simplification

DRAFT of December 21, 1993, 12noon. – for discussion only

INFORMATION INFRASTRUCTURE

Current Law

Under current law and regulations, States and the Federal government have developed elaborate

midst of large-scale (and long-term) computer system change, while others, such as AFDC (with its FAMIS systems), are nearing completion of a development cycle.

Both FAMIS and Child Support Enforcement Systems (CSES) have been funded under an enhanced funding (90 percent) match. Because of this incentive funding many states have integrated, automated, income maintenance systems which assist caseworkers in determining eligibility, maintaining and tracking case status, and reporting management information to the State and Federal governments. Other essential welfare programs, namely JOBS and Child Care have limited and fragmented automated systems. For the most part, States could fund parts of these systems at the 50 percent match rate. States report that administrative funds have not been available to fully automate and interface JOBS and Child Care with other programs within the State.

Many of these systems have serious limitations: limited flexibility, lack of interactive access, limited ability to exchange data electronically, etc. Even the most sophisticated systems fall short of the goal of allowing State agencies to use technology to:

- *Eliminate the need for clients to access different entry points before they receive services;*
- *Eliminate the need for State and local agency workers (and clients) to encounter and understand a wide variety of complex rules and procedures;*
- *Share fully computer data with programs within the State and among States; and*
- *Perform effective case management.*

Vision

Computer and information technology solutions will support and enable welfare reform by providing new automated screening and intake processes, eligibility decision-making tools, and benefit delivery techniques. Application of modern technologies such as expert systems, relational databases, voice recognition units, and high performance computer networks, will help empower families and individuals seeking assistance. Additionally, automated computer matching and electronic communication will assist in reducing fraud and abuse so that Federal and State benefits are available to those who are in need.

State-Level Family Empowerment System and National Clearinghouse

To achieve this vision, we are proposing an information infrastructure which requires, at the State level, establishment of a Family Empowerment System (FES) to integrate and interface multiple systems, for example, AFDC, food stamps, work programs, child care, Child Support Enforcement (CSE), the Earned Income Tax Credit (EITC), and others.

To support the broader information needs, the new information infrastructure needs to include both enhanced state and local information processing systems as well as a national data "clearinghouse".

What is proposed, however, is not a complete new system, but "front-ends" and "back-ends" that interface with existing systems or with somewhat enhanced existing systems. Variations in existing automated systems would make it unreasonable to try to standardize these systems. Rather, we need communication linkages that allow for accurate transmission of data between systems.

Enhanced State Systems. At the State level, the FES would include three subsystems:

- *An Intake, Assessment, and Referral Subsystem (IARS), that is the front-end or program entry point system;*
- *Case Management and Service Delivery Subsystems (CMSDS), for example, the FAMIS system, the JOBS Automated System (JAS), the Child Care Automated Information System (CCAIS), and the Child Support Enforcement System (CSES);*
- *Benefit, Payment, and Reporting Subsystems (BPRS), that is the back-end or benefit/payment issuance systems, including Electronic Benefit Transfer (EBT) systems, Centralized Collections and Electronic Funds Transfer (EFT) systems, and data capture technologies such as Voice Recognition Units (VRU), and card-based technologies for self-reporting of program participation.*

Because most key topics in the welfare reform proposal will have additional data, case management, and computer processing needs, States will have to develop new systems or subsystems and/or enhance existing case management systems. For example, at local sites, the Transitional Assistance Program will need to keep track of clients as they move through scheduled activities; Child Support Enforcement will have substantially increased information system requirements (as described elsewhere); and the several child care programs will have to be coordinated better.

By linking the various programs and systems under the FES, States would be able to provide integrated services and/or benefits to families and individuals "at-risk" of needing financial assistance, those receiving assistance, and those transitioning from a social service program to self-sufficiency. Such an automated system would enable States to provide greater support to families which might otherwise dissolve, as well as to parents who may, because of unmet needs, be forced to terminate employment or training opportunities.

In addition, as Electronic Benefit Transfer (EBT) and Electronic Funds Transfer (EFT) become more widespread, they would be used for other programs, such as Child care reporting and payments, and

JOBS reporting of participation. As an example, a JOBS participant could be required to self-report through a touch-tone phone which communicates to a Voice Recognition Unit (VRU) or through the use of plastic card technology.

For detection and analysis of fraud and abuse, computer matching of records among State programs and at a national level would need to be increased. For example, the Child Support information needs for establishing an order or in review and modification would be extremely valuable for access by the AFDC agency, after the agency has performed prospective eligibility determinations, but before benefits are granted. In addition, to ensure that an individual does not obtain AFDC for more than two years, a national tracking and computer matching system would be extremely helpful.

Data and Reporting on Program Operations and Clients. On the other hand, current methods for data gathering and reporting requirements on program operations and clients could be reduced and what remains could be gathered by periodic sample survey. Many of the current data and reporting requirements will be superseded by new ones, but in any case, many current items are of low data quality or of little interest. Current requirements should be re-examined. Sample surveys could produce higher quality data at less cost while using fewer local resources.

National Clearinghouse. The National Clearinghouse will be a collection of abbreviated case and other data that "points" to where detailed case data resides and provides the minimum information for implementing key program features. Described in detail under the Child Support Enforcement section, this Clearinghouse will not be a Federal data system that performs individual case activities. While information will be coming to and from the Clearinghouse, it will contain severely limited data -- States will retain overall processing responsibility.

The Clearinghouse will maintain at least the following data registries:

- *The National Employment Registry will maintain employment data for individuals, including new hire information.*
- *The National Locate Registry will enhance and subsume the current Federal Parent Locator Service (FPLS) functions.*
- *The National Child Support Registry will contain data on all non-custodial parents who have support orders.*
- *The National Welfare Receipt Registry will provide a central repository of just enough data to operate a time-limited assistance program, namely the number of months of welfare receipt.*

Program Improvement. To ensure continuing program improvement, an expanded Quality Improvement System (QIS) should broaden its scope beyond accuracy of eligibility determination and payments to include program performance, program management, client satisfaction, as well as program integrity. This requirement will require new systems development at the State and Federal levels. [The QIS is discussed more fully in the Welfare Simplification section.]

Issues:

ISSUE: SHOULD A NEW INFORMATION PROCESSING SYSTEM BE DEVELOPED SO STATES CAN IMPLEMENT WELFARE REFORM?

OPTIONS:

1. Develop a new "Family Empowerment System" (FES) model to replace/update the Family Assistance Management Information System (FAMIS) model. FAMIS has been implemented in 34 States since 1983, and has been cited as the most critical factor in the advancement of automation in the public assistance programs.

2. Continue to approve and monitor State automation projects, but allow States the flexibility to develop and implement automated systems to support welfare reform at their own pace, in accordance with State or local needs.

Recommend Option 1.

ISSUE: SHOULD THERE BE A NATIONAL WELFARE RECEIPT REGISTRY AND SHOULD IT BE IN THE CLEARINGHOUSE? CAN OR SHOULD STATES OPERATE TIME-LIMITED ASSISTANCE WITHOUT IT?

OPTIONS:

1. Operate time-limited assistance without such a registry. For example, use client certification of amount of prior receipt. Currently, States have the option of verifying information with other States.

2. Operate a National Welfare Receipt Registry and place it in the Clearinghouse. Time-limited assistance requires much more accurate information about prior receipt than the current system. Locating the registry in the Clearinghouse greatly facilitates matching data with other sources.

Recommend option 2.

ISSUE: SHOULD THE NATIONAL CLEARINGHOUSE CONTAIN ADDITIONAL REGISTRIES, FOR EXAMPLE, FOR THE FOSTER CARE OR FOOD STAMP PROGRAMS?

OPTIONS:

1. Limit the list of registries to the four in the Clearinghouse; others can be added later.

2. Make additional registries a State option: the Federal government would maintain the registry, but States could choose to provide monthly data to it. (They could still access the existing data, however.)

Recommend option 1.

Since an enormous volume of transactions will be processed as it is, additional registries could degrade the operation of the four proposed registries. In any case, other programs could run occasional matches with these registries.

ISSUE: SHOULD DEMONSTRATION OR OTHER FUNDING FOR PROTOTYPE SYSTEMS BE PURSUED? FOR EXAMPLE, JOBS SELF-REPORTING USING TOUCH-TONE TELEPHONES AND VOICE RECOGNITION UNITS COULD BE AN EARLY PROJECT.

OPTIONS:

1. Develop prototype systems and provide them to anyone who wants them. Since prototypes are like "best practices" in that they incorporate the best ideas, it makes sense to develop them.

2. Do not develop them. They are relatively expensive, take time to develop, and users are likely to want substantial changes to them in any case. In addition, the diversity of current systems limits the utility of a single prototype system.

Recommend option 1. ✓

Develop prototype systems. In the long run this is cheaper, because less development costs are incurred overall. State and local agencies do not have to adopt them.

ISSUE: SHOULD ENHANCED FUNDING BE PART OF THE LEGISLATION FOR THE FAMILY EMPOWERMENT SYSTEM? IF SO, AT WHAT RATE AND HOW WILL THE SPENDING BE CONTROLLED?

OPTIONS:

1. Enhanced funding should be pursued, but not at the open-ended 90 percent rate, as was done for FAMIS. A performance based funding model for the development should be designed.

2. Enhanced funding should be pursued for the first two subsystems, as follows: a single capped amount to fund the Intake and Referral, and normal cost-allocation methodology for the Case Management portion of the system. No enhanced funding for the Benefit Issuance and Reporting subsystem.

3. Fund all of the FES at the 75 percent open-entitlement match rate.

Recommend option 2.

ISSUE: SHOULD A MOVE TOWARD ELECTRONIC BENEFIT TRANSFER (EBT) AND ELECTRONIC FUNDS TRANSFER (EFT) TECHNOLOGY BE ENCOURAGED OR MANDATED AS PART OF WELFARE REFORM?

1. Mandate EBT/EFT as part of the Family Empowerment System model.

2. Strongly encourage States to move in the direction of EBT/EFT as part of the automated system enhancements made to support welfare reform. Set a target date for States to begin planning (consistent with the Food and Nutrition Service position), and provide adequate technical assistance to support State efforts.

3. Leave as a State option.

Recommend Option 2.

