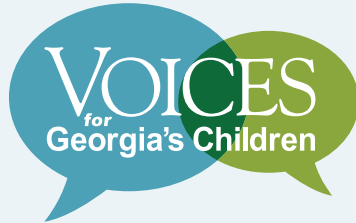


Modernizing Medicaid and PeachCare: Promising Program Design Options for Georgia's Children

Prepared for Voices for Georgia's Children and Georgians for a Healthy Future

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Established in 2003, **Voices for Georgia's Children (Voices)** is a nonprofit child policy and advocacy organization that envisions a Georgia where children are safe, healthy, educated, employable, and connected to their family and community. Its mission is to be a powerful, unifying voice for a public agenda that ensures the well being of all of Georgia's children. To fulfill this mission and, ultimately, improve the well being of Georgia's children, Voices provides the necessary research-based information, measures, collective voice and proposed legislation to help guide decision makers in the right direction – that is, supporting policies that ensure Georgia's children grow up to be healthy, educated and productive citizens. www.georgiavoices.org



Georgians for a Healthy Future (GHF) is a nonprofit health policy and advocacy organization that provides a voice for Georgia consumers on vital and timely health care issues. Its mission is to build and mobilize a unified voice, vision and leadership to achieve a healthy future for all Georgians. GHF approaches its goal of ensuring access to quality, affordable health care for all Georgians in three major ways: 1) outreach and public education, 2) building, managing, and mobilizing coalitions, and 3) public policy advocacy. Since being founded in 2008, GHF has provided substantive health policy information to community leaders and advocates throughout the state, conducted seminars to equip consumers with the tools to become strong advocates, successfully injected the consumer perspective into dozens of health care stories in the media, and engaged with policymakers to spark policy change for a healthier Georgia. www.healthyfuturega.org

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Executive Summary

Georgia is slowly emerging from the Great Recession, but still faces the task of addressing a \$200 million budget deficit in the coming 2012 fiscal year. Despite these difficult budget conditions, policy makers and stakeholders continue to discern how best to prepare for the upcoming Medicaid expansion in 2014. It is against this backdrop that the Georgia Department of Community Health (DCH) is taking a broad approach to assessing current and future options for administering Medicaid and PeachCare for Kids (Georgia's Children's Health Insurance Program).

As DCH considers redesign options, Voices for Georgia's Children and Georgians for a Healthy Future, working with Kellenberg Consulting through philanthropic support, conducted an independent research and analysis effort. The goal of this research is to inform recommendations to DCH for improving the well-being of Georgia's children. The research centered on identifying promising program design options that address the key policy priorities of coverage, access and quality for Georgia's children. These policy priorities are fundamental to creating a sustainable and responsive health care system that: 1) meets the needs of enrollees today and 2) establishes high standards of health care service delivery that can serve as a foundation for expanded models in both the public and private health care system of the future. The recommended program design options described in this paper focus on structural issues that can assist in improving coverage, access and quality for all of Georgia's children, but do not attempt to address detailed policy solutions related to the wide array of issues regarding special populations.

Kellenberg Consulting reviewed performance data, descriptive information, and reports available in published and otherwise publicly available literature. The research included obtaining feedback from state Medicaid and Children's Health Insurance Program (CHIP) officials in study states and, where available, information from independent budget and policy organizations. The goal of the review was to identify promising features of program design options that demonstrated evidence of one or more of the following criteria:

- Improved health care outcomes
- Ensured and improved access to necessary health care services
- Appropriately controlled utilization of health care resources
- Prioritized administrative cost savings

FINDINGS

Further simplification measures would increase coverage of eligible but uninsured children. Children in states with the lowest uninsured rates are more likely to have a medical home and receive preventive care or referrals to needed care than children in states with the highest uninsured rates.¹ Additional simplified policy options could play a useful role in reducing administrative costs and providing children with health coverage. The Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) provides states with enhanced funding and new coverage flexibilities. Georgia should continue to leverage these opportunities to expand coverage to new eligibles and further simplify the eligibility determination process by adopting 12 months continuous eligibility for children, administrative renewal processes, and self declaration of income for application and renewal.

Increasing administrative efficiencies requires modernized eligibility systems. Now, more than ever, technology should be leveraged to automate eligibility tasks where feasible, reduce the risk for human error, and create a system that can be modified quickly based on policy changes or volume demands. Using information technology to coordinate programs and share data can reduce administrative burdens for both enrollees and state workers. Also, the Affordable Care Act of 2010 (ACA) provides a 90 percent enhanced federal match for all state dollars used to make eligibility system improvements. As Georgia takes advantage of this enhanced match to modernize its eligibility system, it should look to other states, such as the Express Lane Eligibility approaches in Alabama and Louisiana as well as Utah's electronic notification process. These approaches provide promising examples of automation, third-party data matching, and enrollment simplifications that improve coverage of children. These approaches also demonstrate the potential for increased administrative cost savings.

Pediatric specialty access gaps exist. Overall, provider access measures fell within the DCH contract terms that Care Management Organizations (CMOs) are required to meet for at least 90 percent of their members. However, weaknesses were identified in certain pediatric specialty networks in five regions of the state. For instance, data provided by DCH shows that CMOs in five of the six regions did not meet geographic access requirements in Pediatric Endocrinology, Pediatric Infectious Disease, and Pediatric Rheumatology. Children need ready access to specialty care to ensure their conditions do not become more severe and their treatment more costly.

Georgia Medicaid and PeachCare quality monitoring is strong, but child quality performance indicators point to need for improvement. DCH maintains a well-developed Quality Improvement Plan for its contracted CMOs, with established performance targets focusing on preventive care for children. DCH was recently recognized for its quality measurement efforts in the *CHIPRA 2011 Annual Report on the Quality of Care for Children in Medicaid and CHIP*.² Georgia reported 18 of the 24 initial CHIPRA measures in FY 2010, more than any other state. Georgia Healthcare Effectiveness Data Information Set (HEDIS) data show the CMOs exceeded Calendar Year 2009 performance targets for Childhood Immunizations and Lead Screenings. However, the CMOs failed to meet the performance targets for well-child visits, with a troubling downward trend from 2008 to 2009. Also, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening rates fall below the national average.

