both populations.

Eligibility Track 2c. Affordable Care Act (ACA) Expansion Adults: Optional coverage group under Medicaid that allows for expanded income limits for individuals ages 19-64, but which in Georgia requires these beneficiaries to satisfy a work or qualifying activities requirement, making this eligibility track significantly less relevant to individuals seeking to access Medicaid LTC services.

Eligibility Track 3a. Medically Needy Aged, Blind, or Disabled: Optional coverage group under Medicaid for aged, blind, or disabled individuals who would qualify for Medicaid under a different track if not for excess income. This track allows these applicants to "spend down" their excess income on medical bills and other related expenses in order to become eligible for coverage.

Eligibility Tracks: Requirements for an individual to qualify for Medicaid and start receiving long-term care benefits. An individual typically must satisfy only one eligibility track to qualify for Medicaid.

Estate Recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services or home and community-based services accessed through the CCSP or SOURCE programs. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age.

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP is computed from a formula that takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50 percent.

Federal Poverty Level (FPL): Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs. The Federal Poverty Level (FPL) is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the FPL), meaning households with annual/monthly income at or below 100 percent of the FPL would qualify based on financial eligibility.

Fee-for-service (FFS): A health care delivery system where providers are paid for each service performed.

Georgia Medicaid for Workers with Disabilities (GMWD): A program beginning in March 2008 that allows workers with disabilities aged 16-64 the opportunity to buy health care coverage through the state's Medicaid program if they are a state resident, earn disability income between $600-699/month, are employed, earn less than 300

Georgia Medical Care Foundation (GMCF): A nonprofit organization contracted by the Department of Community Health (and prior to that, the Department of Medical Assistance) to conduct PASRR Level I screenings as well as validate level of care determinations for Georgia's HCBS waiver programs. Currently, GMCF operates the local division of Alliant Health Solutions as Alliant GMCF and provides a range of support and training services for health programs and practices throughout Georgia.

Georgia Pathways to Coverage (GPC): Program that provides comprehensive health care coverage for a category of eligibility authorized under the Affordable Care Act (ACA), but which has key differences in Georgia that do not make this a full ACA expansion, including a work requirement as well as expanded financial eligibility limits that fall short of the full 138 percent of the federal poverty level allowed in a full ACA expansion. Individuals who are 19-64 years of age, have income at or below 100 percent of the federal poverty level, do not qualify for or are not enrolled in Medicare, do not qualify for or are not enrolled in other Medicaid programs, are not pregnant at the time of application, and are residents of the State of Georgia may qualify for this program.

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

Home Health Services: Services provided in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary.

Home- and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

Instrumental Activities of Daily Living (IADLs): Tasks related to independent living including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.

Intermediate Care Facility (ICF): A long term care facility that provides nursing and supportive care to residents on a non-continuous skilled nursing care basis, under a physician's direction. An ICF is typically regarded as a lower-level nursing care facility when compared to a skilled nursing facility (SNF), but its residents require more care and attention than those in a residential care facility for elderly or an adult residential care facility.

Intermediate Level of Care (ILOC): Intermediate level of care (ILOC) is used to describe nursing facility level of care (NFLOC) functional eligibility criteria for entry into Georgia's home- and community-based service programs (CCSP and SOURCE). ILOC is defined as continuous care limited to persons who, due to physical or mental impairment, require nursing care and supervision under the direction of a physician. The criteria used to determine ILOC are identical to NFLOC determination criteria.

Level of Care Placement Instrument (Form 5588): Standardized form used to authorize nursing facility level of care for the CCSP and SOURCE programs.

Managed Care: A health care delivery system organized to manage cost, utilization, and quality. Under Medicaid, managed care provides for the delivery of state plan services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

Mandatory Categorically Needy: An eligibility track that states are required to cover under Medicaid. This track encompasses several categorical groups, including individuals receiving SSI, pregnant women, and some children.

Medicaid State Plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available.

Medically necessary: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Medically Needy: A group states can elect to insure through Medicaid that would otherwise qualify for Medicaid through a categorically needy pathway if not for their income or assets (i.e., above SSI limits but below state determined limits for income or assets). This pathway for qualifying for Medicaid is an optional pathway.

Minimum Data Set (MDS): A federally mandated tool for conducting annual and quarterly standardized assessments for nursing facility residents, and for facilitating care management in nursing homes. The US currently uses a version of the MDS v.3 of the Resident Assessment Instrument (RAI), a globally standardized instrument used to comprehensively evaluate function, mental and physical health, social support, and service use of individuals in long-term care facilities such as nursing homes.

Minimum Data Set - Home Care (MDS-HC): The MDS-home care (MDS-HC) is used to determine medical and functional eligibility for the CCSP and SOURCE programs. The MDS-HC is a globally standardized assessment system for home care that is compatible with national MDS standards for nursing facilities, allowing for a more integrated assessment system across long-term care programs.

Money Follows the Person: Provides transition support services for nursing home residents who wish to receive care in a home or community-based setting.

Monthly Maintenance Needs Allowance (MMNA): Amount of countable income for a beneficiary's spouse residing in the community if the beneficiary is institutionalized or requires home and community-based long-term care.

Nursing facility care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Nursing facility level of care (NFLOC): Level of care appropriate for individuals who do not require hospital care, but who, on a regular basis, require licensed nursing services, rehabilitation services, or other health-related services ordinarily provided in an institution.

Occupational, Physical, and Speech Therapy: Occupational, physical, and speech therapies are provided by home health agencies or licensed therapists to support rehabilitation services in both home-based and institutional environments.