ISSUE: SHOULD WE ATTEMPT TO FUND (THROUGH DEMONSTRATION FUNDING) AN EXISTING STATE PLAN IN WHICH THE CONCEPT OF THE FAMILY EMPOWERMENT MODEL IS NOW IN PLANNING?

OPTIONS:

1. Be creative with the funding to provide supplemental funding to a State who is pursuing the client registration and referral model.

2 Do not bother with this until legislation is passed.

Recommend Option 1.

ISSUE: SHOULD MUCH OF THE CURRENT DATA GATHERING AND REPORTING REQUIREMENTS BE REPLACED BY, FOR EXAMPLE, PERIODIC SAMPLE SURVEYS OR SUBSTANTIALLY REDUCED REQUIREMENTS?

OPTIONS:

1. Replace most current data gathering and reporting requirements with periodic sample surveys. Current requirements for administrative, program, and client characteristics are excessive and produce data of poor quality.

2. Retain the current method, but reduce the volume of requirements to the essentials.

Recommend option 1.

Sample surveys are much more accurate, flexible, and less burdensome than the current method. Regarding option 2, it may not be easy to reduce the current requirements significantly.

Drafting Specs

(a) Modify current law to allow the Secretary of DHHS, with input from the States and representatives from affected Federal agencies, to:

(1) Require States to enhance their data systems to provide the information needed for the new child support enforcement, JOBS, WORK, child care, etc. programs. These enhanced state systems must be able to exchange data with the national clearinghouse as needed.

(2) Create a National Information Clearinghouse. The Clearinghouse will maintain at least the following data registries: the National Employment Registry, the National

Locate Registry, the National Child Support Registry, and the National Welfare Receipt Registry.

(b) Require that States and the Federal government have the necessary systems working properly before provisions implementing the time-limited assistance system begin full operations.

(c) Modify current law to allow the interchange of personal information between the Clearinghouse and other agencies, such as SSA, SESA/DOL, and the IRS.

ISSUES NOT DIRECTLY RELATED TO DRAFTING LEGISLATIVE SPECS:

- What privacy issues will arise under the proposed system and how will they be addressed?
- How much will the systems cost?
- How long will it take before the systems are working?
- What are the problems in using SSNs and how will they be overcome?

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HYPOTHETICAL MODEL FOR THE FAMILY EMPOWERMENT SYSTEM AND THE THE NATIONAL CLEARINGHOUSE

I. As envisioned in this proposal, the **Family Empowerment System** (FES) would be made up of three interconnected subsystems:

A. **An Intake, Assessment, and Referral Subsystem** (IARS) would serve as the front-end, initial entry point into the State's FES. The IARS would serve as the single point of entry for registering clients into any program-related Case Management and Service Delivery System (CMSDS). Clients would enter into the intake system "one time" to sign up for all eligible programs through the use of "expert system" technology.[1]

Information entered into this application would be passed through the eligibility criteria for each benefit program (AFDC, JOBS, CSE, Child Care, food stamps, Medicaid) and the client would then be registered into each of the programs for which the client met the eligibility criteria. This approach does not envision that a client who wishes Child Support Enforcement services would have to go to an office where a welfare worker would conduct the interview and pre-screening. Designated teams across programs would be able to enter information concerning multiple programs.

Client information for a specific program's Case Management and Service Delivery Subsystem, e.g., JOBS, would be automatically transmitted through a standard and agreed upon electronic data interchange (EDI) transaction format.

At the time of the initial interview, the IARS would transmit an electronic data interchange transaction to the National Clearinghouse to learn if the client has received benefits for two years. If so, the client would be denied. The IARS could also forward EDI transactions to match against other files to check for possible fraud.

B. The **Case Management and Service Delivery Subsystem** (CMSDS) would be the second component of the FES. This subsystem may be thought of as the engine which provides all the automated capability for a given program. These systems will often be large scale, mainframe based systems which will maintain the specific program information, establish ongoing eligibility, and provide case management support.

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1. Expert system technology automates many of the rules and regulations thereby freeing workers from using manuals and coding charts, shortens the intake and eligibility determination process, improves accuracy, and improves productivity by allowing one worker to collect information for several programs.

Due to the variations in the automated systems which are included in the CMSDS, it is unreasonable to undertake an effort to standardize these systems. Rather, we need only ensure that communication linkages are established that allow for accurate transmission of data. EDI does this.

Interfaces between other systems maintained by SSA, DOL, and others, will be needed to the degree necessary for the successful tracking, monitoring, and reporting of clients' activities.

C. The **Benefit Payment and Reporting Subsystem** (BPRS) will interface with the applicable financial institutions and networks to deliver actual benefits and related payments. The benefits will be issued through Electronic Funds Transfer (EFT) and Electronic Benefits Transfer (EBT) technologies. A benefit card will be issued and activated at the point the customer is determined to be prospectively eligible. The card will be re-activated by the CMSDS after ongoing eligibility is established and at the point of redetermination.

II. The FES would interface with the National Clearinghouse relational database utilizing client-server technology. The data base would contain client index information along with some basic case information. The Clearinghouse would not contain all specific case data. Specific case data relevant to track and monitor clients would still be maintained on the relevant State databases.

Welfare Simplification and Coordination Advisory Committee

Press Release

Sammie Lynn Puett, Chair
Contact: 615-974-1542

The nation's welfare system has reached a crisis state and is in danger of collapse unless dramatic reforms are undertaken immediately. These are the findings of a bi-partisan committee created by Congress.

In its report, Time for a Change: Remaking the Nation's Welfare System, the Welfare Simplification and Coordination Advisory Committee recommends that existing programs be replaced with "one, family-focused, client-oriented, comprehensive program" administered by one federal agency and overseen by one committee in each chamber of the Congress. Currently, AFDC, Food Stamps, icaid, and public housing programs are run by four separate federal agencies and are overseen by nine full committees and fifteen subcommittees in Congress.

The new program should:
-- Be simple to administer;
-- Tailor assistance to three types of need: (1) short-term assistance for those who are employable, (2) extended assistance for those who need to acquire additional skills to get a job, and (3) long-term assistance for those unable to earn a living due to mental, social or physical limitations.
-- Make receipt of benefits contingent upon making progress toward self-sufficiency.

"Change is desperately needed," said Sammie Lynn Puett, committee chairman and former commissioner of human services for the State of Tennessee. Puett is a University of Tennessee vice president.

"The conglomeration of separate programs that comprise our 'welfare system' do not form a system at all," Puett said. Caseworkers and clients alike are overwhelmed by the paperwork involved in obtaining assistance from re than one program.

"The Committee hopes this report will be a call to action for the Congress, federal, state and local governments and the private sector to work together to improve the public assistance delivery."

"This is the ninth time in 15 years a major effort has been undertaken to ke welfare programs -- specifically the Food Stamp, Aid to Families with Dependent Children, Medicaid, and housing -- more responsive to human needs. The time to act is NOW!"

The 11-member committee, a cross-section of representatives of state and local welfare agencies, experts and advocates, was asked by Congress to find ways to cut bureaucratic red tape and improve the efficiency of federal welfare programs.

The Committee's single-program plan would provide a coordinated and streamlined approach to meet the interrelated needs of low-income families while they work towards self-sufficiency, Puett said.

"The Committee recognizes that its recommendation for one comprehensive program will not come about overnight," Puett said. "In the interim, the Committee recommends other steps be taken to improve the current state of public assistance delivery."

The report stresses that "tinkering" has compounded coordination and simplification problems and must not continue. Dramatic, long-term measures are needed to move public assistance to a state where the poor are provided the assistance they need on their path to self-sufficiency.

Sarah Shuptrine & Associates

simplification

November 22, 1993

Kathryn J. Way
The White House
Domestic Policy Council
Old Executive Office Building
Room 218
Washington, DC 20500

Dear Kathi:

Enclosed is the invoice for the report on eligibility rules across AFDC, Medicaid and Food Stamps. I spoke with Kathy Dyer who gave me the order number. If I need to do anything further, please let me know.

Thank you for the opportunity to prepare this report on the differing rules.

Sincerely,

Sarah

Sarah C. Shuptrine

SCS:SH

Enclosure

7225 Devine Street • P.O. Box 5345 • Columbia, SC 29250 • (803) 779-8268

Sarah Shuptrine & Associates

INVOICE

Services Rendered

Preparation of A Discussion Paper on Eligibility Policies and Rules Across AFDC, Medicaid and Food Stamps, submitted to Kathryn J. Way on November 15, 1993.

Order Number: DP 4018

Amount: $9,760

11/22/93

2725 Devine Street • P.O. Box 5345 • Columbia, SC 29250 • (803) 779-8607

AN ASSESSMENT AND ACTION PLAN TO IMPROVE MEDICAID ELIGIBILITY, OUTREACH AND PERINATAL CASE MANAGEMENT SERVICES

Prepared for

GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE

Sarah Shuptrine & Associates

June 1993

AN ASSESSMENT AND ACTION PLAN TO IMPROVE MEDICAID ELIGIBILITY, OUTREACH AND PERINATAL CASE MANAGEMENT SERVICES

Prepared by

SARAH SHUPTRINE AND ASSOCIATES
Columbia, South Carolina

Sarah C. Shuptrine
Vicki C. Grant
Genny G. McKenzie

for

GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE

June 1993

ACKNOWLEDGMENTS

The opportunity to conduct this four county assessment of the eligibility process, outreach services and Perinatal Case Management is greatly appreciated. The authors are especially grateful to Commissioner Russell B. Toal of the Georgia Department of Medical Assistance for his recognition of the importance of reviewing policies and identifying systemic barriers to benefits and services. Special appreciation is extended to Commissioner James G. Ledbetter of the Georgia Department of Human Resources, Dr. Douglas Greenwell, Director of the DHR Division of Family and Children Services, Dr. Virginia Galvin, Interim Director of the DHR Division of Public Health and Dr. Frank Houser, former Director of the DHR Division of Public Health, for their support of the assessment.

