CHAPTER 3
ACTION PLAN

The Action Plan on the following pages provides specific steps to address the findings, lists the responsible party and others involved and specifies the desired completion date. The following entities would have specific roles in the implementation of the Action Plan:

- Georgia Department of Medical Assistance (DMA)
- Georgia Department of Human Resources (DHR)
- DHR Division of Family and Children Services (State DFCS)
- DHR Division of Public Health (State DPH)

- Medical Center of Central Georgia
- Bibb County DFCS
- Macon-Bibb County Health Department

- Phoebe Putney Memorial Hospital
- Dougherty County DFCS
- Dougherty County Health Department

- The Medical Center
- Muscogee County DFCS
- Columbus Department of Public Health

- Medical College of Georgia Hospital
- Richmond County DFCS
- Richmond County Health Department

In addition, Grady Memorial Hospital, Memorial Medical Center, DFCS offices and health departments in Chatham, DeKalb and Fulton counties will be asked to participate on certain issues.

Sarah Shuptrine and Associates will serve as the facilitator and staff for many of the initiatives, as noted on the Action Plan.

STATE AND LOCAL ACTION PLAN
JUNE 1993

PRINCIPAL	PARTICIPANTS	OBJ. #	OBJECTIVE	COMPLETION DATE
Project Organization				
Each participant	• DMA • State DFCS • State DPH • Regional Hospital • County DFCS • County Health Dept.	1	DMA, State DFCS, State DPH, each of the regional hospitals (including Grady Memorial Hospital and Memorial Medical Center), county health departments and DFCS offices should designate a project coordinator.	August 1993
DMA	• DHR Commissioner • State DFCS Director • State DPH Director • Regional Hospitals' CEOs • Georgia Hospital Assoc. • Georgia Medical Assoc. • East Albany CHC • Sarah Shuptrine and Associates (to staff the steering committee)	2	The DMA Commissioner should establish a steering group to assess progress on the action plan and to resolve interagency issues. Steering group members should include the DMA Commissioner (as chairman), DHR Commissioner, State DFCS Director, State DPH Director, Regional Hospital CEOs (including Grady Memorial Hospital and Memorial Medical Center), Georgia Hospital Association, Georgia Medical Association, a representative of the community health center in Dougherty County. The steering group should meet not less than every six months over an 18 month period.	December 1993 (first meeting) June 1994 (second meeting) December 1994 (final meeting)
Regional Hospital	• County DFCS • County Health Dept. • Sarah Shuptrine and Associates (technical assistance to include attendance at initial meeting)	3	Each community should set up a working group to reflect the composition of the state steering group to collaborate, assess progress and resolve interagency issues.	September 1993 (first meeting)

STATE AND LOCAL ACTION PLAN
JUNE 1993

PRINCIPAL	PARTICIPANTS	OBJ. #	OBJECTIVE	COMPLETION DATE
SSA		4	Prepare a final report on the status of the recommendations. The draft of the status report will be reviewed at the last meeting of the steering group in December 1994.	February 1995
Eligibility Outcomes by County				
County DFCS		5	County DFCS should begin routinely collecting eligibility outcome data in order to determine the proportion of denials due to "no show" as opposed to not returning verification information.	October 1993
County DFCS		6	County DFCS should initiate strategies to encourage completion of the application process so that procedural denials can be avoided.	January 1994
County DFCS		7	Procedural denials should be reduced to less than 10% of all denials for AFDC and RSM applications.	January 1996
Reapplications and Change in Income				
County DFCS		8	Applicants denied for excess income should be encouraged by eligibility workers to reapply if their circumstances change. In order to give applicants a sense of how their income relates to eligibility criteria, denial notices should specify the amount of income in excess of the eligibility level. County DFCS eligibility workers should attempt to contact RSM pregnant women denied for excess income every two months to determine if their financial circumstances have changed.	October 1993

STATE AND LOCAL ACTION PLAN
JUNE 1993

PRINCIPAL	PARTICIPANTS	OBJ. #	OBJECTIVE	COMPLETION DATE
Presumptive Eligibility				
Regional Hospital	• County DFCS • County Health Dept.	9	The county health department or regional hospital should place a presumptive eligibility worker at the county DFCS office to take and process presumptive eligibility applications from pregnant women who apply at the DFCS office. This arrangement should continue until such time as the federal law is amended to allow DFCS workers to take and process presumptive eligibility applications. The health department, regional hospital and DFCS in each county should meet to determine how best to implement in their community.	October 1993
SSA	• DMA Commissioner • DHR Commissioner	10	Efforts should be made to inform federal policymakers on the need to amend the federal definition of "qualified providers" who are authorized to determine presumptive eligibility so as to include AFDC and Medicaid eligibility workers employed by local or state governments.	September 1993 (meet with federal officials)
Delay in Medicaid Cards for Newborns				
DMA	Sarah Shuptrine and Associates (to convene and staff the work group)	11	The DMA Commissioner should establish a short term work group to determine the action needed to assure that on discharge, all Medicaid infants have a Medicaid number. The work group should be composed of DMA, DFCS (local and state), DPH (local and state), regional hospitals (including Grady Memorial Hospital and Memorial Medical Center) and Electronic Data Systems.	September 1993 (first meeting) January 1994 (complete report outlining actions needed by which entity)