Medical Homes are an essential component of a quality-driven delivery system. Medical homes, in a variety of increasingly sophisticated models, play a major role in driving accountability and system coordination through the use of data-driven performance measures, health information technology, and a patient-centered focus on access to primary and preventive care. Whether it is fully capitated managed care, enhanced primary care case management, or somewhere in between, in the broad spectrum of care management program design options, a usual source of care is essential to ensuring access and quality of children's health care. Medical homes serve as the primary vehicle for providing children's health care that:

- ensures access and coordination of services;
- integrates physical/behavioral health care; and
- ensures accountability for quality through rigorous contractual obligations related to performance incentives/penalties, data collection, and public sharing of performance outcomes, among others.

The Texas Health Passport Electronic Health Records (EHR) program and Rhode Island's use of Family Resource Specialists in the Pediatric Practice Enhancement Project (PPEP) embody key characteristics of a medical home model that would improve the quality of care for Georgia's children.

RECOMMENDATIONS

1. Further simplify eligibility processes to ensure coverage for all children.

Georgia should leverage, not just some, but all of the new program flexibilities and enhanced funding available through CHIPRA and ACA to accomplish the following:

- Continue the good progress with DCH's CHIPRA Outreach Grant, but take these efforts to the next level like Alabama and Louisiana by further simplifying the enrollment policies and creating electronic interfaces with multiple public program data sources for Express Lane Eligibility (ELE) determination at application and renewal.
- Consider following Utah's lead in developing online capacity for families to access their eligibility information. Also, consider using email and text messages to communicate with parents of enrolled children. User-specific online access is currently available to PeachCare enrolled families. Its expansion to Medicaid, along with the electronic notifications for both PeachCare and Medicaid could potentially improve a family's experience in accessing and retaining coverage for their children, as well as, promote administrative efficiencies.

2. Improve access to specialty care for children.

DCH should continue to attend to provider access issues, particularly in specialty care for children. Higher reimbursement for some Pediatric provider types may be necessary to fill network gaps. DCH should also monitor compliance with CMOs out-of-network provider requirements for children needing care. Telemedicine, e-consultations, digital photography, and other applications of technology could help bridge gaps in specialist access.

3. Modernize program design features in medical home models to establish value-driven, high quality care for children in Medicaid and CHIP.

Establishing a comprehensive medical home that holds providers accountable for quality and ensures access to coordinated care is an integral aspect of any contractual arrangement Georgia opts to pursue. Georgia should consider modernized service delivery features such as:

- Using Electronic Health Records (EHR), similar to Texas Health Passport, to enable medical home providers to coordinate access to care, reduce duplication of services, improve monitoring of compliance with prescription regimens, and enhance preventive care through improved documentation of well-child exams.
- Developing patient-centered, care coordination in partnership with primary care providers that integrates all aspects of care (both physical and behavioral). DCH should consider using specific techniques such as peer-to-peer approaches found in Rhode Island, through the use of Family Resource Specialists, to ensure care is accessible and coordinated for all children.

4. Strengthen contract standards to hold providers and CMOs accountable for better quality.

The state should intensify their efforts to hold plans accountable for performance on national benchmark HEDIS well-child measures. Georgia has the opportunity to enhance the following quality components:

- Strengthen quality benchmarks by increasing the FY12 performance standard for Childhood Immunizations and Lead Screening from the 50th percentile to the 75th percentile. This would bring them in line with the well-child visit standards, currently at the 75th percentile.
- Add well-child visits for older age groups to the performance standards beyond the first 15 months of life. This change would signal to CMOs the priority DCH places on children's care, as well as, challenge CMOs to intensify their efforts to increase quality in these areas.

5. Pursue public and private grants to achieve goals.

Alabama, Louisiana, Utah, Rhode Island, and Texas all used public and private sector grants to obtain technical assistance and financing necessary to achieve their program goals. Georgia can and should follow this approach in garnering available resources to supplement expertise and financing.

Introduction

In 2006, Georgia implemented a statewide managed care program for its Medicaid and Children's Health Insurance Program (CHIP) called Georgia Families. The program currently serves more than a million enrollees on a mandatory enrollment basis. Georgia, along with most other states, faces the task of addressing a pressing budget deficit in the coming 2012 fiscal year. Additionally, Georgia is in the midst of discerning how best to implement a health insurance exchange and prepare for a Medicaid expansion to approximately 479,000 individuals with incomes above 133 percent of the Federal Poverty Level (FPL) beginning in 2014.

Medicaid spending per enrollee varies sharply by eligibility group. In 2007, the average national per capita cost for children covered by Medicaid was about \$2,100, compared to \$2,500 per adult, \$14,500 per disabled individual, and \$12,500 per elderly individual. The top 5 percent of enrollees using the health care system in Medicaid account for nearly 60 percent of total spending.³ Considering this distribution, cutting costs or slowing cost growth will require policy changes for this top 5 percent more so than income-eligible children in Medicaid and CHIP. Even so, children's health care must remain at the forefront of any policy debate to ensure a system that provides them with the best opportunity for a strong and healthy future.

In FY 2011, total expenditures for Georgia Medicaid and PeachCare for Kids (Georgia's CHIP program) climbed to over \$2.6 billion.⁴ Nationally, total Medicaid spending will rise under health reform, as almost a half million people become eligible for the program. However, new spending will represent only a 2.7 percent increase above what Georgia would spend on Medicaid without the expansion⁵ because the federal government will finance 96 percent of the cost of the coverage expansion over the next ten years.⁶ While these are challenging times, Georgia has an unprecedented opportunity to develop a health care coverage and delivery system that blends the strengths of its current program infrastructure and experience with innovative approaches successfully implemented in other states.