The authors would like to express appreciation to the many individuals who participated in the site visits to Bibb, Dougherty, Muscogee and Richmond counties. Special appreciation is extended to the Chief Executive Officers of the four regional hospitals, Edward Howell at the Medical College of Georgia Hospital, Damon King at the Medical Center of Central Georgia, Larry Sanders at The Medical Center, Inc. and Joel Wernick at Phoebe Putney Memorial Hospital. Each participated personally at the initiation of the assessment and assigned staff to make arrangements for the site visit. The hospital contact persons for the site visits spent many hours providing assistance and advice ranging from logistics to hospital operations and appreciation is extended to each: Mike Sims and Jean Hartin at The Medical Center, Inc., Ed Ollie and Ellen Watkins at Phoebe Putney Memorial Hospital, Hilda Hilliard at the Medical Center of Central Georgia and Pat Findling-Sodomka and Lisa Collis at the Medical College of Georgia Hospital.

Appreciation is also expressed to the staff at each county Department of Family and Children Services (DFCS) and the county departments of health for their willingness to share experiences and insight during the site visit discussions. Special thanks are extended to Marjorie Almand and Sherry Brown at Bibb County DFCS, Robert Pollock and Nina Davis at Dougherty County

DFCS, Kittye Crockett and Jane Claybrook at Muscogee County DFCS and Pat Fitzgerald and Donna Landers at Richmond County DFCS, and Dr. Craig Lichtenwalner, Ollie Askew, Dr. Daniel Purdom, Barbara Adams, Dr. Frank Rumph and Bodie Adams with the health districts and county health departments serving the four counties.

Special appreciation is also extended to Margaret Park and Sophia Litman at the DHR Division of Public Health and Truman Moore at the DHR Division of Family and Children Services for their support and assistance during the assessment.

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CHAPTER 1
INTRODUCTION

In January 1993, the Georgia Department of Medical Assistance (DMA) commissioned Sarah Shuptrine and Associates to conduct an assessment and make recommendations to improve access to health care and improve the effectiveness and efficiency of services for pregnant women, infants and children in four Georgia counties: Bibb County, Dougherty County, Muscogee County and Richmond County. Four regional hospitals, the Division of Family and Children's Services (DFCS) and the Division of Public Health (DPH) within the Georgia Department of Human Resources (DHR) participated in the assessment.

The assessment focused on outreach, Medicaid sponsored Perinatal Case Management and the application process for Aid to Families with Dependent Children (AFDC) and Medicaid. The regional hospital in each of the four counties served as the host organization for the on-site visit. The four regional hospitals are:

- Medical Center of Central Georgia in Macon (Bibb County)
- Phoebe Putney Memorial Hospital in Albany (Dougherty County)
- The Medical Center, Inc. in Columbus (Muscogee County)
- Medical College of Georgia Hospital in Augusta (Richmond County)

The county DFCS and the county and district health departments in each community participated fully in the on-site assessments.

Commissioner Russell B. Toal, Georgia Department of Medical Assistance, directed that the assessment be patterned after the work conducted by Sarah Shuptrine and Associates in 1989 in Greenville County, South Carolina for the Greenville Hospital System. The report of the Greenville assessment served as the blueprint for public/private sector actions to improve access to health services for pregnant women and infants in Greenville County. The resulting

partnership produced significant improvements in eligibility outcomes. From 1989 to 1991, the following results were achieved countywide:[1]

- The approval rate for Medicaid only pregnant women increased from 63% to 80%.
- The AFDC approval rate increased from 38% to 55%.
- The average number of days to process an application for Medicaid only pregnant women decreased from 39 days to 19 days.
- The average number of days to process an application for AFDC decreased from 61 days to 32 days.

As part of the project evaluation subsequent to the assessment report, a study was conducted of obstetrics clinic patients at the Greenville Hospital System.[2] The results were as follows:

- Of all clinic patients, the percentage with Medicaid coverage at the time of delivery increased from 58% to 90%.
- Of the clinic patients in the Greenville Hospital System case management program, 98% had Medicaid coverage at delivery.

For pregnant women who participated in the Greenville Hospital System case management program, pre-project and post-project clinical comparisons show the following:

- On average, pregnant women received prenatal care six weeks earlier.
- The average number of prenatal care visits increased by three.
- On average, pregnant women receiving adequate prenatal care increased from 10.9% to 43.1%, as measured by the Kessner Index.
- The gestational age at birth increased from 37.4 weeks to 38.6 weeks.
- Birthweights increased from an average of 6.55 pounds to 7.04 pounds.

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[1]Sarah C. Shuptrine and Vicki C. Grant, A Comparison of Medicaid Eligibility Performance in South Carolina Counties, 1989 and 1991 (Columbia, SC: South Carolina Hospital Association, October 1991).

[2]Douglas B. Welch, Evaluation of the Case Management and Outreach Programs, prepared for the Greenville Hospital System and the South Carolina Health and Human Services Finance Commission (August 1991).

As in Greenville County, the four counties included in the Georgia assessment have infant mortality rates above the statewide rate as shown in Table 1.

TABLE 1
GEORGIA INFANT MORTALITY RATES
1987 - 1991

COUNTY	INFANT MORTALITY RATE
Bibb	16.8
Dougherty	16.0
Muscogee	14.7
Richmond	14.5
State	12.3

Source: Georgia State Center for Health Statistics.

The specific objectives of the Georgia DMA project are described below:

- Identify eligibility issues and the intervention points at the local, state and federal levels.
- Identify special initiatives required at the local level to improve opportunities for applicants to complete the eligibility process.
- Determine the need for outreach and identify the specific target population to be served by outreach in each county.
- Determine the availability of case management services in each county and whether these services are adequate and sufficient to meet projected need.
- Identify changes to improve DMA's Perinatal Case Management program.
- Make recommendations for action at the local, state and federal levels to improve the eligibility process, outreach services and Perinatal Case Management services.

Chapter 2 of this report presents findings from the site visits and findings from the analysis of data submitted by each study site. Chapter 3 presents an Action Plan which organizes and describes recommendations for the local, state and federal levels. Chapter 4 describes local initiatives which have potential for replication.

CHAPTER 2
FINDINGS

Two-day visits to each of the four Georgia counties were conducted in February and March 1993. Sarah Shuptrine and Associates met with over 185 persons in the four communities.

In each community, the assessment team from Sarah Shuptrine and Associates was given an extensive tour of the regional hospital's maternity and pediatric inpatient and outpatient facilities, emergency room and eligibility/admission offices. Subsequent to the tour, a meeting was held with hospital staff representing the areas visited, plus other areas, to discuss questions and to request additional information.

On each site visit, eligibility issues were discussed with front line and supervisory staff at the county DFCS offices and AFDC and Medicaid eligibility interviews were observed. A meeting was also held in each community with representatives of the district and county health departments to discuss services provided by the health department for pregnant women, infants and children. Perinatal Case Management, Pregnancy Related Services, outreach and Medicaid eligibility were discussed.

On the final day of the site visit, the regional hospital hosted a meeting with all participants. Physicians, community agencies and advocacy organizations were also invited to participate in this joint meeting.

Each regional hospital, local health department and county DFCS office were asked to provide numbers of maternity and pediatric inpatients and outpatients and programmatic information on physician participation, indigent care programs, Perinatal Case Management and eligibility outcome data. The data were analyzed prior to the site visits.

The findings of the site visit and data analysis have been categorized into specific topics and are presented below.

Medicaid Eligibility

Avenues to Medicaid

There are two programs which are the major avenues to Medicaid coverage for pregnant women, infants and children. The Aid to Families with Dependent Children (AFDC) program provides cash assistance and Medicaid coverage to poor families with children. The Right from the Start Medicaid (RSM) program provides Medicaid coverage for pregnant women, infants and children.

Georgia income eligibility levels for AFDC and RSM are displayed in Table 2. Effective July 1, 1993, the income eligibility level for RSM pregnant women and infants will be increased to 185% of the federal poverty level. Additionally, on July 1, 1993, the RSM age requirements will be increased so that children age 18 or younger with family income at or below 100% of the federal poverty level can qualify for Medicaid.

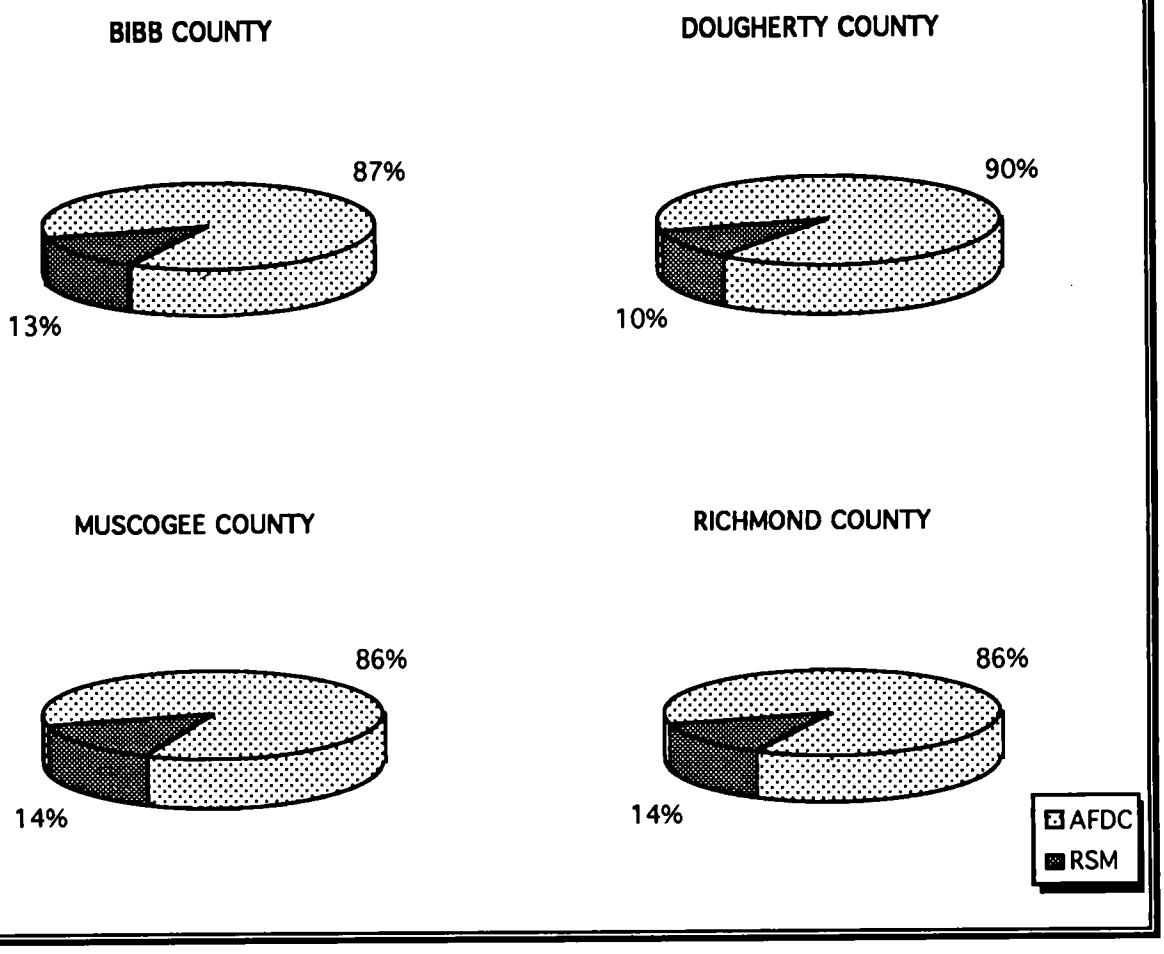
TABLE 2
GEORGIA INCOME ELIGIBILITY LEVELS EXPRESSED AS A PERCENTAGE OF THE 1993 FEDERAL POVERTY LEVEL