STATE AND LOCAL ACTION PLAN
JUNE 1993

PRINCIPAL	PARTICIPANTS	OBJ. #	OBJECTIVE	COMPLETION DATE
AFDC Versus RSM				
Bibb County DFCS and Muscogee County DFCS		12	As a matter of routine, an RSM application should be processed first and an AFDC application should be pended, unless the applicant specifically requests that the AFDC application be processed first.	October 1993
SSA	• DMA • State DFCS	13	Special informational materials should be developed by DMA and State DFCS to communicate that a family does not have to be on welfare for the children to be eligible for Medicaid. One objective is to get the message across that children in two-parent families are not excluded from Medicaid coverage due to family composition. Another objective is to communicate to families where there is a full time wage earner that income eligibility levels have been increased to include children in working families. (Note: Partial funding to support implementation of this objective will be sought from foundations.)	April 1994
Verification Most Often Not Returned				
County DFCS		14	In order to develop intervention strategies, county DFCS should identify employers who are not cooperating with applicants to provide required wage and income verification in a timely manner.	October 1993
County DFCS	• Regional Hospital • Sarah Shuptrine and Associates to (provide technical assistance)	15	Each regional hospital and county DFCS office should jointly develop a plan to educate employers identified in #14 on the importance of providing wage and income verification within a specified time. The planning document should identify employers who are not able to respond at the local level because payroll is handled at a corporate office.	January 1994

STATE AND LOCAL ACTION PLAN
JUNE 1993

PRINCIPAL	PARTICIPANTS	OBJ. #	OBJECTIVE	COMPLETION DATE
SSA	• DMA • State DFCS	16	A plan should be developed and implemented to work with specific corporate offices to improve cooperation in providing timely verification of income. (Note: Funding to support implementation of this objective will be sought from foundations.)	January 1994 (first meeting) April 1994 (complete plan) July 1994 (complete contacts with corporate offices)
Child Support Enforcement				
State DFCS	• County DFCS • DMA • Sarah Shuptrine and Associates	17	The State DFCS Director should establish a work group to develop special informational materials and design staff training for eligibility workers on how to effectively communicate to custodial parents the importance of establishing paternity to future economic security. The materials should focus on the economic needs of children into the future rather than on Child Support Enforcement process and rules. The training materials should be incorporated into ongoing training.	October 1993 (first meeting) July 1994 (complete development of informational materials) September 1994 (complete staff training materials)

STATE AND LOCAL ACTION PLAN
JUNE 1993

PRINCIPAL	PARTICIPANTS	OBJ. #	OBJECTIVE	COMPLETION DATE
Lack of Uniform Program Rules and Federal Error Rate Sanctions				
SSA	• DMA Commissioner • DHR Commissioner	18	Efforts should be made to advise federal policymakers of the need to implement uniformity in administrative procedures and resource limits for the major poverty related programs where such uniformity will improve access to benefits, reduce the likelihood of errors and improve efficiency in administration. To facilitate the development of uniform program rules, a joint report should be prepared by the Secretary of Health and Human Services and the Secretary of Agriculture outlining the differences across Medicaid, AFDC and Food Stamps. In the development of uniform rules, resource limits should reflect current costs and should be updated periodically so as not to become more restrictive over time.	September 1993 (meet with federal officials)
Outstationed Eligibility Workers				
Dougherty County DFCS and Muscogee County DFCS		19	On-site eligibility workers at regional hospitals should devote full time to intake and processing of AFDC and RSM applications for inpatients and outpatients.	October 1993
Bibb County DFCS	Medical Center of Central Georgia	20	Two DFCS eligibility workers should be placed on-site at the hospital to take and process AFDC and RSM applications from maternity and pediatric inpatients and outpatients. The hospital should provide match for one worker and DFCS should provide match for the second worker. The hospital should provide the match to purchase computer and other equipment for both workers. Care should be taken to assure that the on-site eligibility workers closely coordinate with the hospital staff who currently handle applications in order to incorporate effective mechanisms already in place.	October 1993

STATE AND LOCAL ACTION PLAN
JUNE 1993

PRINCIPAL	PARTICIPANTS	OBJ. #	OBJECTIVE	COMPLETION DATE
Muscogee County DFCS	The Medical Center	21	One DFCS eligibility worker should be placed on-site at the ambulatory clinic to take AFDC and RSM applications placing a strong focus on pediatric patients. The hospital should provide match for the position and equipment needs.	October 1993
Richmond County DFCS	Medical College of Georgia Hospital	22	One additional DFCS eligibility worker should be placed on-site at the hospital to take and process AFDC and RSM applications for pediatric inpatients and outpatients. The on-site DFCS workers should take and process AFDC and RSM applications from maternity and pediatric inpatients and outpatients. The hospital should provide the match for the new position and equipment needs.	October 1993
Bibb County DFCS and Muscogee County DFCS	• Macon-Bibb County Health Department • Columbus Dept. of Public Health	23	One DFCS eligibility worker should be placed on-site at the health department to take AFDC and RSM applications from pediatric patients. The match for the position and equipment needs should be provided by DFCS.	October 1993
Community Outreach				
County DFCS		24	DFCS should take and process all applications regardless of applicant's county of residence.	October 1993

STATE AND LOCAL ACTION PLAN
JUNE 1993

PRINCIPAL	PARTICIPANTS	OBJ. #	OBJECTIVE	COMPLETION DATE
SSA	• DMA Commissioner • DHR Commissioner	25	DMA and DHR should cosponsor a forum on outreach models for staff from the regional hospitals, county DFCS offices and county health departments so that each community can determine how best to organize outreach within that community. Presenters at the forum would include the Greenville Hospital System, Chatham County DFCS, Charleston County DSS, Richmond County DFCS and Grady Memorial Hospital. Sarah Shuptrine and Associates will staff a planning group, handle conference arrangements and prepare proceedings.	September 1993 (establish planning group) November 1993 (hold forum) January 1994 (report completed)
DMA	Sarah Shuptrine and Associates (to provide technical assistance)	26	DMA should develop a model contract by which it can contract with a hospital to provide for outreach workers to assist applicants with the Medicaid eligibility process and to find children in need of primary health care and pregnant women to help them access prenatal care in the first trimester. The contract should have the following features: a) A mechanism for the hospital to provide the 50% state match. b) The use of administrative dollars without the need to conduct time studies or allocate costs. c) A budget for the costs of office space, equipment, etc. d) A budget for development of marketing tools, etc.	October 1993