The Georgia Department of Community Health (DCH) is in the midst of conducting a research and analysis effort to discern the best program design options for the future of Medicaid and PeachCare for Kids (PeachCare). To inform recommendations to DCH for improving the wellbeing of Georgia's children as it considers redesign options, Voices for Georgia's Children and Georgians for a Healthy Future, working with Kellenberg Consulting through philanthropic support, conducted an independent research and analysis effort. The objective of this research was to identify promising program design options that would improve health care coverage, access and quality for Georgia's Medicaid and PeachCare members.

Methodology

Identifying promising program design options on measures related to health coverage, access, and quality involved a two-phased approach. First, an environmental scan was conducted by reviewing the literature, following up with state officials, and analyzing performance data from a select number of states that were considered most relevant to Georgia. The environmental scan identified promising programs through demonstrable evidence that the programs met one or more of the following criteria:

- improved health care outcomes;
- ensured and improved access to necessary health care services;
- appropriately controlled utilization of health care resources; and
- prioritized administrative cost savings.

To gather evidence regarding each state's progress toward meeting these criteria, the environmental scan included gathering the following information:

- Performance data, descriptive information, and reports available in published and otherwise publicly available literature;
- Feedback from state Medicaid and CHIP officials in study states; and
- Where available, information from independent budget and policy organizations within each study state to affirm, dispute, and/or offer qualifications to state-provided information.

The second phase of the research included collecting and analyzing performance data provided by Georgia Families CMOs and DCH to assess Georgia's efforts to date and identify strengths and opportunities for improvement. The analysis included a review of HEDIS data, provider access and network adequacy data, CMO contract terms, eligibility policy information and enrollment data, and supplementary information provided by two of the three CMOs.

Key Themes

As anticipated, the environmental scan shows states have developed a wide array of approaches to addressing the health care service needs of children enrolled in their Medicaid and CHIP programs. The various program designs encompass the unique characteristics of each state's provider and beneficiary community - building on strengths and historical experience, all while factoring in policy priorities and fiscal constraints. Despite this variation, three key themes emerged as common features of promising program design options for DCH to consider as it undertakes the Medicaid and CHIP redesign initiative.

Coverage Matters. Numerous studies link continuous insurance coverage to improved health outcomes.⁷ Children in states with the lowest uninsured rates are more likely to have a medical home and receive preventive care or referrals to needed care than children in states with the highest uninsured rates.⁸ Children without health coverage are more likely to experience problems accessing needed health care services.⁹ Georgia continues to work toward creating a simplified eligibility process for children and has reduced the rate of uninsured children from 11 percent to 9.8 percent between 2008 and 2010.¹⁰ However, Georgia could look to several other states, as discussed in this paper, for examples of further opportunities to optimize the Medicaid and CHIP enrollment processes to ensure all children in Georgia are covered by 2014.

Ensuring Access to Care Requires Adequate Network Capacity and Accountability. Securing affordable coverage for families is only a first step to ensure that children obtain essential care that is well coordinated and patient-centered.¹¹ The two major forms of managed care, Enhanced Primary Care Case Management (EPCCM) and full-risk, capitated managed care organizations (known in Georgia as Care Management Organizations [CMO]), are an increasingly predominant approach to delivering health care services in Medicaid and CHIP programs. States continue to try out new models of care organization, delivery and financing, thereby creating a wide continuum of managed care arrangements between full-risk capitation and EPCCM approaches.¹² Seventeen states in FY 2011 and 24 states in FY 2012 reported expanding their managed care programs, primarily by expanding the areas and populations covered. Two-thirds of the nation's 54 million Medicaid beneficiaries in October 2010 were enrolled in some form of managed care.¹³ Establishing a comprehensive medical home that holds providers accountable for quality and ensures access to coordinated care is an indispensable feature of any contractual arrangement Georgia opts to pursue for children enrolled in Medicaid and PeachCare for Kids. Medical homes, in a variety of increasingly sophisticated models, play a major role in driving accountability through the use of data-driven performance measures, health information technology, and a patient-centered focus on access to primary and preventive care.

Ensuring Quality of Care Requires System Coordination. Our research found that Georgia well-care visits and Early Periodic Screening, Diagnostic and Treatment (EPSDT) screenings are below national averages. Additionally, less than half of Georgia's children with behavioral health care needs obtain the care they need.¹⁴ Improved care coordination is necessary to ensure they can access the full spectrum of necessary behavioral and physical services. States are increasingly prioritizing program design options that enable access and coordination of care by ensuring that enrollees have a designated primary care provider (PCP), and by relying on the PCP to serve as a medical home and ensure high quality preventive and primary care.

The following sections describe features of program design options that reflect the policy priorities that Voices for Georgia's Children and Georgians for a Healthy Future have identified as critical to "best in class" program design options for Georgia. The key policy priorities - coverage, access and quality - are viewed as fundamental to creating a sustainable and responsive health care system that: 1) meets the needs of enrollees today and 2) establishes high standards of health care service delivery that can serve as a foundation for expanded models in both the public and private health care system of the future.

Ensure Coverage

The Center for Children and Families at Georgetown University finds that between 2008 and 2010, Georgia has achieved one of the largest declines in the number of uninsured children in the nation (ranked 7th overall).¹⁵ Georgia's uninsured rate has steadily improved from 11 percent in 2008 (278,016 children) to 9.8 percent in 2010 (244,004 children).¹⁶ Despite this great progress, there is more work to be done. Approximately 75 percent of uninsured children are eligible but not enrolled in Medicaid and PeachCare for Kids. This rate is 10 percent higher than the national percentage of eligible but uninsured children (65 percent).¹⁷ Across the U.S., uninsured children are disproportionately older, Hispanic, and low income. Hispanic children are not disproportionately represented in Georgia compared to the national average. However, Georgia's population share of older children is slightly higher than the national average (22.2 percent compared to 21.8 percent), and 16.6 percent of Georgian's live below the poverty line, compared to 14.3 percent nationally.¹⁸ Despite these demographic challenges, Georgia has the opportunity to join other leading southern states like Alabama to set a new standard for universal coverage by identifying and enrolling all eligible but uninsured children by 2014. Georgia's reason to do this is two-fold. As mentioned earlier, children with continuous coverage have better health outcomes than those who do not. Secondly, this paper documents how a streamlined eligibility process not only has the potential to save administrative costs, but is essential for creating the capacity Georgia needs to accommodate the expansion of Medicaid in 2014.