PROGRAM	% OF 1993 FEDERAL POVERTY LEVEL	ANNUAL INCOME (FAMILY OF THREE)
AFDC	43%	$5,088
RSM pregnant women and infants[a]	150%	$17,835
RSM children ages 1-5	133%	$15,814
RSM children ages 6-9[b]	100%	$11,890

Notes: a) Effective July 1, 1993, the eligibility level for pregnant women and infants is scheduled to increase to 185% of the federal poverty level ($21,997).
b) Effective July 1, 1993, children ages 10-18 will be added.

Most children are eligible for Medicaid because of their eligibility for AFDC. The chart below illustrates the proportion of individuals provided Medicaid through AFDC and RSM for each county.

CHART 1
PROPORTION OF INDIVIDUALS PROVIDED MEDICAID THROUGH AFDC AND RSM BY COUNTY OCTOBER-DECEMBER 1992



Eligibility Outcomes by County

The likelihood that an application submitted for RSM coverage will be approved is much greater than an application submitted for AFDC coverage. Table 3 shows that of the four counties, the chances of not being approved are highest in BIBB County for AFDC and RICHMOND County for RSM. It should be noted that these statistics precede the implementation of presumptive eligibility for RSM applicants.

TABLE 3
PROPORTION OF AFDC AND RSM APPLICANTS NOT APPROVED BY COUNTY
OCTOBER - DECEMBER 1992

COUNTY	AFDC % NOT APPROVED	RSM % NOT APPROVED
Bibb	48%	3%
Dougherty	37%	8%
Muscogee	38%	9%
Richmond	35%	11%

Note: Applications not approved is a combination of applications denied and applications withdrawn from consideration. Withdrawals represent a small percentage of the applications not approved.
Source: Data taken from the DFCS County Case Load Activity Summary for the quarter October - December 1992.

Tables 4 and 5 show that failure to comply with procedural requirements is the leading reason applicants are denied AFDC and RSM. "Failure to comply" includes denials for not keeping the required interview appointment as well as denials for not returning required verification information subsequent to an interview. All four county DFCS offices operate on an appointment system. County offices utilizing an appointment system typically have a high rate of procedural denials due to applicants failing to keep an application interview appointment. RICHMOND and DOUGHERTY DFCS offices were able to document that the majority of procedural denials were due to failure to keep required interview appointments. BIBB and MUSCOGEE DFCS offices were unable to provide data on the "no show" rate.

TABLE 4
AFDC APPLICATIONS DENIED FOR FAILURE TO COMPLY WITH PROCEDURAL REQUIREMENTS BY COUNTY
OCTOBER - DECEMBER 1992

COUNTY	% OF AFDC CASES DENIED	% OF AFDC DENIALS DUE TO FAILURE TO COMPLY	# OF AFDC CASES DENIED FOR FAILURE TO COMPLY	# OF AFDC INDIVIDUALS DENIED FOR FAILURE TO COMPLY
Bibb	41%	68%	307	798
Dougherty	31%	66%	158	411
Muscogee	33%	70%	259	673
Richmond	28%	71%	236	614

Notes: 1) Denials do not include applications withdrawn. 2) The estimate of the number of individuals was based on 2.6 persons per AFDC case.

TABLE 5
RSM APPLICATIONS DENIED FOR FAILURE TO COMPLY WITH PROCEDURAL REQUIREMENTS BY COUNTY
OCTOBER - DECEMBER 1992

COUNTY	% OF RSM CASES DENIED	% OF RSM DENIALS DUE TO FAILURE TO COMPLY	# OF RSM CASES DENIED FOR FAILURE TO COMPLY	# OF RSM INDIVIDUALS DENIED FOR FAILURE TO COMPLY
Bibb	3%	43%	3	6
Dougherty	7%	35%	6	13
Muscogee	7%	85%	22	46
Richmond	9%	56%	24	50

Notes: 1) Denials do not include applications withdrawn. 2) The estimate of the number of individuals was based on 2.1 persons per RSM case.

Reapplications and Change in Income

It is not clear whether denied applicants are advised to reapply if their circumstances change. Currently, no mechanism is in place to revisit the question of eligibility for pregnant women who have been denied for excess income to determine if their circumstances have changed. An inpatient financial counselor at the Medical Center of Central Georgia indicated that she thinks the majority of patients who are not certified for Medicaid at delivery have been in contact earlier with someone about eligibility and some were probably denied. Changes in their circumstances may have resulted in their becoming income eligible for Medicaid, but they are "scared" to tell the inpatient worker they were previously denied for excess income. It was specifically mentioned that families of construction workers regularly experience variation in monthly income.

Presumptive Eligibility

Presumptive eligibility is an option available to states to grant immediate Medicaid eligibility to pregnant women served by "qualified providers," e.g., disproportionate share hospitals, health departments and community health centers. To expedite access to early prenatal care, Georgia DMA enacted presumptive eligibility for pregnant women in January 1993. Presumptive eligibility has expedited the process of certifying pregnant women for the Right from the Start Medicaid program (RSM). All four regional hospitals and county health departments conduct presumptive eligibility.

Table 6 provides presumptive eligibility information specific to the regional hospitals and health departments.

TABLE 6
PRESUMPTIVE ELIGIBILITY AT REGIONAL HOSPITALS AND COUNTY HEALTH DEPARTMENTS

COUNTY	REGIONAL HOSPITAL	HEALTH DEPARTMENT
Bibb	The Medical Center of Central Georgia has one full time presumptive eligibility worker who is present during clinic hours.	The health department has two admissions clerks who are the presumptive eligibility workers.
Dougherty	Phoebe Putney Memorial Hospital has two financial counselors who serve as presumptive eligibility workers.	The health department has four presumptive eligibility workers: two nurses and two human service technicians.
Muscogee	The Medical Center utilizes OB Coordinators in the pre-admission process to take presumptive eligibility applications.	Presumptive eligibility applications are taken by the Nursing Unit and the Perinatal Case Management Unit.
Richmond	The Medical College of Georgia Hospital has placed a financial counselor in the clinic area to take presumptive eligibility applications.	The health department certifies for presumptive eligibility and on-site DFCS workers process RSM.

The presumptive eligibility application must be taken by employees of qualified providers. It does not replace the RSM application, although it duplicates most of the same information on the RSM application. Both applications are almost always taken at the same time. Presumptive eligibility workers are not authorized to approve eligibility beyond a temporary period. The final decision on continuous eligibility rests with the DFCS eligibility worker. DFCS eligibility workers are not allowed to determine presumptive eligibility because they are not included in the federal definition of qualified providers. In one hospital, the presumptive eligibility worker and the DFCS eligibility worker share the same office space. The presumptive eligibility worker conducts the interview and hands the completed presumptive eligibility application to the DFCS worker for a final determination under RSM. The DFCS eligibility worker cannot conduct interviews for presumptive eligibility,

but she handles the same applications in her capacity as the on-site RSM worker.

Clearly, the federal prohibition against DFCS workers taking presumptive eligibility applications produces inefficiency. It makes little sense to exclude DFCS eligibility workers who are highly qualified to make the determination of presumptive eligibility under the guidelines set forth by DMA. Additionally, because DFCS workers cannot take presumptive eligibility applications, pregnant women who file applications at DFCS offices are not afforded the opportunity for expedited Medicaid through presumptive eligibility. To expedite Medicaid for pregnant women who apply at the DFCS office, DFCS must refer them to presumptive eligibility workers at provider sites which can create a "run around" situation for the pregnant woman.

Delay in Medicaid Cards for Newborns

By federal law, a newborn of a mother covered by Medicaid is automatically entitled to Medicaid coverage up to age one as long as the infant continues to live with the mother. On the site visits, it was frequently reported that there are delays in eligible newborns receiving Medicaid cards. This is particularly problematic for newborns who become sick shortly after discharge. It can become a serious threat to health if illness occurs on a weekend when telephone verification is not available. In all communities, it was reported that pharmacists typically insist on seeing a Medicaid card before filling prescriptions. In RICHMOND County, a mother brought her five-day old baby to DFCS on a Friday to obtain a Medicaid card. The newborn was ill and needed medical attention. The mother had not reported the birth to DFCS so the newborn had not been assigned a Medicaid number. The RICHMOND County DFCS worker who assisted the mother explained that the mother would not have been able to get a temporary Medicaid number for the newborn had this situation occurred on a weekend. Her only available source of care would have been the emergency room.

Staff of the Medical Center of Central Georgia indicated that DFCS offices in surrounding counties, not Bibb County, refuse to provide a copy of the DMA Form 964 (Certificate of Retroactive Medicaid) until the hospital forwards a copy of the birth certificate. According to hospital staff, several of the surrounding counties tell the mother of the newborn that they will activate the infant's Medicaid number when the mother comes in for an AFDC interview, which is not

necessary for automatic eligibility. In both instances, the receipt of the infant's Medicaid card is delayed.

Eligibility workers speculated that other reasons for the delay in issuance of Medicaid cards could be that the AFDC family is not always asked about pregnancy on redetermination of eligibility so an unborn number is not added to PARIS prior to delivery, there is a time lag between PARIS and Electronic Data Systems and Electronic Data Systems does not always pick up on address changes.