Omnibus Budget Reconciliation Act of 1993: The 1993 OBRA comprised a number of provisions aimed at reducing the federal budget deficit, including a mandate that states develop and implement Medicaid estate recovery programs to allow state Medicaid programs

to recover costs associated with LTC and HCBS incurred after the age of 55 from an individual's estate.

Optional Categorically Needy: An eligibility track that states may opt in to cover. This track encompasses several groups, including aged and disabled individuals not receiving SSI, some individuals receiving long-term care.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

Personal Care Services: Medicaid optional state plan benefit that provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility.

Personal Needs Allowance: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by institutionalized beneficiaries.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996,, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Preadmission Screening and Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

Private Duty Nursing: Skilled nursing interventions on an individual and continuous basis (in contrast to intermittent or part-time) and respiratory care for participants who are ventilator dependent.

Program of All-Inclusive Care for the Elderly: PACE progides comprehensive medical and social services to some older adults still living in the community. Most PACE participants are dually eligible for both Medicare and Medicaid. However, enrollment in PACE programs is typically capped at a relatively low number of participants.

Protected Income Level (PIL): The income limit Medically Needy applicants must spend down to meet. Federal rules require PILs to be no higher than 133 percent of the maximum state Aid to Families and Dependent Children (AFDC) level in effect as of July 16, 1996.

PRUCOL: An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

Respite care: Services provided to participants who are unable to care for themselves, furnished on a short-term basis because of the absence or need of relief for those persons normally providing care for the participant.

Service Options Utilizing Resources in a Community Environment (SOURCE): A program initially piloted in 1997 to integrate primary and preventive care with home and community-based care through coordinated case management. By 2008 the SOURCE program was moved under the same federal HCBS program as CCSP, and the two programs continue to maintain two different financial eligibility criteria but provide the same service options to elderly and disabled Georgians.

Skilled Nursing Facility (SNF): A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

Skilled Nursing Services: Skilled nursing care consists of those services that must, under State law, be performed by or under the supervision of a licensed or certified nurse. These services include injections, tube feedings, catheter changes, observation and assessment of a patient's conditions, and more.

State Supplementary Payment (SSP): Monthly cash payments offered by states to low-income individuals in addition to Supplemental Security Income (SSI). States offering optional SSPs may do so to account for higher costs of living or as an additional income disregard for individuals in certain living arrangements (e.g., nursing facility). In Georgia, SSPs act as a $20 additional income disregard for residents of Medicaid-certified nursing homes.

Structured Family Caregiving (SFC): A benefit added to the CCSP and SOURCE programs in 2019, SFC provides financial, social, and technical support to family caregivers who live with and provide care to a CCSP or SOURCE program beneficiary requiring assistance

with ADLs or IADLs. Eligibility for this program requires that the caregiver to be living with the care recipient, that the caregiver not be receiving income from other sources, and that they provide at least five hours of personal support services daily.

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI): The U.S. old-age cash assistance program for aged, blind, and disabled persons of limited means.

Notes

This section reports notes from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1. Some SSI recipients may receive a State Supplementary Payment (SSP) if they reside in a Medicaid-certified nursing home. Receipt of this payment marginally increases the income limit under this track. See SSA (2011) for more information.
2. In 1992 the look back period was 30 months prior to the date of application for all assets. In 1993 the look back period was extended to 36 months for assets and 60 months for trusts.
3. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of and permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees) (SSA, 1998).
4. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2023c) for more information on these requirements.
5. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 1992, the MMNA in Georgia was $1,718.
6. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which was $68,715 in 1992. Countable assets/property are real and personal property that are counted to determine eligibility.
7. In 1997, the look back period was 36 months prior to the date of application for all assets, and 60 months for trusts. The Deficit Reduction Act of 2005 extended the look back period for all assets to 60 months beginning in 2006.
8. The equity value is derived by subtracting any legal encumbrances (e.g., liens, mortgages) from the fair market value of the home. Exceptions exist if the person's spouse, child, or adult child with a disability is living in the home.
9. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 1997, the MMNA in Georgia was $1,976. From 2014, the ACA required states to extend spousal impoverishment rules to spouses of individuals receiving Medicaid HCBS. Authors were not able to verify whether Georgia extended these rules to HCBS recipients prior to 2014.
10. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which was $79,032 in 1997. Countable assets/property are real and personal property that are counted to determine eligibility.
11. In 2004, Georgia terminated its medically needy eligibility track for nursing facility services as well as for home and community-based services received through the CCSP and SOURCE programs. Beneficiaries who make above the income limits specified in track 2a were instead given the option of setting up Qualified Income Trusts, also known as Miller Trusts, to allow individuals to spend down excess income.

12. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) or enrolled in an HCBS program and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2022, the MMNA in Georgia was $3,435.
13. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which was $137,400 in 2022. Countable assets/property are real and personal property that are counted to determine eligibility.
14. The look-back period is 60 months prior to the date of application for all assets.
15. As of 2023 Georgia is one of 7 states that has used a Section 1115 waiver, called the Georgia Pathways to Coverage (GPC), to expand Medicaid in ways that fall short of a full ACA expansion. GPC beneficiaries receive the standard state plan benefit package, but must satisfy a work requirement and are required to pay insurance premiums if earning between 50-100% of the federal poverty limit. The financial eligibility criteria also fall short of the 138% of the federal poverty limit permitted in a full ACA expansion, allowing individuals to qualify at up to 100% of the FPL.
16. Work report must show 80 hours per calendar month of one or more of the following: Having a job or income; being a student; on-the-job training, specified job readiness activities, certain community service activities, or vocational educational training.

Version information

Current Version: 1.0 (November 2023)

Version History

- 1.0 (November 2023): First version.