Medicaid and PeachCare policy makers have made good progress toward creating simplified approaches for families to obtain and retain health coverage for their children. Further simplifying the enrollment process, with special attention on retaining eligible children during renewal, is necessary to ensuring all children have access to continuous coverage and better health outcomes. Both Medicaid and PeachCare programs maintain the following simplified eligibility policies:

- Joint application between Medicaid and PeachCare for Kids
- Web-based application
- No asset test for low income Medicaid categories
- Elimination of in-person interview
- Express Lane Eligibility (ELE)

Additionally, DCH was recently awarded a \$2.5 million grant from the U.S. Department of Health and Human Services (HHS) that will allow program administrators to design and implement technology solutions to better coordinate enrollment and renewal in Medicaid and PeachCare programs. The initiatives funded by the grant include introducing a pre-populated Medicaid renewal form and redesigned notices; enhanced electronic data-matching capacity to verify citizenship; portable scanners and laptop computers to facilitate off-site enrollment and verification; on-line renewal module and electronic referral process from Medicaid to PeachCare so children do not lose coverage when their family circumstances change.¹⁹

COVERAGE POLICY OPTIONS REMAIN UNTAPPED

Additional simplified policy options could play a useful role in reducing administrative costs and providing children with health coverage. Table 1 describes the policy options provided in the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA). Significant increases in Federal funding allotments through FFY 2013 combined with newly established contingency funds will ensure CHIP programs do not run out of federal funds as Georgia did in previous years. Additionally, the Affordable Care Act of 2010 (ACA) provides for a 90 percent enhanced federal match for all state dollars used to make eligibility system improvements.²⁰

In addition to pursuing the options described in Table 1, Georgia could further simplify the eligibility process for children by adopting the following measures:

- 12 months continuous eligibility for children
- Administrative renewal process
- Self declaration of income

TABLE 1: SUMMARY OF CHIPRA OPTIONS TO PROMOTE HEALTH COVERAGE FOR CHILDREN

CHIPRA Policy Options	Georgia Adopted?		Other
	Yes	No	
Population Expansions			
Option to cover children of State Employees through CHIP	Yes, beginning 1/1/12		
Option to eliminate the five-year waiting period for covering lawfully residing immigrant children and pregnant women in Medicaid and CHIP		No	
Simplified Eligibility Policies			
Option for states to use ELE to determine Medicaid and CHIP eligibility using other needs-based public assistance programs	Yes, WIC		
Option for states to verify citizenship status by data matching SSNs with the Social Security Administration's database	Yes		
Additional Funding			
Outreach and Enrollment grants	Yes, \$2.5 million awarded in FY2011		
Enrollment bonuses for states who exceed 10 percent enrollment growth over previous year (and have adopted 5 of 8 eligibility simplification strategies) ¹		No	Bonus anticipated

¹ 1) Adopt 12-month continuous eligibility for all children; 2) Eliminate the asset test for children (Georgia); 3) Eliminate in-person interview requirements at application and renewal (Georgia); 4) Use joint applications and supplemental forms and the same application and renewal verification process for the two programs (Georgia); 5) Allow for administrative or paperless verification at renewal through the use of pre-populated forms or ex parte determinations (Georgia); 6) Use presumptive eligibility when evaluating children's eligibility for coverage; 7) Use Express Lane Eligibility (Georgia); and 8) Use premium assistance.

States using these policies are covering uninsured children and eliminating administrative burden, all while maintaining program integrity. For example, Louisiana performs eligibility determinations using administrative renewal and self-declaration of income and maintains an independently validated eligibility error rate of 3 percent or less each year.²¹

The time is ripe for Georgia to leverage not just some, but all of these new program flexibilities and enhanced funding to work toward the goal of providing health coverage to all of Georgia's children by 2014.

INCREASING ADMINISTRATIVE EFFICIENCY REQUIRES ELIGIBILITY SYSTEM MODERNIZATION

Administrative efficiency has never been more important in the face of an estimated \$200 million budget deficit in FY 2012 and a scope of responsibilities that will only increase as Georgia contemplates the expansion of Medicaid in 2014. ACA expands Medicaid eligibility to individuals with incomes up to 133 percent of FPL in 2014. With an across the board 5 percent income disregard, the expansion is effectively to 138 percent FPL. This expansion creates an estimated 479,000 individuals newly eligible for Georgia's Medicaid program.²² Now, more than ever, technology should be leveraged to automate eligibility tasks where feasible, reduce the risk for human error, and create a system that is agile enough to be modified quickly based on policy changes or volume demands. Using information technology to coordinate programs and share data can reduce administrative burdens for both enrollees and state workers. Technology can also enhance eligibility determination and enrollment through online applications and premium payments. Online applications may also promote the enrollment of younger, healthier populations in the Medicaid program.²³ Therefore, using technology to assist enrollees in obtaining continuous coverage is an efficient and cost-effective use of financial resources.

To facilitate states' efforts along this front, HHS is providing significant financial assistance, in the form of a 90 percent federal match on state dollars, to assist states in modifying their eligibility systems. In a matter of months, DCH plans to release a Request for Proposals to procure a modernized eligibility determination system for Medicaid, Temporary Assistance to Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP). This highly anticipated new system is needed to replace the existing legacy system that lacks the capacity to handle the growing demands of Medicaid eligibility functions. Georgia's current efforts with the CHIPRA outreach grant to create an on-line renewal module and greater web-based access for out-stationed eligibility workers are further steps in the right direction.