The delay in issuance of Medicaid cards was found in DeKalb and Fulton counties in an earlier study.[3] DFCS eligibility workers and staff with community health centers reported that the delay in issuing Medicaid cards was an access barrier for newborns needing medical attention.

AFDC Versus RSM

While ultimately an AFDC applicant receives more benefits if approved, the probability of being approved for AFDC is much lower than for RSM. Discussions with DFCS eligibility workers in BIBB and MUSCOGEE counties indicate that for very poor families with children, it is typical for eligibility workers to encourage parents to apply for AFDC so that the family can have cash assistance in addition to Medicaid coverage. An eligibility worker in MUSCOGEE County captured the view of many DFCS workers: "It is to their benefit to apply for AFDC."

As discussed above, staff from the Medical Center of Central Georgia indicated that several surrounding counties tell the mothers of newborns that they will activate the infant's Medicaid number when the mother comes in for an AFDC interview. In BIBB County, unless it is obvious that the applicant is not eligible for AFDC, DFCS eligibility workers initiate an AFDC application instead of an RSM application.

In DOUGHERTY and RICHMOND counties, DFCS supervisors stated that intake workers are instructed to look for RSM eligibility first. If the applicant is also interested in AFDC, then an AFDC application is pended for an eligibility decision subsequent to the RSM approval. This approach provides the best opportunity to assure Medicaid coverage.

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[3]Sarah C. Shuptrine, Vicki C. Grant, and Genny G. McKenzie, Improving Access to Medicaid for Pregnant Women and Children (Atlanta: The Robert Wood Johnson Foundation and Grady Memorial Hospital, February 1993).

A related issue was mentioned by staff at the Medical College of Georgia Hospital who stated that stigma attached to welfare is a barrier to eligibility for Medicaid. They indicated that many families do not apply for Medicaid because they do not understand that RSM provides Medicaid to two-parent families and working families.

Verification Most Often Not Returned

In each county, DFCS eligibility workers were asked which verification documents were most often not returned in AFDC and RSM. Without exception, income verification was most likely not returned by AFDC applicants. Income verification appears to be most difficult when the employer pays in cash, when the employer is a temporary agency or when payroll information is maintained by an out of town corporate office. In general, eligibility workers indicated that they assist applicants with income verification when applicants request assistance, but caseloads hinder active assistance in most cases.

In BIBB and RICHMOND counties, eligibility workers said the document most likely not returned by RSM applicants is pregnancy verification and expected date of delivery (EDC). DOUGHERTY County DFCS eligibility workers indicated that the contribution form specifying sources of financial support is most likely not returned by RSM applicants. MUSCOGEE County DFCS workers said that RSM applicants have difficulty verifying wages.

Child Support Enforcement

Except for an unborn child, federal law requires that AFDC and Medicaid applicants cooperate with child support recovery and provide the name and information on the location of the absent parent. Federal law allows applicants to claim good cause due to fear of harm to the child and/or the custodial parent, as long as they provide proof. Additionally, applicants who do not cooperate with child support recovery are not eligible for benefits, but their children are not denied benefits if they otherwise meet eligibility requirements.

During the site visits, discussions were held with DFCS, hospital and health department staff to discuss whether child support requirements pose a barrier to Medicaid eligibility for children. DFCS staff stated that many applicants are aware of child support requirements and simply maintain that they have no information on the absent parent. Other applicants are unwilling to provide the name and whereabouts of the absent parent. Still others either do

not know who the father is or they have no information on his whereabouts. Some never apply because they are unwilling to answer questions regarding the absent parent. Eligibility workers in BIBB and MUSCOGEE counties indicated that they know of cases where applicants withdrew their applications or refused to file for AFDC and Medicaid because of the child support requirements. They also stated that, regardless of need, many Food Stamp recipients will decline to apply for AFDC or Medicaid to avoid a referral of the father to child support recovery. Hospital and health department staff stated that child support requirements do present barriers to eligibility.

Reporting the absent parent is often problematic. Some custodial parents fear that the absent parent will discontinue voluntary child support if a referral to child support recovery is made. Another major problem is that reporting the absent parent is an emotional issue for many applicants. It can mean the end of the relationship, it can cause the breakup of a marriage if the absent parent is married to someone else and it can produce fear of the reaction of the absent parent even though there is no proof that there is likelihood of harm. DFCS staff in BIBB County said that often an applicant's body language changes when the issue of child support is discussed during the interview. BIBB County DFCS staff also stated that they have received calls from persons asking whether the father will be referred to the Office of Child Support Recovery if they apply for Medicaid. DFCS staff in DOUGHERTY County indicate that obtaining information on the absent parent is a particular problem with teenagers who do not want to "get the father in trouble because they believe he will take care of them." MUSCOGEE County DFCS staff said that if the absent parent is providing voluntary child support, the applicant may be reluctant to involve his employer. RICHMOND County DFCS staff said some fathers refuse to document voluntary child support because they do not want their children on welfare.

Even when absent parents cooperate with establishment of paternity, there is no guarantee that they will receive child support payments. It is generally recognized that there is often no substantial economic incentive for the absent parent to initiate and stay with the difficult process of establishing paternity. The National Commission on Children recommended the establishment of an insured child support payment backed by the government to provide the absent parent a strong incentive to succeed at establishment of paternity. The recommendation is as follows:

> The National Commission on Children recommends that a demonstration of suitable scale be designed and implemented to test an insured child support plan that would combine enhanced child support enforcement with a government-insured benefit when absent parents do not meet their support obligations. Contingent on positive findings from this demonstration, the Commission recommends the establishment of the insured child support benefit in every state.[4]

Lack of Uniform Program Rules and Federal Error Rate Sanctions

Previous studies conducted by Sarah Shuptrine and Associates identified the federal error rate sanctions and the lack of uniform program rules across AFDC, Medicaid and Food Stamps as major barriers to eligibility and efficiency of eligibility services.[5] The site visits confirmed these findings. Additionally, the lack of uniformity in rules across AFDC, Medicaid and Food Stamps significantly increases the chances for agency and applicant errors.

Medicaid Outreach

Outreach is necessary to provide opportunities for preventive and primary care for pregnant women, infants and children. An important strategy for outreach is outstationing of eligibility workers at provider sites. An equally important strategy is the establishment of an outreach unit to assist applicants in meeting the requirements of the application process. Both of these strategies are discussed below.

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[4]Beyond Rhetoric (Washington: The National Commission on Children, 1991), 98.

[5]Sarah C. Shuptrine, Vicki C. Grant, and Genny G. McKenzie, Improving Access to Medicaid for Pregnant Women and Children (Atlanta: Grady Memorial Hospital and The Robert Wood Johnson Foundation, February 1993); Sarah C. Shuptrine and Vicki C. Grant, Study of the AFDC/Medicaid Eligibility Process in the Southern States (Washington, DC: The Southern Regional Project on Infant Mortality, April 1988); Sarah C. Shuptrine and Vicki C. Grant, The Relationship of the Reasons for Denial of AFDC/Medicaid Benefits to the Uninsured in the United States (Columbia, SC: Sarah Shuptrine and Associates, October 1988); An Assessment of Medicaid Revenue Potential at the Greenville Hospital System, Volume II (Columbia, SC: Sarah Shuptrine and Associates, September 1989); Sarah C. Shuptrine and Vicki C. Grant, Medicaid Eligibility Performance in South Carolina Counties (Columbia, SC: South Carolina Hospital Association, April 1990); Sarah C. Shuptrine and Vicki C. Grant, Assessment of the Medicaid Eligibility Process in Chatham County, Georgia (Savannah, GA: Memorial Medical Center, June 1991).

Outstationed Eligibility Workers

Regional Hospitals. DFCS offices in DOUGHERTY, MUSCOGEE AND RICHMOND counties have placed eligibility workers at the regional hospital to take Medicaid applications. At Phoebe Putney Memorial Hospital and The Medical Center, the DFCS eligibility workers take and process applications from maternity and pediatric patients, except for out-of-county applications which are forwarded to the home county for processing. The DFCS eligibility workers at the Medical College of Georgia Hospital provide intake services only. The on-site workers take applications from inpatients and outpatients and all applications are processed by staff at the RICHMOND DFCS office. Additionally, RICHMOND DFCS has outstationed two eligibility workers at University Hospital to take applications for Richmond County residents.

There are no outstationed eligibility workers in BIBB County. Several years ago, one DFCS eligibility worker was outstationed part-time at the Medical Center of Central Georgia. Hospital staff indicated that it did not work well with a part-time worker and as the DFCS workload grew, the eligibility worker was pulled back into the DFCS office full time. In the absence of outstationing, the Medical Center of Central Georgia has assigned hospital staff to assist potentially eligible persons to apply for Medicaid.

Table 7 displays the status of outstationing eligibility workers by regional hospital.

TABLE 7
STATUS OF OUTSTATIONED ELIGIBILITY WORKERS AT REGIONAL HOSPITALS

REGIONAL HOSPITAL	OUTSTATIONED ELIGIBILITY WORKERS	SOURCE OF MEDICAID STATE MATCH	FOCUS OF ELIGIBILITY
Medical Center of Central Georgia	No on-site eligibility worker*		
Phoebe Putney Memorial Hospital	Two full time eligibility workers	Hospital matches one worker and DFCS matches one worker	Maternity and pediatric inpatients, plus foster care cases assigned by DFCS
The Medical Center	One eligibility worker 30 hours per week	DFCS	Maternity and pediatric inpatients
Medical College of Georgia Hospital	Two full time eligibility workers	DFCS	One assigned to all inpatients and one to all outpatients

* MCCG has assigned two MCCG workers to take Medicaid applications from maternity inpatients and infants. Out of county applications are forwarded to the DFCS office in the patient's county of residence.

Health Departments. Two county DFCS offices (DOUGHERTY AND RICHMOND) have placed eligibility workers at the county health departments to take and process Medicaid applications. In DOUGHERTY County, one full time eligibility worker is on-site at the health department to take and process applications. One-half of the eligibility worker's time is devoted to health department patients and the other half to patients assigned by DFCS. The DOUGHERTY County Health Department provides the match for the position. RICHMOND County DFCS has outstationed two full time DFCS eligibility workers at the Richmond County Health Department to take and process RSM applications, plus another eligibility worker goes to the health department one day per week to assist with the caseload.