STATE AND LOCAL ACTION PLAN
JUNE 1993

PRINCIPAL	PARTICIPANTS	OBJ. #	OBJECTIVE	COMPLETION DATE
Regional Hospital	• County DFCS • County Health Dept. • Sarah Shuptrine and Associates (to provide technical assistance)	27	Each community should establish an outreach program to assist applicants with the Medicaid eligibility process and to find children in need of primary health care and pregnant women to help them access prenatal care in the first trimester. County DFCS, the regional hospital and the county health department should determine the most effective organizational arrangement and programmatic linkages for the outreach program in each community and implement. The hospital should provide the match for implementation of the community outreach program regardless of its administrative location.	April 1994
Perinatal Case Management Caseloads and Target Population				
DMA	Sarah Shuptrine and Associates (to staff the work group)	28	The DMA Commissioner should appoint a work group to develop a classification of need along with an associated protocol for perinatal case management. The work group of public and private providers should include representatives from the State DPH, State DFCS, community health centers, physicians, nurses and perinatal case managers. Upon development, DMA should implement the policy.	October 1993 (first meeting) July 1994 (implement policy)
Home Visits				
DMA		29	DMA should require that a minimum of two home visits be made in Perinatal Case Management: one to assess the pregnant woman and one to assess the newborn.	October 1993
Case Management for Infants				
DMA		30	DMA should extend Medicaid coverage of Perinatal Case Management to age one.	October 1993

STATE AND LOCAL ACTION PLAN
JUNE 1993

PRINCIPAL	PARTICIPANTS	OBJ. #	OBJECTIVE	COMPLETION DATE
Pregnancy Related Services				
DMA		31	DMA should terminate Pregnancy Related Services and require that Perinatal Case Managers take responsibility for assuring that appropriate medical care for the mother and newborn is received during the postpartum period.	October 1993
High Risk Pregnant Women				
DMA	Sarah Shuptrine and Associates (to provide technical assistance)	32	In collaboration with public and private providers, DMA should develop standards of appropriate care for pregnant women according to assessed risk and implement. The work group of public and private providers, should include representatives from the State DPH, State DFCS, community health centers, physicians, nurses and perinatal case managers.	April 1994
DMA	Sarah Shuptrine and Associates (to provide technical assistance)	33	In cooperation with public and private providers, DMA should develop a maternity risk screening tool and require all pregnant women to be screened and establish a fee for screening.	April 1994
Verification of Pregnancy and EDC				
County Health Dept.	State DPH	34	All health departments should provide free pregnancy testing regardless of outcome or assure its availability within each county.	October 1993
DMA	• State DFCS • County DFCS	35	DMA should accept self declaration of the estimated date of delivery (EDC) or eliminate the requirement to have medical verification. State DFCS should implement accordingly.	October 1993

STATE AND LOCAL ACTION PLAN
JUNE 1993

PRINCIPAL	PARTICIPANTS	OBJ. #	OBJECTIVE	COMPLETION DATE
Shortage of Primary Care Providers for Children				
DMA		36	DMA should hold local discussions with pediatricians and family practitioners to identify barriers to their participation in Medicaid. Issues should be resolved in an active effort to enroll more primary care providers for children in each community.	July 1994
Regional Hospital	• County Health Dept. • DMA	37	DMA should assure through the Indigent Care Trust Fund and regional hospitals that all Medicaid newborns are discharged to a primary care provider. In the absence of private provider participation, the hospital, county health department and community health center should develop a plan for the recruitment of a pediatrician.	July 1994
Inappropriate Use of Emergency Rooms by Children				
SSA	• Grady Memorial Hospital • Memorial Medical Center • Phoebe Putney Memorial Hospital • Medical College of Georgia	38	DMA should conduct a literature review and interview emergency room staff to identify specific medical conditions of children inappropriately showing up in emergency rooms for care.	September 1994

STATE AND LOCAL ACTION PLAN
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PRINCIPAL	PARTICIPANTS	OBJ. #	OBJECTIVE	COMPLETION DATE
SSA	• DMA • State DPH	39	To reduce inappropriate use of emergency rooms, DMA should conduct a literature search to identify parenting programs which focus on building knowledge of how to prevent injuries and promote health of young children. DMA should then develop a special initiative for pregnant women and parents of Medicaid children to educate them on childhood development and childhood diseases and illnesses. Special attention should be paid to the need to communicate with parents who have low literacy levels. Consideration should be given to establishing a hot line for parents to provide information on how to treat non emergency conditions. Perinatal Case Management should work with parents of infants to teach them how to appropriately link with medical services in order to avoid inappropriate use of emergency rooms. (Note: Partial funding to support implementation of this objective will be sought from foundations.)	January 1994 (complete lit search) July 1994 (complete design of special initiative) September 1994 (implement initiative)
Regional Hospital		40	The regional hospitals should review clinic operating procedures, such as appointment systems and operating hours, to determine how to attract children to the clinic and away from the emergency rooms in non emergency situations.	January 1994
Lack of Transportation				
DMA		41	DMA should review its policies on transportation and take action to improve access. It should also determine through EPSDT or other means how to provide transportation for a parent of a child undergoing a long hospital stay and implement.	October 1993