USHERING IN A NEW CULTURE OF COVERAGE

Three proposed rules released this past summer by the Centers for Medicare and Medicaid Services (CMS)²⁴, Center for Consumer Information and Insurance Oversight (CCIIO)²⁵, and Internal Revenue Service (IRS)²⁶, offer a glimpse of the new approach states will take toward conducting eligibility determinations for public health insurance and public subsidies for private health insurance. Georgia must adopt eligibility policies laid out in these three rules that center on streamlining and automating the eligibility process. These rules ultimately redefine the approach to eligibility determination in three key ways and promote a "culture of coverage":

- The rules move the burden of eligibility verification from the individual to the state.
- For the first time, the hierarchy of data sources is rearranged, making electronic data and self-attestation more important than paper documentation.
- The rule shifts the eligibility paradigm for states from whether an individual is eligible to where the individual belongs in a continuum of coverage options that the state manages or facilitates.²⁷

An analysis conducted in 2010 for Voices for Georgia's Children describes how with separate agencies responsible for policy (DCH) and administration of the eligibility process (Department of Human Services), numerous opportunities exist for both operations and systems to be better coordinated to achieve the shared goals of improved enrollment and retention and administrative cost savings.²⁸ Currently there is no process in place to electronically refer to PeachCare, Medicaid applications that are denied for having income that exceeds eligibility thresholds. The applicants must start the process over by completing another application and providing new documents for verification of eligibility for PeachCare. This process is not only cumbersome for applicants, but an unnecessary duplication of state resources. DCH's CHIPRA outreach grant initiatives address some of these operational inefficiencies and are a necessary start toward fully adopting a "culture of coverage" for all of Georgia's children.

Eligibility approaches in place in Alabama, Louisiana and Utah provide examples of policies that take further advantage of the opportunities to automate and simplify the eligibility process and promote continuity of coverage. The recently adopted Express Lane Eligibility (ELE) policy that uses Women Infant and Children (WIC) eligibility data to determine Medicaid and PeachCare eligibility is a good step toward pursuing a more comprehensive ELE strategy similar to what is used in Louisiana and Alabama.

Additionally, Georgia should look to other states like Utah for examples of efforts to improve continuity of coverage by leveraging the ever-increasing use of email and text messaging by Medicaid and CHIP enrolled families, through electronic notifications of application and renewal determinations and premium payment due dates.

Importantly, Alabama, Louisiana, and Utah all used funding from the Robert Wood Johnson Foundation's Maximizing Enrollment Initiative²⁹ to obtain technical assistance and financing necessary to achieve their program goals. Georgia can and should follow this approach in garnering available public and private sector resources to supplement expertise and financing.

STATE EXAMPLES

Alabama's Express Lane Eligibility and Simplification Efforts Significantly Reduce the Number of Uninsured Children

The Alabama Department of Public Health, which administers the state CHIP program (All Kids), and the Alabama Medicaid Agency have a history of maintaining a successful collaborative relationship that benefits enrollees in both programs and promotes administrative efficiencies. Similar to Georgia, Alabama's efforts to share marketing and outreach efforts, align eligibility rules, and improve system interfaces, have helped the two agencies overcome many common barriers to enrolling children in health insurance. However, Alabama's efforts to take advantage of opportunities to expand coverage provided through CHIPRA have been especially noteworthy; garnering themselves by far the highest enrollment bonus payments in the nation over the past two years – \$39.7 million in 2009 and \$54.9

million in 2010. In 2010, Alabama exceeded their enrollment baseline by 132,999 children (36 percent). With 94 percent of children insured as of 2008-09, the state has one of the highest children's insurance rates among Southern states. Alabama maintains the following simplified eligibility policies for children enrolling in Medicaid and CHIP:

- Elimination of face-to-face interview and assets test
- Joint application and renewal process with CHIP
- 12 months continuous eligibility for children
- Administrative renewal process
- Self declaration of income
- Online application with use of electronic signature
- Verification of Citizenship through SSA
- Expedited newborn certification
- Use of a third-party wage database ("The Work Number") to verify income

ALABAMA

Alabama has garnered the highest enrollment bonus payments in the nation over the past two years – \$39.7 million in 2009 and \$54.9 million in 2010.

In 2010, Alabama exceeded their enrollment baseline by 132,999 children (36 percent). With 94 percent of children insured as of 2008-09, the state has one of the highest children's insurance rates among Southern states.

Alabama has established a phased-in approach to ELE by creating an interface between the Department of Human Resources to match eligibility data with TANF and SNAP data. The process to establish these system interfaces has been labor intensive, with different eligibility systems for All Kids, Medicaid, and TANF/SNAP that all "speak different languages."³⁰ For Phase 1 of the ELE effort, Alabama Medicaid and CHIP eligibility workers auto-enrolled for renewals only, based on the results of a manual check of income information against the TANF and SNAP case information. Phase 2 is currently in place, whereby

workers manually check income against the TANF and SNAP case information for applications and renewals. However, the state plans to build on its technological infrastructure to leverage administrative efficiencies by developing electronic matches for the various programs case information. Phase 3 of the ELE effort is in its early implementation phases and will automate re-enrollment using SNAP income determination along with renewal information provided by household. Phase 4 will involve automated use of ELE findings for enrollment of new applicants based on SNAP or TANF eligibility via automated data matching. The final Phase 5 will involve adding other agencies such as subsidized child care or WIC.^{31 32}

LOUISIANA

In February 2010, the month after ELE was launched, Medicaid enrolled more than 10,000 children. Four months later, the total number of children enrolled using ELE reached 14,000.

Despite a 12 percent reduction in the Medicaid workforce in the last two years, neither the volume nor the quality of eligibility processing has declined.