There are no outstationed eligibility workers at the health departments in BIBB and MUSCOGEE Counties. When a DFCS worker was originally outstationed at the Macon-Bibb County Health Department, Medicaid applications for children were taken which is no longer the case.

Community Outreach

Community Outreach serve two purposes:

- Locate indigent persons who are under utilizing health care, such as pregnant women who are not receiving prenatal care; and
- Assist indigent or underinsured persons in applying for Medicaid by helping them complete the application and secure all required documentation.

Three types of Medicaid outreach units for pregnant women and children are described below:

- The Greenville Hospital System in Greenville, South Carolina employs staff to work with its patients to complete the Medicaid eligibility process and to find indigent pregnant women who are not receiving prenatal care. The Greenville Hospital System contracts directly with the state Medicaid agency under an administrative contract. The hospital provides the state Medicaid match of 50% and the remainder is federal Medicaid funds.
- In Chatham County, Georgia, DFCS implemented a Medicaid outreach program in 1991. The Outreach Unit is staffed by eligibility workers. The county pays the state Medicaid match of 50% and the remaining 50% is federal Medicaid match funds. The Outreach Unit intervenes prior to an applicant being denied for failure to comply with procedural requirements. The unit also works to encourage applicants who missed the application interview appointment to continue with the eligibility process so that a determination of eligibility can be made.
- In Charleston County, South Carolina, the Department of Social Services employs eligibility workers to provide outreach services to patients at the Medical University of South Carolina. The Medical University of South Carolina provides the state Medicaid match of 50% and 50% is provided by federal Medicaid funds.

Grady Memorial Hospital in Fulton County established an outreach program patterned after the Greenville Hospital System outreach unit. However, Grady provides 100% of the funding because Georgia DMA has not yet begun contracting with providers to conduct outreach at the administrative match rate.

The RICHMOND County DFCS has established an outreach unit modeled after the CHATHAM County DFCS program. The RICHMOND County DFCS proposed to the county that an outreach program would save the county money by assisting applicants to be approved for Medicaid coverage rather than using county indigent care funds. The county approved the proposal and will pay the 50% state Medicaid match for 21 positions, including supervisory and clerical staff. The outreach workers will provide assistance to persons applying for Medicaid or other benefits, however, none of the workers will be assigned the task of finding individuals in the county who need health care. None of the other three counties had plans to initiate an outreach program at the time of the site visit.

Pregnant Women

The trimester in which a pregnant woman enters prenatal care has been used as an important indicator of access to care. Additionally, the indicator is used as a measurement of the effectiveness of infant mortality initiatives. Table 8 shows that MUSCOGEE and RICHMOND counties are below the statewide average. In MUSCOGEE County, only 64% of pregnant women enter prenatal care during the first trimester. In RICHMOND County, 71% of pregnant women begin prenatal care in the first trimester.

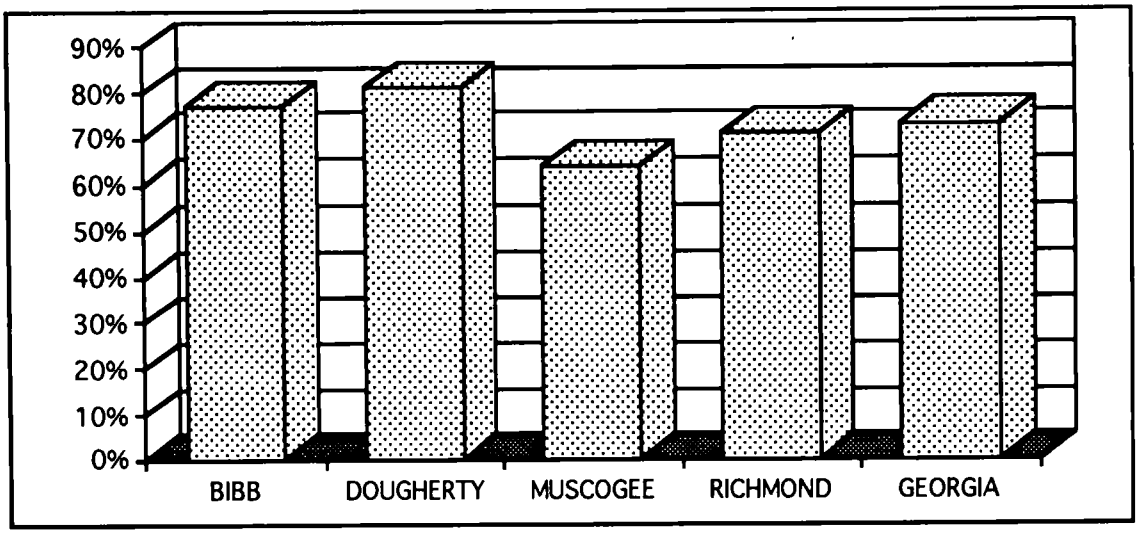
TABLE 8
DISTRIBUTION OF PREGNANT WOMEN BY TRIMESTER PRENATAL CARE BEGAN AND COUNTY AVERAGE OF 1989-1991

TRIMESTER	BIBB	DOUGHERTY	MUSCOGEE	RICHMOND	GEORGIA
First	77%	81%	64%	71%	73%
Second	17%	16%	28%	22%	20%
Third	3%	2%	5%	4%	4%
No Care	2%	0%	3%	3%	2%
First	1,970	1,400	2,206	2,591	80,275
Second	440	282	958	814	21,970
Third	83	34	172	148	4,309
No Care	53	6	100	97	2,688
Total	2,547	1,723	3,437	3,651	109,242

Source: Data taken from birth certificates by the State Center for Health Statistics, Georgia DHR.

The chart below displays the percentage of pregnant women entering prenatal care in the first trimester for each county and the state.

CHART 2
PERCENTAGE OF PREGNANT WOMEN ENTERING PRENATAL CARE IN FIRST TRIMESTER



All county health departments and regional hospitals aggressively provide Medicaid eligibility assistance for pregnant women. Each hospital and health department conducts presumptive eligibility. While these eligibility initiatives make it easier for pregnant women to apply for Medicaid, outreach efforts to find pregnant women are very limited. This lack of outreach hinders efforts to promote early entry into prenatal care.

As the table below shows, large percentages of births are self pay at the Medical Center of Central Georgia and the Medical College of Georgia Hospital. It is possible that patients in a Medicaid pending payor status were reported as Medicaid patients by Phoebe Putney and The Medical Center.

Perhaps the most significant aspect of the table is the proportion of pregnant women from other counties. Pregnant women from out of county ranges from 21% at The Medical Center to 75% at the Medical College of Georgia Hospital. Hospitals and DFCS offices with Medicaid outreach programs can have a major impact on increasing the approval rate of Medicaid applications submitted by non resident pregnant women.

TABLE 9
NUMBER OF TOTAL BIRTHS, MEDICAID AND SELF PAY BIRTHS AND PREGNANT WOMEN OUT OF COUNTY BY REGIONAL HOSPITAL
FY 1992

HOSPITAL	TOTAL BIRTHS	MEDICAID		SELF PAY		PREGNANT WOMEN OUT OF COUNTY
		# OF BIRTHS	% OF BIRTHS	# OF BIRTHS	% OF BIRTHS	
Medical Center of Central Georgia	2,924	1,212	41%	783	27%	59%
Phoebe Putney Memorial Hospital	2,669	1,510	57%	125	5%	33%
The Medical Center, Inc.	3,820	1,830	50%	271	7%	21%
Medical College of Georgia Hospital	2,044	368	18%	1,262	62%	75%

Note: Births with payor code of Medicaid pending are included in self pay at MCG and MCCG.
Source: Regional hospitals.

Infants and Children

The outstationed DFCS eligibility workers at the three regional hospitals in DOUGHERTY, MUSCOGEE AND RICHMOND counties take applications on self-pay infants and children. At the Medical College of Georgia Hospital in RICHMOND County, applications are taken on pediatric outpatients as well as inpatients. There are no eligibility services directed at children in BIBB County.

There are no outreach efforts in the four counties to find children who are in need of health care, but who are not utilizing available services. Likewise, there are no outreach initiatives to assist children to apply for Medicaid.

The table below shows that a large proportion of Medicaid and Self Pay pediatric inpatients at the four regional hospitals reside in another county. The Medical Center of Central Georgia and the Medical College of Georgia Hospital have a significant proportion of pediatric inpatients from out of county. Medicaid outreach programs can assist the regional hospitals in increasing the

approval rate of out of county patients by helping them with the Medicaid application process.

TABLE 10
NUMBER OF MEDICAID AND SELF PAY PEDIATRIC INPATIENTS AND PERCENTAGE FROM OUT OF COUNTY BY REGIONAL HOSPITAL FY 1992

HOSPITAL	TOTAL	% OUT OF COUNTY
Medical Center of Central Georgia	971	67%
Phoebe Putney Memorial Hospital	3,803	33%
The Medical Center, Inc.	3,779	22%
Medical College of Georgia Hospital	3,945	73%

Source: Regional hospitals.

Perinatal Case Management

Perinatal Case Management is a Medicaid sponsored service typically provided by local health departments and community health centers.[6] DMA defines Perinatal Case Management in its policy manuals as follows:

> Perinatal Case Management is a set of interrelated activities for coordinating and monitoring appropriate services for eligible pregnant women. The purpose of Case Management Services is to assist those pregnant women eligible for Medicaid in gaining access to needed medical, nutritional, social, educational and other services; to encourage the use of cost-effective medical care through referrals to appropriate providers; and to discourage over utilization of costly services.

Pregnant women certified for Medicaid coverage can receive case management services throughout pregnancy and until 60 days following

[6]In Richmond County, a home health agency is also a Medicaid provider of Perinatal Case Management.

delivery. DMA requires that providers of Perinatal Case Management have full time staff who are registered nurses, licensed social workers or paraprofessionals.

There are four case management services for which Medicaid will provide reimbursement. No more than one service can be billed within a month per patient. The four services are as follows:

1) Comprehensive assessment and development of a care plan for a new patient which can only be billed once per pregnancy. It must be conducted by registered nurses or licensed social workers.

2) Brief Follow-up is a minimal direct or indirect contact to monitor compliance with the care plan. Only one Brief or Extended Follow-up can be billed per month with a maximum allowance of eight prior to delivery.