STATE AND LOCAL ACTION PLAN
JUNE 1993

PRINCIPAL	PARTICIPANTS	OBJ. #	OBJECTIVE	COMPLETION DATE
Need for Social Services				
Regional Hospital	DMA	42	Regional hospitals should assign a social worker to each Medicaid and uninsured pediatric inpatient to work with the medical staff and the family. Discussions should be initiated with DMA to determine if Medicaid reimbursement could be made available to assist in financing this need.	October 1993
Lack of Prenatal Care Coverage for Illegal Aliens				
SSA	DMA Commissioner	43	Efforts should be made to inform federal policymakers of the need to amend the Medicaid law to provide payment of prenatal care for illegal aliens.	September 1993 (meet with federal officials)
Immunizations				
County DFCS		44	County DFCS should assure that ex parte determinations are conducted in the event AFDC cases are closed as a result of the new statewide immunization law.	July 1993
DMA	Electronic Data Systems	45	DMA should explore the feasibility of printing a RSM or AFDC child's immunization history on his/her Medicaid card.	October 1993

CHAPTER 4
LOCAL INITIATIVES

Bibb County

On-Site EPSDT Clinic at the Department of Family and Children Services

In September 1992, the Bibb County DFCS created an on-site EPSDT clinic. The clinic is staffed by a nurse practitioner, a registered nurse, a caseworker, a clerical worker and a community worker. The purpose of the clinic is to provide quality health screenings and counseling for children in Bibb County. Transportation to clinic appointments is provided to any parent needing assistance. If referral to a physician is necessary, the clinic staff will make the appointment. Transportation to the referral appointment is also provided when requested by parents.

In order to make each child feel more comfortable about his visit, the clinic staff devote extra time to explain each test that is given and the equipment used. The caseworker helps parents to understand the importance of the screenings and the referral appointments with physicians. The caseworker also follows up with families to ensure they keep their referral appointments and provides assistance when necessary.

Clinic nurses also assist with Child Protective Service investigations and complete screenings for Head Start in Bibb and Monroe counties.

Future plans include having an LPN from the Bibb County Health Department on-site to provide immunizations.

Contact Person Marjorie Almand, Director
Bibb County Department of Family and Children Services
(912) 751-6051

RSM Group Interviews

The Bibb County DFCS conducts RSM group interviews every Monday for pregnant women with RSM age-eligible children and RSM children only applicants. The group interview process allows DFCS to give an appointment to every RSM

applicant within seven to 10 days of the application. There is an average of 20 applicants in each group.

Group interviews last approximately one hour and then brief individual interviews are held. Individual interviews are conducted in order to obtain confidential information, required documentation and budget information.

The group interview operates similarly to a classroom situation. There are two eligibility workers who conduct the interview. Each applicant receives a folder containing an application and other forms. The group leader walks the participants through the application and the additional forms while the other eligibility worker moves around the room to assist individuals as needed. During the group interview, the group leader discusses the WIC program and the importance of prenatal care.

Contact Person Sherry Brown, Program Director
Bibb County Department of Family and Children Services
(912) 751-3102

Providing Emergency Telephone Service For High Risk Infants

The Medical Center of Central Georgia facilitates emergency telephone service for high risk infants who are being discharged with high tech needs. If a home assessment reveals that the family does not have telephone service, the reason is determined. In some cases, if telephone service has been disconnected due to outstanding telephone bills, the hospital's Social Services Department is able to assist by finding charitable organizations to pay the bill. In some situations, the family will realize the necessity of having access to the telephone and will find the resources to pay its outstanding bill. If resources to pay an outstanding telephone bill cannot be found, the hospital coordinates with the telephone company to assess if "Quick Start" services are available for the home. "Quick Start" allows the family to dial 911 from the home.

Contact Person Hilda Hilliard
Director of Social Services
The Medical Center of Central Georgia
(912) 744-1575

Promoting and Supporting Breast Feeding in Neonatal Intensive Care Unit

The Medical Center of Central Georgia's Beginnings program realizes the birth of a premature infant poses numerous obstacles to successful breast feeding. The lactation specialists make a valuable addition to the neonatal intensive care unit (NICU) health care team. For the past several years, the Medical Center of Central Georgia has been encouraging mothers who have babies in the Intensive Care Nursery to pump their breasts and store the milk for their baby. When the baby shows signs of strong sucking instinct, the baby begins feeding directly from the mother's breast. In March of 1993, the Medical Center assisted 17 mothers with pumping and/or breast feeding in the Intensive Care Nursery. Nine of the babies were discharged or "back transported" and eight of the babies continue to breast feed successfully.

In addition to the nutritional value, the hospital believes that allowing a mother to provide her own breast milk to her baby will promote the bonding process and give the mother a sense of worth during a traumatic time. Providing milk for her premature infant allows a mother to be an active participant of the caregiving team.

Contact Person

Lactation Specialist
BABY Line
The Medical Center of Central Georgia
1-800-228-2055

Dougherty County

Wee Care Room

For seven years Phoebe Putney Memorial Hospital has operated a transitional "apartment room" for families of neonatal intensive care babies ready to leave the hospital. The room is designed and equipped as if the family were at home. The transitional room allows the parents to receive training and become adjusted to caring for their baby in a new environment with the nursing staff close by.

Hospital staff strongly recommends to each family with a baby about to be discharged from the intensive care nursery to stay in the room for at least one night with the baby. Most families elect to stay in the room two to three nights before taking their baby home.

Contact Persons

Ellen Watkins
Assistant Vice President for Maternal and Child Health
Phoebe Putney Memorial Hospital
(912) 889-4191

Kim Heath
Head Nurse Manager, Nursery
Phoebe Putney Memorial Hospital
(912) 889-2594

Southwest Georgia Community Health Institute, Inc.