Louisiana's Express Lane Eligibility Efforts Increase Coverage for Children and Save Administrative Costs

Louisiana provides another example of automated strategies to find and enroll eligible but uninsured children. Louisiana's Department of Health and Hospitals (DHH) began ELE data matching between SNAP and Medicaid in 2010. Louisiana policy makers, starting with the Governor, have prioritized ensuring health coverage for children on the premise that "coverage now saves costs in the future."³³ Like Alabama, the system modifications necessary to automate this process were difficult and time-intensive. However, the impact on enrollment points to a positive payoff:

- In February 2010, the month after ELE was launched, Medicaid enrolled more than 10,000 children
 - By June 2010, the total number of children enrolled using ELE reached 14,000.
- Despite a 12 percent reduction in the Medicaid workforce in the last two years, neither the volume nor the quality of eligibility processing has declined.
- Over 30 percent of newly enrolled children have already used their coverage to obtain care, especially dental services and prescription drugs.³⁴

Utah's Electronic Notifications Modernizes the Eligibility Process for Families and State Staff

Utah's online eligibility system for public assistance programs allows customers enrolled or applying for Medicaid, CHIP, SNAP, Financial Assistance, and Child Care Assistance Programs, to perform the following functions when they register for a "myCase" account online:

- View current and next month's benefits
- Print out 12-month history of benefits
- Read and print notices and forms
- Report changes
- Make online payments
- Opt to receive paperless notices and eAlerts
- Link to an online chat
- Online recertification

In February 2011, the Utah Department of Workforce Services (DWS), the eligibility determination entity for Medicaid, CHIP, SNAP, Financial Assistance, and Child Care Assistance Programs, started a CMS-approved pilot policy of allowing families and individuals with registered "myCase" accounts to receive eligibility notices and reminders electronically. DWS customers (in the case of child enrollees, it would be the

UTAH

In February 2011, the Utah Department of Workforce Services started a CMS-approved pilot policy allowing families and individuals with registered "myCase" accounts to receive eligibility notices and reminders electronically. As of the end of the second quarter of the pilot program, approximately 41,349 (35 percent) of the DWS myCase customers opted to receive all of their correspondence electronically.

Utah's online eligibility system for public assistance programs will save the state an estimated \$6 million in administrative and mailing costs.

parents/guardians) can opt to receive application forms, notices of eligibility determination, premium reminders, and renewal forms by email or text messaging. As of the end of the second quarter of the pilot program, approximately 41,349 (35 percent) of the DWS myCase customers opted to receive all of their correspondence electronically.³⁵ The current electronic correspondence rate represents an annualized savings of \$501,150. The Department calculates the annualized savings based on an average annualized savings of \$12.12 per customer. Governor Herbert supports this approach as an effort to streamline the process for customers and achieve administrative savings. The Governor has publicly stated that they are estimating saving \$6 million in administrative and mailing costs.³⁶ Savings estimates for Georgia could be significantly larger given this state is proportionately larger in population than Utah.

It is too soon to quantify the impact the myCase and electronic notification system has had on enrollment. However, DWS officials believe enrollment will be positively impacted, pointing to the fact that the anonymity of myCase may mean people are more likely to apply. Additionally, the number of cases that are closed due to failure to complete the renewal process has declined. Customers can apply, maintain their cases, and recertify without ever entering an office.³⁷

Advocates have noted some weaknesses in the system. Medicaid populations have inconsistent access to computers and the internet. Those who may choose paperless notification run the risk of missing important notices if they are in between points of internet access. Advocates are currently discussing with DWS strategies for establishing different levels of paperless options as a compromise approach to saving administrative costs but still ensuring families get the most important notices such as renewal and late premium notices. Other system weaknesses identified by advocates center around some of the steps required to log-in to myCase. Individuals must enter the applicant's social security number as a step in the log-in process. However, if a parent inadvertently enters their own SSN rather than the child's they are locked out of the system and must call an eligibility worker to fix the error. This is a common mistake made by parents and may be mitigated with clearer messaging on the log-in screen. DWS staff state they understand that internet access is not available to all of the customers they serve. However, they are targeting it towards those who can use the system to free up staff time for those requiring personal assistance. Consumer advocates interviewed for this report find this sentiment reasonable and believe the system is a promising approach to modernizing the enrollment process for families and eligibility workers.³⁸

User-specific online access similar to myCase is currently available to PeachCare families. Its expansion to Medicaid, along with the electronic notifications for both PeachCare and Medicaid would potentially improve a family's experience in accessing and retaining coverage for their children, as well as, encourage administrative efficiencies.

Ensure Access

A 2011 study by the U.S. Government Accountability Office (GAO) found that 83 percent of Primary Care Providers and 71 percent of specialists participate in Medicaid and CHIP. On the basis of a physician survey, the researchers found that physicians experience much greater difficulty referring children in Medicaid and CHIP to specialty care, compared to privately insured children. Eighty-four percent of primary care physicians experience difficulty referring Medicaid and CHIP children to specialty care. This rate is more than three times higher than the rate of physicians who reported experiencing difficulty referring privately insured children - 26 percent.³⁹

SOME GAPS EXIST IN PEDIATRIC SPECIALTY CARE

Georgia CMO data appears to substantiate the GAO study findings. Overall, provider access measures met the DCH contract parameters (see Table 2) that CMOs are required to meet for at least 90 percent of their members in each region regarding Pediatricians and Primary Care Providers. However, certain counties in each region do not meet the 90 percent access requirement for Pediatricians.⁴⁰

TABLE 2: GEORGIA FAMILIES GEOACCESS® STANDARDS

	Urban	Rural
PCPs	Two (2) within eight (8) miles	Two (2) within fifteen (15) miles
Specialists	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
General Dental Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Dental Subspecialty Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Hospitals	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Mental Health Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Pharmacies	One (1) twenty-four (24) hours a day, seven (7) days a week within fifteen (15) minutes or fifteen (15) miles	One (1) twenty-four (24) hours a day (or has an after hours emergency phone number and pharmacist on call), seven (7) days a week within thirty (30) minutes or thirty (30) miles

However, significant weaknesses were identified in pediatric specialty networks in certain regions of the state. For instance, data provided by DCH shows that CMOs in five of the six regions did not meet GeoAccess® requirements in Pediatric Endocrinology, Pediatric Infectious Disease, and Pediatric Rheumatology. (Table 3).⁴¹ Access to these provider types is limited in general in these parts of the states, and not just for managed care networks.