3) Extended Follow-up is a direct contact to reassess necessitated by complications of pregnancy or changes in environmental factors. Only one Extended or Brief Follow-up can be billed per month with a maximum allowance of eight prior to delivery.

4) Postpartum Follow-up is an assessment of the mother and assistance with Medicaid eligibility, WIC, EPSDT and other services needed by the infant. The Postpartum Follow-up must be conducted by registered nurses or licensed social workers and can only be billed once per pregnancy.

Issues identified during the site visits related to Perinatal Case Management are discussed below.

Caseload and Case Mix

DMA has not adopted a standard for caseload size. Discussions with national experts indicate that information on optimum size of caseloads for perinatal case managers has not been synthesized. As Table 11 shows, there is wide variation in the size of the caseload per FTE among the four county health departments. Caseloads per FTE range from 81 in BIBB County to 213 in DOUGHERTY County. Case management staff are typically nurses. It should be noted that comparisons between counties on caseloads are not fair without knowing the case mix of the cases. Medical risks, social functioning and social support systems are key to defining the intensity of case management services. Some pregnant women require a great deal of attention and assistance with social services while others need far less assistance from case managers.

The relationship between caseload and case mix is that as the needs of recipients vary, so should the intensity of services provided. Therefore, caseload size should vary by caseload mix. DMA does not have a typology of need and associated protocol for perinatal case managers. By recognizing a mix of patients, DMA would be better able to assure that its Perinatal Case Management goals are met. Additionally, classifying recipients on the basis of need might allow for a simpler reimbursement system than the current system of units of service provided, possibly using a capitated payment system based on type of case or upon case mix.

TABLE 11
PERINATAL CASE MANAGEMENT CASELOAD AND STAFF
BY COUNTY HEALTH DEPARTMENT

COUNTY	TOTAL CASES	# OF FTES*	CASELOAD/FTE*
Bibb	387	4.75	81
Dougherty	425	2.00	213
Muscogee	362	3.00	121
Richmond	270	2.10	129

* The number of FTEs and the caseload per FTE excludes administrative or clerical staff. Only nurses, social workers and human service technicians are included.

A comparison of the case management caseload to the number of Medicaid births reveals the need to provide case management services to more pregnant women. Table 12 presents current caseloads along with births in 1990. It should be noted that the number of Medicaid sponsored births is larger now because of increases in the eligibility level for pregnant women since 1990.

TABLE 12
PERINATAL CASE MANAGEMENT CURRENT CASELOADS,
MEDICAID BIRTHS AND TOTAL BIRTHS

COUNTY HEALTH DEPARTMENT	TOTAL CASES (APRIL 1993)	MEDICAID BIRTHS (1990)	TOTAL BIRTHS (1990)	% OF BIRTHS TO MOTHER AGE 18 & YOUNGER
Bibb	387	1,295	2,672	19.8%
Dougherty	425	989	1,832	23.1%
Muscogee	362	1,398	3,563	19.6%
Richmond	270	1,609	3,696	18.0%

Target Population

DMA policy does not address targeting of Perinatal Case Management services. RICHMOND County gives priority to women who enter the health care system through the health department, women who are at the highest risk of a poor outcome and Medicaid certified women younger than 21. In the other counties, case management services are provided on a first-come, first-serve basis. To date, the three health departments have not had to refuse services although it is anticipated that this will be a problem in the near future.

In a system that recognizes case mix, targeting becomes unnecessary as a way to allocate resources. Excluding groups of patients from case management services would be less likely to occur under a case mix strategy.

Home Visits

Most case management services are delivered within the prenatal care clinic or the facility in which the clinic is located and over the telephone. Few home visits are made. DMA case management policy does not require home visits or face-to-face contact for brief monthly follow-ups, nor does the fee structure encourage field work. The health departments indicated a desire to provide more home visits, but it is not feasible with current caseloads. Home visits increase a case manager's knowledge of the pregnant woman's total environment and enriches understanding of need.

With proper supervision, Resource Mothers can be used as case management aides to visit pregnant women in their homes. Because they are less expensive than nurses or social workers, Resource Mothers can visit a home more often.

Case Management for Infants

In accordance with DMA policy, Perinatal Case Management services to infants end at the age of two months. Many infants leaving hospitals in the four communities do not have primary care providers and return to emergency rooms when they are sick. Emergency room staff in each community visited stated the need for parent education and observed that many parents do not understand prevention and how to use health care services appropriately. The termination of case management when the infant is only two months old results in lost opportunities to assure access to primary and preventive care and to teach parents about child health and development. A physician at the Medical College of Georgia Hospital made the point that infants who are discharged after 60 days do not receive any case management services at a critical point.

Another issue related to infants was reported by MUSCOGEE County DFCS. Infants must be recertified for Medicaid eligibility by their first birthday. Many parents allow Medicaid certification to lapse until the child gets sick. If the mother continued to have contact with a case manager, the loss of continuous Medicaid eligibility would likely be avoided.

Pregnancy Related Services

Pregnancy Related Services are Medicaid sponsored in-home services provided by specified medical personnel for the purpose of conducting a medical assessment of a mother and newborn, assessing the home/environment, providing nutritional counseling and scheduling appointments for EPSDT, WIC and family planning. Two home visits may be made within the 28 day postpartum period. The first visit must be made within 14 days of the mother's discharge from the hospital and the second visit must be made within 28 days of discharge. In cases where the infant dies or the newborn remains in the hospital beyond 28 days, only one postpartum visit is reimbursable. Medicaid will pay a Pregnancy Related Services provider $60 for each postpartum home visit.

There are overlapping responsibilities between Perinatal Case Management and Pregnancy Related Services. Both offer assessments and

referral services during the postpartum period. In an attempt to coordinate, DMA issued revised rules establishing a sequence for the two services during the postpartum period. Effective May 1993, Pregnancy Related Services policy provides that the Perinatal Case Management postpartum assessment must be conducted after the last home visit of Pregnancy Related Services. This policy interrupts the ongoing relationship established during pregnancy by the case manager.

The only service currently performed by Pregnancy Related Services that cannot be performed by Perinatal Case Managers is the medical screening. Perinatal Case Managers could be required to provide the postpartum services in the home. However, funding for the Perinatal Case Management program is inadequate to make home visits a requirement for all patients. Thus, Perinatal Case Managers have allocated resources to larger caseloads at the expense of home visits. If the Perinatal Case Managers were required to make postpartum home visits and to assure that the medical postpartum service is received, then the added value of conducting a medical postpartum assessment in the home by a Pregnancy Related Services provider is questionable.

The health departments in BIBB, MUSCOGEE and RICHMOND counties are attempting to integrate the delivery of health department services, such as Pregnancy Related Services, Perinatal Case Management, EPSDT and family planning. This can be done where a single entity provides all of the services. However, in DOUGHERTY County, the health department does not provide Pregnancy Related Services. In DOUGHERTY County, DFCS gets new mothers to sign a release of information and then DFCS refers them to providers of Pregnancy Related Services.

In MUSCOGEE County, the social worker at The Medical Center attempts to coordinate independent services. At discharge following birth, the social worker refers the mothers and newborns to one of two Pregnancy Related Services providers. The provider gives a written report of the home visit to the hospital social worker. At the suggestion of Sarah Shuptrine and Associates, the social worker has agreed to provide a copy of the Pregnancy Related Services report to the primary care physician.

The Macon-Bibb County Health Department attempted to find out if other providers are delivering Pregnancy Related Services to county residents, but DMA said there are no others in the county. Staff stated that postpartum women have told health department staff that a "Medicaid nurse" has already visited.

Related Issues

High Risk Pregnant Women

Table 13 below shows an overview of prenatal care within each community and the discussion follows.

TABLE 13
OVERVIEW OF PRENATAL CARE BY COUNTY

COUNTY	PRENATAL PROVIDERS	RISK ASSESSMENT	LOW RISK	HIGH RISK
Bibb	Private physicians, health department, and the Medical Center of Central Georgia	Health department	Health department	Medical Center of Central Georgia
Dougherty	Private physicians	Health department and private physicians	Private physicians	Private physicians
Muscogee	Health department and The Medical Center	Health department	Health department and The Medical Center	Health department and The Medical Center
Richmond	Private physicians; University Hospital; and Medical College of Georgia Hospital	Health department	University Hospital and Medical College of Georgia Hospital	Medical College of Georgia Hospital

In BIBB County, prenatal care to Medicaid and indigent women is provided by private physicians, The Medical Center of Central Georgia and the

Macon-Bibb County Health Department. The health department assesses all of its new OB patients for risk status. Low risk pregnant women are retained by the health department and high risk pregnant women are referred to The Medical Center of Central Georgia for the high risk clinic. After delivery, the health department patients return for postpartum care and Medicaid Pregnancy Related Services. The Medical Center of Central Georgia operates two high risk clinics: one for BIBB County residents and one for residents of other counties. Crawford, Jones, Twiggs and Wilkinson counties routinely refer high risk patients.

In DOUGHERTY County, Phoebe Putney Memorial Hospital, the health department and the community health center refer all pregnant women to the private sector for prenatal care. All but one of the obstetricians in DOUGHERTY County participate in providing prenatal care to Medicaid eligible pregnant women. The health department and private physicians assess pregnant women for risk status.

In MUSCOGEE County, The Medical Center and the county health department share responsibility for prenatal care. The first prenatal care visit takes place at the health department where a complete physical, related lab work and assessment of risk is conducted. Routine care patients continue to be seen at the health department. High risk pregnant women are seen in the High Risk Prenatal Clinic located within the health department. The Medical Center Chief of OB/GYN is the attending physician in the high risk clinic and coordinates placement of residents. Lab work for the high risk clinic is provided by The Medical Center.

In RICHMOND County, pregnant women access prenatal care through the county health department where they are assessed for risk. The health department estimates that 88% of Medicaid eligible pregnant women seek prenatal care through the health department. Low risk pregnant women are referred to University Hospital for continued care and delivery. (University Hospital was not visited as a part of this study.) Most RICHMOND County residents receive prenatal care and delivery from University Hospital which is the county hospital. High risk pregnant women are referred by the health department to the Medical College of Georgia Hospital for prenatal care and delivery. The majority of obstetrical patients at the Medical College of Georgia Hospital are from out of county.