In November 1992, the Southwest Georgia Community Health Institute, Inc. (SOWEGA-CHI) was established through funding from the Indigent Care Trust Fund. The Institute is represented by the following groups:

- Albany Area Primary Health Care, Inc.
- Phoebe Putney Memorial Hospital
- Southwest Georgia Family Practice Residency Program
- Albany State College
- Darton Junior College
- Dougherty County Medical Society
- Georgia Health District 8-2
- Southwest Georgia Area Health Education Center

The purpose of SOWEGA-CHI is to provide funds for health care programs in the southwest area through public and private grants and contracts. Some examples of programs are perinatal case management, improvements in immunization rates, housing for HIV/AIDS patients and cancer screenings. SOWEGA-CHI recognizes that the area it represents faces major health problems. It seeks to facilitate coordinated and collaborative health planning and service delivery through an integrated process involving health providers, educators, local officials, payers and consumers.

Contact Person Melissa H. Posey
Business/Finance Manager
Southwest Georgia Community Health Institute
(912) 888-6559

Muscogee County

Health and Human Services Campus

The development of a 200,000 square foot health and human services facility in the central part of Columbus is scheduled to be completed in the summer of 1995. The new facility will house the Muscogee Health Department, the Muscogee County DFCS and renal dialysis and outpatient primary and specialty clinics offered through Columbus Ambulatory Healthcare Services. The Health and Human Services Campus will house a comprehensive case management program. Those eligible for services will be registered into the system once, then followed through a structured program which cuts across agency and service lines. This will ensure the medical, health and social service resources are used effectively and with greatest benefit to the client.

Columbus Regional Healthcare System will raise approximately $8.5 million to fund the new facility and will also purchase the existing health department and DFCS buildings from the city. In return, the city will invest proceeds from the sale into the project.

Contact Person
Kevin Sass
Director, Community Healthcare Network
Columbus Regional Healthcare System, Inc.
(706) 571-1900

Community Healthcare Network

The Community Healthcare Network was developed to improve access to health care services in rural and underserved areas. The Network is funded by the Georgia Indigent Care Trust Fund and focuses delivery of services in Harris, Talbot, Muscogee, Chattahoochee and Marion counties. A diagnostic and treatment van goes to each community monthly to provide services. There is active involvement with Hamilton Family Practice in Harris County, Talbotten Family Practice in Talbot County and Marion Family Practice in Marion County. The van also visits the Chattahoochee Health Department on the second Friday of every month to perform mammograms scheduled by the health department. Plans to provide services at housing projects in South Columbus are still under development.

In collaboration with the county health department, the Community Healthcare Network involves communities in the determination of services offered which will complement existing services.

Contact Person
Kevin Sass
Director, Community Healthcare Network
Columbus Regional Healthcare System, Inc.
(706) 571-1900

Women's Medical Services, Inc.

Women's Medical Services, Inc. (WMS) was established in September, 1986 as an affiliate of Columbus Regional Healthcare System. The purpose of WMS is to improve the access and quality of perinatal care by providing private obstetrician coverage for family practice residents treating Medicaid and uninsured patients. WMS consists of approximately 12 obstetricians, each a participant in the Medicaid program, who provide support to this program. WMS is primarily governed by the participating physicians. In order to create sufficient financial incentives, WMS provides all billing and administrative services for the participating physicians. By consolidating the billing and administrative matters, WMS has achieved lower cost billing, improved collections and eliminated one of the common reasons physicians chose not to participate in Medicaid. In addition to providing reasonable and consistent compensation to the physicians, WMS has generated sufficient income to underwrite the cost of prenatal classes and support the cost of The Medical Center's Chief and Associate Chief of Obstetrical Services. Since its creation, WMS and its participating physicians have provided care for over 4,000 deliveries. Approximately 50% of all patients have been covered by Medicaid.

Contact Person
Jean Hartin, RN
Vice President
The Medical Center, Inc.
(706) 571-1312

Pediatrics Afterhours

Pediatrics Afterhours was formed by Columbus Pediatrics, P.C., a group of area pediatricians, in May 1987 in conjunction with The Medical Center and Columbus Regional Healthcare System. The pediatricians were searching for ways to open access for after-hours pediatric care and to promote improved quality and continuity of care. The concept of Pediatric Afterhours was to provide an after-

hours care facility, operated and professionally staffed by the pediatricians and managed by Columbus Regional Healthcare System. Pediatric Afterhours is located in The Medical Center adjacent to the hospital's emergency service entrance. Through consolidated billing and administrative services the pediatricians were able to offer expanded pediatric service and share the financial risks of the program. Reducing the administrative burdens related to operating, billing and collecting for this new program was a significant benefit for the pediatricians in starting and continuing this program. During the past six years, Pediatric Afterhours has cared for more than 33,000 patients. Due to the success of the Pediatric Afterhours, the service is planning to relocate to the Regional Pediatric Center, a new clinical and medical office facility under construction on The Medical Center campus.

Contact Person Charles Hecht
President and Chief Executive Officer
Columbus Healthcare Resources, Inc.
(706) 571-1925

Telephone Grannies

The Senior Referral Service, a program of the Columbus Health Department, operates a program called Telephone Grannies. The health department has four maternity clinics each week. A list of patients who did not show up for their appointments is generated after each clinic. Telephone Grannies follows up with the patient to find out why they missed their appointment and to encourage them to make another appointment. Between five and ten pregnant women per clinic require follow up due to missed appointments.

The health department reports that the program has been successful.

Contact Person Frances Mooney
Program Coordinator, Senior Referral Service and Health Education
Columbus Health Department
(706) 327-1541

Richmond County

Department of Family and Children Services Outreach Program

The Richmond County DFCS has established an outreach program which is modeled after the outreach program at the Chatham County DFCS. Richmond County approved the outreach program and will pay the match for 21 positions. Outreach workers will assist residents with the application process and help them become eligible for Medicaid. The outreach unit will assist applicants filing applications at the DFCS office, the Richmond County Health Department, the Medical College of Georgia Hospital and University Hospital.