TABLE 3: SUMMARY OF PEDIATRIC SPECIALTIES BELOW 90% ACCESS BY GEORGIA FAMILIES REGION

Region	North	East	SW	SE	Central
Provider Type					
24 hour pharmacy		✓	✓	✓	
Behavioral Health Facilities			✓		
Dental Specialties			✓		
FQHCs and RHCs				✓	
Neonatology		✓		✓	
Pediatric Allergy Immunology			✓		
Pediatric Dermatology			✓		
Pediatric Endocrinology	✓	✓	✓	✓	✓
Pediatric Home Health				✓	
Pediatric Infectious Disease	✓	✓	✓	✓	✓
Pediatric Neurology			✓		
Pediatrics Orthopedics					✓
Pediatric Rheumatology	✓	✓	✓	✓	✓
Pediatric Urology					✓
Pediatric Vascular Surgery	✓		✓	✓	
Pediatricians		✓	✓		

However, the future program design model must ensure adequate access to pediatric specialists. Children with complex health issues need ready access to specialty care to ensure their conditions do not become more severe and their treatment more costly. A likely solution for Georgia is to pay specialists more. DCH should also monitor to ensure CMOs are complying with policies for establishing timely and appropriate out-of-network provider arrangements for children needing care. DCH and its contracted providers should explore technological approaches to addressing access barriers. For example, telemedicine, e-consultations, digital photography, and other applications of technology could help bridge gaps in specialist access.⁴² Telemedicine enables a provider at a distant location to communicate real-time with a patient, through audio and video technology. States like Texas have added telemedicine benefits to their Medicaid programs to ensure access for pediatric specialty care in metropolitan areas.⁴³

PROVIDER REIMBURSEMENT IMPACTS ACCESS

Provider rate reductions are one of the most commonly utilized cost control mechanisms available to states. Maintenance of effort requirements in the American Recovery and Reinvestment Act of 2009 (ARRA) and ACA prohibit states from restricting eligibility – leaving states with fewer options to control spending. *The Kaiser Family Foundation's 2011-2012 Annual 50-State Medicaid Budget Survey* reports that a total of 39 states restricted provider rates in FY 2011 and 46 states reported plans to do so in FY 2012.⁴⁴

As of 2008, average Medicaid/CHIP physician payment for pediatric services was estimated at 72 percent of Medicare. Commercial-to-Medicare physician fees were estimated at 113% for 2008.⁴⁵ Georgia CMO reimbursement rates to providers are not accessible as they are generally considered proprietary information. In contrast, fee-for-service (FFS) reimbursement rates are available. Compared to other states in the region and the U.S. average, Georgia FFS reimbursement rates are relatively high (Table 4). Georgia pays, on average, 21 percent more than the national average FFS physician reimbursement rate for Medicaid.

TABLE 4: MEDICAID FEES AS A PERCENTAGE OF NATIONAL MEDICAID FEES, 2008 (FEE FOR SERVICE RATES)⁴⁶

	All Services	Primary Care
United States	1.00	1.00
Louisiana	1.24	1.31
Georgia	1.21	1.29
Alabama	1.10	1.11
Texas	1.01	1.00
Florida	0.89	0.85

The Medicaid fee index measures each state's physician fees relative to national average Medicaid fees. The data are based on surveys sent by the Urban Institute to the forty-nine states and the District of Columbia that have a fee-for-service (FFS) component in their Medicaid programs (only Tennessee does not). These fees represent only those payments made under FFS Medicaid. The Medicaid fee index is a weighted sum of the ratios of each state's fee for a given service to the national average, using 2000 expenditure weights.

Table 5, from the Kaiser Budget Survey Report, provides details on the number of states making rate changes by three provider categories: PCP, Specialists, and Dentists. DCH did propose rate cuts for all providers (excluding hospitals, skilled nursing facilities, home and community-based services, FQHCs, RHCs and hospice providers) for FY2012 but later rescinded the proposal.⁴⁷ The decision is commendable as any further reductions will likely contribute to continued declining provider participation, thereby creating additional access problems.

TABLE 5: NUMBER OF STATES CHANGING PHYSICIAN OR DENTAL PAYMENT RATES, FY 2011 AND FY 2012⁴⁸

Certain Provider Rate Changes	Fiscal Year 2011		Fiscal Year 2012	
	Increase	Decrease	Increase	Decrease
Primary Care Physicians	5	11	1	9
Specialists	5	14	1	14
Dentists	4	11	3	13

NEW FEDERAL POLICIES AFFECT PROVIDER REIMBURSEMENT

ACA plays a role in addressing primary care access by increasing Medicaid payments for primary care to 100 percent of the Medicare payment rates for 2013 and 2014 with 100 percent federal financing for the increased payment rates.

On May 6, 2011, CMS issued a proposed rule⁴⁹ that provides the first federal regulatory guidance regarding what states must do to demonstrate their compliance with the access requirements specified in federal law (42 CFR § 438 Subpart D).⁵⁰ Some state Medicaid officials see the rule as overly burdensome, citing the many steps required to document adequate access. Significantly, the rule applies to FFS providers arrangements only and not managed care. The rule requires states to conduct "medical assistance access reviews" that include 1) beneficiary input; 2) data comparing Medicaid payment rates to customary charges and to Medicare rates, commercial payment rates, and/or Medicaid allowable costs, and stratified by public versus private ownership of the provider; and 3) any access issues identified by the review and the state agency's recommendations.⁵¹ It is difficult to tell what shape the final rule will take. However, the rule has the potential to play a significant role in how states comply with the federal Medicaid access requirement.

Ensure Quality

The American Recovery and Reinvestment Act of 2009 (ARRA), CHIPRA, and ACA, fostered a new manner and expectation for quality improvement activities in Medicaid and CHIP. The recently developed Pediatric Core Quality measures⁵², CHIPRA Quality Improvement Grants⁵³, the CHIPRA Technical Assistance and Analytic Support Program⁵⁴, and numerous HHS-led efforts established to effect quality improvement in all public programs⁵⁵ are all aimed at developing an efficient and effective infrastructure for quality monitoring and improvement activities in Medicaid/CHIP.