Pregnant women can be assessed for health and social risks to good birth outcomes. Women determined to be at risk of a poor outcome typically receive more intensive pregnancy management. The results of assessments can place pregnant women in various risk groups and pregnancies can be managed according to appropriate medical protocols and appropriate utilization of health care resources.

A key factor in the assessment of risk is a clear definition of risk and objective criteria for measuring risk. There is no consensus among providers in the four site visit counties on the definition of a high risk pregnancy. DHR developed a definition of high risk for its High Risk Pregnant Women program, but it is not universally used. DMA has not articulated a policy delineating standards of appropriate prenatal care and delivery based on risk status.

Verification of Pregnancy and EDC

Verification of pregnancy by a health provider is a requirement in the determination of Medicaid eligibility for pregnant women. Further, DFCS eligibility workers direct applicants to get written verification of the expected date of delivery (EDC). While the EDC is not a condition of eligibility, it is used by DFCS and DMA to calculate when a pregnant woman should have given birth and should no longer be covered by Medicaid. In the absence of verification of EDC, Medicaid certified pregnant women must report each month to their caseworkers to let them know that they are still pregnant. In one application interview observed, the applicant had written verification of pregnancy, but not EDC, and the eligibility worker told the applicant to have another pregnancy test at a different location and bring back the written verification of EDC. This can result in a delay in the determination of eligibility.

Free pregnancy testing is almost nonexistent in the four communities. Table 14 displays information on pregnancy testing in each community.

TABLE 14
AVAILABILITY OF PREGNANCY TESTING AND CHARGE

PROVIDER	CHARGE
Bibb County	
Macon-Bibb County Health Department	No charge if positive; sliding scale charge if negative; however, will not deny service for inability to pay.
Medical Center of Central Georgia	$18
Save a Life	Free, but EDC not provided.
Dougherty County	
Dougherty County Health Department	Free through Family Planning and Prenatal Program; sliding scale if pregnancy testing is sole service; however, will not deny service for inability to pay.
Phoebe Putney Memorial Hospital	$30.58 or $37, depending on type of test.
Muscogee County	
Columbus Department of Public Health	$5; however, will not deny service for inability to pay.
The Medical Center	$8.65 or $25, depending on type of test.
Richmond County	
Richmond County Health Department	$16, or less if income is below 200% of the federal poverty level; however, will not deny service for inability to pay.
Medical College of Georgia Hospital	$12
Birthright	Free, including written EDC.
Crisis Pregnancy Center	Free, including written EDC.

The extent to which charging for pregnancy testing serves as a barrier to Medicaid eligibility and to initiation of early prenatal care was not assessed. It is safe to assume that, in many instances, prenatal care is delayed until pregnancy is certain. Charging for pregnancy testing may be a particular problem for adolescents who may not have the resources to pay. As such, the

lack of free pregnancy testing is counterproductive to access to care, early prenatal care and infant mortality reduction efforts.

Shortage of Primary Care Providers for Children

There are too few private providers of primary care for children in the four communities visited. There is a strong likelihood that use of emergency rooms for primary care is greater when too few physicians provide medical homes. In DOUGHERTY County, there is a shortage of pediatricians, regardless of patient payment source. Most pediatric care is provided by the East Albany Medical Center. At the time of the site visit, it was reported that a common practice among pediatricians in Albany was the requirement that parents pay a retainer of $75 - $125 prior to delivery. This expense is not reimbursable since no service has been provided. It was estimated that each year between 500 and 800 infants do not have a pediatrician when they leave the hospital despite efforts made by the discharge planner. Phoebe Putney Memorial Hospital is addressing the problem by developing an ambulatory pediatric care program staffed by the Family Residency Program with assistance from the East Albany Health Center. It is anticipated that by 1994, discharge planners can refer all newborns without private physicians to the ambulatory program for continuing care.

In RICHMOND County, it was estimated that only 10-20% of newborns have pediatricians at discharge. Children without private pediatricians are referred to the health department of the county of residency or to the Medical College of Georgia Hospital or University Hospital clinics. According to the health department, newborns without private pediatricians do not have a medical home.

In BIBB and MUSCOGEE counties, the Medical Center of Central Georgia and The Medical Center require every baby to have a provider at discharge. The provider can be the health department, hospital clinic or a private physician. However, it should be noted that health departments are not primary care providers.

It was pointed out on the site visit to the Medical College of Georgia Hospital that the impersonal nature of teaching hospitals may contribute to a lack of motivation on the part of pregnant women as well as parents to consider the clinic as a medical home.

A data table in the appendix presents information on the volume of Medicaid claims submitted by primary care physicians in each of the study sites.

The volume of claims was measured by less than 1,000 Medicaid claims and more than 1,000 Medicaid claims. The distribution of physicians submitting claims within each community is not even. In relative terms, a few physicians submit the majority of Medicaid claims.

Inappropriate Use of Emergency Rooms by Children

Children comprise a large portion of the population seeking care in the emergency rooms of the regional hospitals. Staff at the emergency room in each community indicated that many visits by children could be avoided if primary care were available or utilized. Children not in need of emergency or urgent care are brought to emergency rooms because of the lack of parental knowledge, convenience or the lack of care elsewhere.

- At The Medical Center of Central Georgia, emergency room staff indicated that about 50% of the pediatric visits are not true emergencies. Many children are brought because of fevers: "Mom can't read the thermometer." Staff stated that the hours are convenient and there is not a long wait to see a physician as there would be in the clinic or in a private physician's office. They attribute part of the problem to a lack of awareness of community resources and "kids raising kids." Health department staff said that infants are taken to the emergency room for primary care.

- Phoebe Putney Memorial Hospital staff indicated that the Emergency Room provides care for many children who are not emergency cases and could be seen in a physician's office. While many of these children are uninsured, some are Medicaid eligible and have pediatricians. Staff attributed long waits in physicians' offices and parents wanting health care for their children "today" as reasons Medicaid children are taken to emergency rooms.

- The Medical Center staff estimated that one-third of emergency room patients come for primary care, of which approximately 25% are children. The emergency room sees about 140 patients a day. Staff indicated that fevers are a common reason parents bring children to the emergency room. They believe that parental education would have a significant impact on reducing inappropriate utilization. The hospital staff indicated that children of young parents without social supports have more admissions because of their lack of understanding of childhood illnesses. It was suggested that the family network of transferring information from one generation to the next had declined.

- At the Medical College of Georgia Hospital emergency room, hospital staff estimated that approximately 30% of 900 pediatric visits each month are for primary care. One reason for the visits is convenience for the parents

because the hospital pediatric clinic operates on an appointment system from 8:00 AM to 4:30 PM weekdays. Staff indicated that many visits could possibly be avoided if parental education were available and if primary care were used appropriately. Parents have difficulty understanding what to do for a sick child, particularly with medications. Staff also stated that another reason the emergency room is used for non-urgent care is a lack of planning on the part of parents.

Lack of Transportation

Each of the four communities cited the lack of transportation as a major barrier to health care and to Medicaid eligibility. The lack of transportation as a barrier occurs not only within the communities visited, but also between counties and within counties. Transportation as a barrier to health care becomes even more pronounced with efforts to regionalize rural and urban areas into perinatal care systems, dependent on certain patients traveling away from home to receive the appropriate level of care.

On the site visits, it was reported that in recent years, DMA instituted changes in transportation policy which have resulted in a lack of transportation for Medicaid recipients. Additionally, Medicaid will not pay transportation costs for parents to visit infants or children in intensive care units or in the midst of extended hospitalizations. Staff at Phoebe Putney Memorial Hospital and The Medical Center indicated that length of stays are increased when parents are unable to be at the hospital to receive training on how to care for their child and operate equipment at home.

Participants at site visit meeting in BIBB and RICHMOND Counties reported that there is an over reliance on ambulance services for non emergency transportation to hospitals and to appointments with physicians when there is no other way to get to the service. This has become a bigger problem since Medicaid reduced Medicaid rates for non emergency care. It was reported that patients take the Trailways Bus system home from the Medical College of Georgia Hospital, but must go from Augusta to Atlanta to change buses to go home. It was reported in RICHMOND County that some Medicaid drivers ask riders to pay more out of pocket.

Medical College of Georgia Hospital staff indicated that at one time, Jefferson County had a transportation coordinator and the program worked well. The suggestion was made that administrative funding of 50% state match and 50% federal Medicaid funds could be used to hire a transportation coordinator.

Need For Social Services

All of the communities visited indicated that more hospital social services were needed to improve the effectiveness of health care services for children. According to hospital staff, many of the new mothers do not have family or social support systems or good role models. It was reported that children of young parents without social supports have more admissions because of parents not knowing how to treat childhood illnesses.

Hospital staff emphasized that an array of social services are needed to enable parents to be with hospitalized children. Meal tickets are needed to allow parents to have meals with their children. Space for families to sleep in a child's room and lockers for storing personal effects are needed.

Problems mentioned on the site visits which could be impacted by social support services include parental inability to properly care for their children due to illiteracy, increased numbers of pregnant women physically abused and increases in drug related births.

Lack of Prenatal Care Coverage for Illegal Aliens

By federal law, pregnant illegal aliens are not eligible for Medicaid sponsored prenatal care, although Medicaid will pay for the delivery. This federal policy is counterproductive to efforts to improve access to prenatal care and it places a financial burden on some public hospitals and health departments. The DOUGHERTY County Health Department indicated that, even though small, the number of pregnant illegal aliens is increasing. According to the health department, cost of providing prenatal care to illegal aliens was depleting the funds available for non Medicaid pregnant women.

Immunizations

The immunization rate of children is low and a problem for providers is not knowing a child's immunization history. Effective January 1993, a state law was implemented which conditioned the receipt of AFDC upon immunization of preschool age children. Families that do not comply with the requirement can be sanctioned, which means that the AFDC cash benefit will be reduced for each child who is not up to date with immunizations. If the AFDC case is closed and an ex parte determination is not conducted, the children lose Medicaid coverage.

Because the program has only been in effect for a few months, the impact of conditioning AFDC on immunization status is not known. DFCS plans to contract with an independent party to evaluate the program.

A physician in RICHMOND County indicated that it is difficult to know if a child is up to date on an immunizations. He suggested that it would be tremendously helpful to providers if the immunization history could be printed on the back of a child's Medicaid card.