Although the 21 positions have not all been filled, after the first six months of operation, the number of applications approved has increased.

Contact Person Pat Fitzgerald, Director
Richmond County Department of Family and Children Services
(706) 721-2536

APPENDIX

TABLE 15
DISTRIBUTION OF MEDICAID CLAIM VOLUME BY PHYSICIAN SPECIALTY AND COUNTY, GEORGIA
FISCAL YEAR 1992

MEDICAID PROVIDER SPECIALITY	# OF PROVIDERS SUBMITTING <1,000 CLAIMS	% OF PROVIDER SPECIALITY	# OF PROVIDERS SUBMITTING >1,000 CLAIMS	% OF PROVIDER SPECIALITY
Bibb County				
Family Practice	33	85%	6	15%
Obstetric/Gynecology	15	83%	3	17%
Pediatricians	12	80%	3	20%
Dougherty County				
Family Practice	5	83%	1	17%
Obstetric/Gynecology	10	59%	7	41%
Pediatricians	11	69%	5	31%
Muscogee County				
Family Practice	33	97%	1	3%
Obstetric/Gynecology	16	80%	4	20%
Pediatricians	6	38%	10	63%
Richmond County				
Family Practice	59	83%	12	17%
Obstetric/Gynecology	40	77%	12	23%
Pediatricians	58	88%	8	12%

Source: Selected data from Georgia Department of Medical Assistance reports ADHC4838R-2 and ADHC4838R-1, dated 10/22/92, by date of service.

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Gloria B. Kwayisi, Administrative Assistant

• Medicaid
• AFDC
• HUD
• FS

PS-Charge

simplification

WELFARE REFORM

CHARGE FOR [redacted] IMPROVEMENTS AND SIMPLIFICATION

The AFDC Improvements and Simplification Group met with David Ellwood and Mary Jo Bane and other staff on April 29 and revised its charge as follows: Simplify and standardize the major means tested program(s) which will be available for a limited time, including AFDC, Food Stamps and public housing programs.

The analysis will focus on three key questions?

1. What are the issues around dramatically simplified programs where 2/3's of the rules are eliminated and categorical requirements are standardized?

2. How would these changes affect other programs?

3. Do these issues change with a time-limited or transitional eligibility?

4. Should we look more broadly at administration of program (beyond single state agency)

Specific issues to be addressed include the following:

- Examine negative incentives to work like monthly reporting, verification, redeterminations, etc.;
- what incentives do you implement administratively to encourage clients to leave welfare.
- Examine equity issues such as the 100 hour rule, disregards, asset accumulation and attachment to the work force;
- Coordinate rules for assets, income, and categorical eligibility better;
- Examine administrative issues such as cost, complexity, levels of government and how people might go back and forth between welfare and a work support agency.
- What would get people off income support quickly?
- How should we measure programs (QC, data collection)?
- Explore the role of EBT;
- How does EA fit into welfare reform?

emergency ASSISTANCE 50/50 (30days) $250-350M Federal $

A guiding principle in this effort should be that work makes people better off. People should not be subject to onerous requirements because they work. The program should be administered n such a way that work is rewarded.

, what emergency assistance is available thru HUD, AG.

FAX for DIANN & MACK
205-5887

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WELFARE SIMPLIFICATION

HEARING

BEFORE THE

SUBCOMMITTEE ON DOMESTIC MARKETING, CONSUMER RELATIONS, AND NUTRITION

OF THE

COMMITTEE ON AGRICULTURE
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

SECOND SESSION

ON

H.R. 4046

JUNE 23, 1992

Serial No. 102-84

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Kathi -
fyi and let
Richard or me know
what you think -
Belle

EXECUTIVE OFFICE OF THE PRESIDE

04-Feb-1994 09:48am

TO: Isabel Sawhill

FROM: Richard B. Bavier
Office of Mgmt and Budget, HRVL

CC: Barbara S. Selfridge
CC: Keith J. Fontenot
CC: Stacy L. Dean
CC: Wendy C. New

SUBJECT: EITC "bank"

I've been thinking about the notion of an EITC "bank" since Kathi Way mentioned it in the meeting with the Deputy Director on Monday. It seems like several issues might be addressed by combining advanced payment with the bank concept.

People qualifying for EITC would have a choice of: a) receiving some or all in advance through the current process; b) receiving up to some maximum (say $500) as a lump payment at tax time; c) receiving some or all in monthly or quarterly payments from the June after filing to the following May.

This policy would reduce the size of lump sum payments (and the attendant risk of abuse) while allowing for the risk aversion of low-income filers. It would not require filers to wait for their EITC, but require that they choose the advance payment or the post-payment for EITC above an amount set low enough to reduce the payback to EITC-mills and high enough to reduce low-income filers' concerns about owing taxes in April.

Treasury would be required to mail out checks throughout the year. OTA staff tell me that the idea of a post-payment was dismissed earlier in the year by Maurice Foley, but without a substantive discussion.

I don't have any idea what the scoring of this policy would be. The limit on lump sum payments might increase advance payments, which costs money. The post-payment presumably would save. Given what we know about lack of interest in advance payments, my guess would be there would be more choosing the post payment than the advance.

Do you think we should float this option with the make-work-pay people at HHS?

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

18-Nov-1993 09:26am

TO: Kathryn J. Way

FROM: Laura A. Oliven
Office of Mgmt and Budget, OIRA

SUBJECT: Simplification Paper

Having read carefully through the Report, I have prepared the following comments for your consideration:

I. The Narrative
A. On page 10, we should flesh out the discussion of how to simplify the application process for recipients at the intake level. We could also introduce the idea of an 800 number for welfare recipients in this section. In thinking about a national 800 number, we need to explore how many of the eligibility requirements are universal across the States. If many of the requirements are State specific, we may want to consider a new system of State 800 numbers. We would have to fund this however, or risk being criticized for imposing an unfunded mandate.

B. At some point in the body of the paper, we should include a short discussion of the Vice-President's Electronic Benefit Transfer initiative. This coordinates all programs at the benefit payment level.

II. The Chart
As the list stands, the majority of the recommendations are costers. While I will refrain from comment on these, it is important to note that in a number of instances in the chart Sarah goes well beyond the goal of uniformity and recommends a more liberal standard than any of the programs. The following is a list of suggested changes to her recommendations:

Number 6. Application Process Verification
Liberalizes existing policy in all three programs by recommending that IEVS be made optional. The IEVS system is the central accountability mechanism for Federal oversight of fraud prevention. The system has been completely coordinated with one form for all three programs. To make IEVS optional would eliminate our primary oversight tool which ensures State accountability.
Recommend: Expand State flexibility on targeting recipients.

Number 27. Eligibility Students
Removes eligibility restrictions on Food Stamp students to

coordinate with Medicaid policy. To remove restrictions on student eligibility for Medicaid and AFDC makes sense because the women are pregnant or have small children. The Food Stamp restrictions are aimed at keeping off otherwise middle class independent students who do not have an alternative income source.
Recommend: "No recommendation for uniformity because there are reasons for the differences."

Number 36. Irregular Income
Liberalizes existing policy in all three programs. Recommends disregard of $60 per individual, when the highest existing disregard is $30.
Recommend: Uniform policy of $30 disregard per quarter.

Number 43. Recertification Periods
Liberalizes existing policy in all three programs. Recommends recertification every 24 months, when highest existing timeframe requires States to conduct recertifications every 12 months.
Recommend: Uniform policy of 12 month certification period.

Number 52. Resource Vehicles
Liberalizes existing policy in all three programs. Recommends complete exclusion of first vehicle regardless of value.
Recommend: Adopt Food Stamp standard of $4,500 market value for all programs.

Please feel free to call me to discuss these or let me know if you need any other help on the project. I think we can make a significant contribution through this effort. Thanks.

P.S. Norbert is downstairs in Washinton Square, I called Kevin to tell him to give you a great haircut.

TO: Kathi Way DATE: 11/18/93

OF PAGES (Including this sheet): 4 FAX #: 202-456-7028

FROM: Sarah Shuptrine FAX #: (803) 254-6301

ADDITIONAL INFORMATION:

Maybe this will be helpful to you. It's the info prepared by FNS & HHS/ACF on the filing unit laws & regs.

Please call (803) 779-2607 if you do not receive all the pages.

2725 Devine Street • P.O. Box 5345 • Columbia, SC 29250 • (803) 779-2607

CONFORMANCE ISSUE: ELIGIBILITY - CERTIFIED UNIT

FOOD STAMP PROGRAM PROVISIONS

Section 3(i) of the Food Stamp Act defines "household" as an individual who lives alone or who lives with others and purchases and prepares meals separately or a group of individuals who live together and customarily purchase and prepare meals together. In general, siblings or parents and their children who live together are treated as one household even if they do not purchase and prepare food together. However, these relatives may be separate households under certain conditions if they purchase and prepare their food separately. An elderly or disabled parent may be a separate household from his or her children, and an elderly or disabled sibling may be a separate household from the sibling with whom he or she resides. Another exception exists for parents of minor children who are living with their parents or siblings. These parents of minor children and their children may be separate households from their parents or siblings if they purchase and prepare meals separately. A special exception is made for persons who are elderly and so disabled that they cannot purchase and prepare meals separately from the individuals with whom they live. These elderly and disabled persons may be separate households even if they do not purchase and prepare meals separately if the gross income of the others with whom they live does not exceed 165 percent of the poverty level.

The Act also provides that people who live in institutions or boarding houses or live with others and pay compensation for their meals are ineligible. This prohibition does not apply to the following: certain elderly or disabled recipients who live in group homes, temporary residents of public or private nonprofit shelters for battered women and children, residents of public or private nonprofit shelters for the homeless, and residents of certain drug or alcohol treatment centers. Boarders may participate as members of the household with which they live.

In addition to these provisions in the Act, there are additional requirements in the Food Stamp Program regulations. Section 273.1(a) provides that a spouse or a minor child under the control of an adult household member cannot be a separate household. Section 273.1(b) lists nonhousehold members who may participate as separate households (roomers, live-in-attendants, and other nonrelatives) and persons who cannot participate as separate households because they are recipients of Supplemental Security Income in States that include food stamp allotments in the State supplemental payments; ineligible aliens or ineligible students; or disqualified for fraud, failure to provide a social security number or failure to comply with work-related requirements. Under Section 273.1(c), boarders are ineligible to participate separately from the individuals with whom they live. However, as a result of a recent court decision, individuals receiving foster care payments are to be considered boarders, but

they may participate as households separate from the family with which they live, at their option.

AFDC PROVISIONS

Under Section 401 of the Social Security Act, AFDC assistance is provided to needy dependent children and the parents or relatives with whom they live.

Sections 406 defines "dependent child" as a needy child who has been deprived of parental support because of the death, continued absence, or incapacity of a parent and who is living with a parent, sibling or specified relative in a home maintained by the parent or relative. The dependent child must be under 18 or, at State option, may be 18 and a full-time student expected to finish school before turning 19. Section 407 provides that the definition of "dependent child" includes needy children who have been deprived of support because of the unemployment of the principal earner. Section 402(a)(41) requires State agencies to provide AFDC to dependent children of unemployed parents.

Section 206.10(a)(1)(vii) of the AFDC regulations provides that the assistance unit must include any natural or adoptive parent, or stepparent (in the case of States with laws of general applicability) and any blood-related or adoptive brother or sister. However, the needs and income of disqualified alien siblings are not considered in determining the eligibility and payment of an otherwise eligible dependent child.

Section 233.10(a)(3) prohibits participation in AFDC of a person who is receiving assistance under Titles I, X, XIV or XVI of the Social Security Act.

Section 233.10(b)(3)(ii) provides that Federal financial participation will be provided only for the following: (1) needy children under 18 or 18 and a full-time student in a secondary school or in the equivalent level of vocational or technical training and reasonably expected to complete the program before reaching age 19 who are deprived of parental support because of the death, continued absence, or incapacity of a parent or the unemployment of the principal wage earner; and (2) the parent or other caretaker relative of a dependent child and, in certain situations, the parent's spouse. Section 233.90(c) defines the terms used in the definition of "dependent child."

Section 233.20(a)(2)(vii) gives States the option of including in the assistance unit other needy persons in the home who are essential to the dependent child's basic well-being, including those individuals who provide child care or care for an incapacitated person so that a caretaker relative can work,

receive training or attend GED classes full-time, or participate in an AFDC work program. In 1989, 24 States included essential persons in the assistance unit and 30 did not. States may limit eligibility as an essential person to specified relatives and/or their spouse.

SUMMARY

In food stamps, the certified unit usually consists of individuals who live together and purchase food and prepare meals together. In AFDC, the assistance unit consists of a dependent child and specified relatives or other individuals with whom he or she lives.

December 6, 1991

PRELIMINARY COST ESTIMATES
AFDC - FOOD STAMP CONFORMITY ISSUES

(Fiscal Year 1992 dollars in millions)

PROPOSAL	COST OF CONFORMING			Type of Change Needed	
	FSP TO AFDC	AFDC TO FSP			
		AFDC	FSP	AFDC	FSP
APPLICATION PROCESS:					
Alien/citizenship declaration	a	a	a	L	L
Application form	a	a	a	L	L
Delay procedures	a	a	a	R	R
Processing standards	-$333	$488	-$139	O	L
Requirement to schedule second interview	a	a	a	R	W
Verification	a	a	a	O	L
BUDGETING:					
Best estimate/anticipating income	a	a	a	O	W
Income from a terminated source	a	a	a	R	W
Suspension	a	a	a	R	W
Converting income to a monthly amount	0	0	0	O	
Proration of contract and self-employment income	a	a	a	R	L
CHANGES:					
Effective date of changes	$19	b	b	L	R
Monthly reporting and budgeting requirements	a	a	a	L	L
Notice of adverse action	a	a	a	R	R
Reporting requirements	a	b	b	R	L
Supplemental benefits for new members	$6	-$2	a	R	W

PROPOSAL	COST OF CONFORMING			Type of Change Needed	
	FSP TO AFDC	AFDC TO FSP			
		AFDC	FSP	AFDC	FSP
DEDUCTIONS:					
Dependent care	-$4	-$3	$1	L	L
Earned income deduction	$421	-$424	$121	L	L
Earned income deduction penalty	-$1	a	a	L	L
ELIGIBILITY:					
Alien status	a	a	a	L	L
Certified unit	$532	b	b	L	L
Child support assignment and cooperation	-$30	b	b	L	L
Potential sources of income	-$390	b	b	R	L
Residency requirements	a	a	a	R	R
Social security numbers	a	a	a	R	R
Striker definition	-$1	a	a	L	L
Students eligibility	$72	a	a	L	L
INCOME:					
Complementary programs	a	a	a	O	L
Earnings of 18-year-old high school students	$2	-$3	$1	L	L
Earnings of students under 18	a	a	a	L	L
Energy assistance	b	b	b	L	L
HUD utility payments	$160	-$274	$78	L	L
In-kind income/vendor payments	-$6	$9	-$3	L	L
Income excluded by other laws	b	b	b	L	L
Irregular income	a	a	a	R	L
JTPA earnings from State training programs	a	a	a	L	L
Lump sum payments	-$147	$6	-$2	L	L
Self-employment - calculating boarder income	a	a	a	R	R

PROPOSAL	COST OF CONFORMING			Type of Change Needed	
	FSP TO AFDC	AFDC TO FSP			
		AFDC	FSP	AFDC	FSP
Self-employment expenses	a	a	a	R	R
Student educational assistance	$10	-$16	$5	L	L
Title IV-D, $50 disregard	$110	-$411	$117	L	L
Treatment of income of ineligible members	a	a	a	L	L
RECERTIFICATION (REDETERMINATION):					
Certification periods	a	a	a	O	L
Recertification process	a	a	a	O	L
RESOURCES:					
Resource accessibility	a	a	a	R	R
Burial plans	a	a	a	L	L
Income-producing real property	a	a	a	L	L
Licensed vehicles	-$257	$700	-$200	L	L
Cash surrender value of life insurance	-$13	a	a	L	L
Real property for sale	a	a	a	L	L
Resource limit	-$249	$136	-$39	L	L
Transfer of resources	a	a	a	L	L
RESTORED BENEFITS:					
Policy regarding restored benefits/underpayments	$28	-$6	$2	L	L
Time limit for restoring benefits	a	a	a	L	L

FNS/OAE/FPS

Key: L - Legislation; R - Regulation; O - State Option; W - Waiver

a Minimal budgetary impact anticipated
b Costs/savings not estimated