The majority of children in Medicaid and CHIP programs across the nation are healthy and relatively inexpensive in terms of health care utilization. Ensuring access to high quality preventive health services such as well-child visits, immunizations, and prenatal care, is essential. When compared to children with commercial coverage, children without coverage or public coverage have significantly higher rates of total hospital admissions, as well as admission for chronic illness, asthma, diabetes, vaccine-preventable disease, psychiatric disease, and ruptured appendix.⁵⁶ It is important for policy-makers seeking to improve the value of Medicaid and CHIP spending to consider both sides of the value equation – slowing cost growth in ways that do not harm quality, and improving quality for little or no extra cost. The increased attention toward developing and tracking uniform quality metrics will better inform CMS and states, thereby highlighting opportunities to improve the value of health care for Medicaid and CHIP.

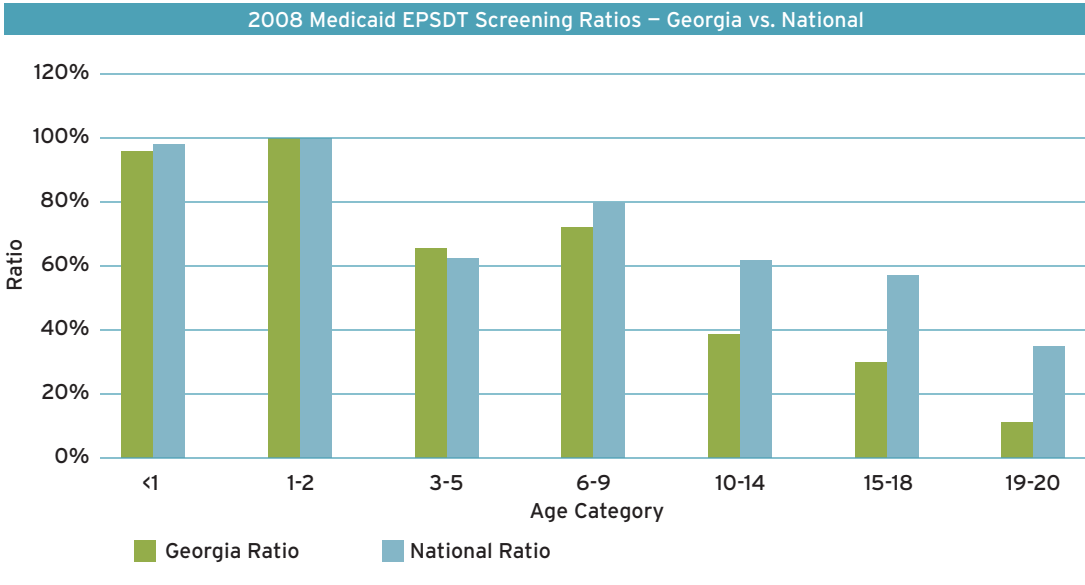
GEORGIA FAMILIES QUALITY: STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT GEORGIA'S QUALITY STANDARDS ARE STRONG

DCH maintains a well-developed Quality Improvement Plan for its contracted CMOs, with established performance targets focusing on preventive care for children. DCH was recently recognized for its quality measurement efforts in the *CHIPRA 2011 Annual Report on the Quality of Care for Children in Medicaid and CHIP*. Georgia reported 18 of the 24 initial CHIPRA measures in FY 2010, more than any other state. Overall, DCH requires its CMOs to report 32 quality measures. DCH contracts also link performance incentives to auto-enrollment, which assigns a higher rate of Medicaid and CHIP enrollees to the care management organization (CMO) that has the highest level of quality.⁵⁷ Additionally, the FY 2010 amendment to the CMO contract contains language allowing the CMOs to develop performance incentives for their network providers to drive achievement of the performance targets. This contract addendum also contains liquidated damages that may be levied should a CMO fail to achieve the established performance targets.⁵⁸

PERFORMANCE MEASURES SHOW OPPORTUNITIES FOR IMPROVEMENT

However, despite these commendable quality improvement strategies, Georgia Medicaid and PeachCare well-child performance data point to a need for improvement. All Medicaid and PeachCare enrolled children are eligible to receive Early Periodic Screening, Diagnostic and Treatment services (EPSDT). These services encompass a comprehensive and preventive child health program including screening and treatment for physical and behavioral development, vision, dental, and hearing services. The EPSDT services are particularly designed to identify and treat health problems before they become more complex and their treatment more costly. Figure 1 illustrates screening ratios by age category for all children enrolled in Medicaid in FY 2008. The screening ratio is calculated by dividing the number of children eligible for a screening by the number who actually received a screening. The data shows that Georgia lags behind the national average in most age categories. Additionally, Figure 1 illustrates the decline in screenings as children become older, both on the national level and in Georgia.

FIGURE 1: ANNUAL EPSDT PARTICIPATION REPORT, FY 2008. CENTERS FOR MEDICARE AND MEDICAID SERVICES⁵⁹



The CMO contract requires all CMOs to maintain comprehensive EPSDT outreach plans designed to educate and remind parents to make well-child appointments. For instance, one plan has a gift card incentive program for older adolescent children aimed at increasing the well-child performance measures and lead screening and immunizations are part of their 2011 provider Pay for Performance program. The public health literature reflects positively on the potential for these incentive programs to improve rates of on-time wellness behaviors.⁶⁰ But the lags illustrated in the screening ratios in Figure 1 point to a need for further improvement.

Georgia HEDIS data show the CMOs exceeded CY2009 performance targets for Childhood Immunizations and Lead Screenings, but failed to meet the performance targets for well-child visits, with a troubling downward trend from CY 2008 to CY 2009 (Table 6).

An increasing number of states are using National Committee for Quality Assurance (NCQA) or state-based qualification standards to develop patient-centered medical home initiatives. These efforts include incentive payments to support providers in implementing key features of the medical home model of care. Even though these initiatives are relatively new, early results show promising trends for costs, quality and improved access to care.⁶² Although the initiatives are relatively new, the medical home

TABLE 6: 2008/2009 PERFORMANCE MEASURE RESULTS – CHILDREN'S HEALTH⁶¹

	CY 2008 CMO Rate	CY 2009 CMO Rate	CY 2009 Performance Target
First 15 Months of Life: Six or More Visits	60.1%	55.5%	65.4%
Third, Fourth, Fifth, and Sixth Years of Life	–	61.4%	No contractual performance standard set
Adolescent Well Care	–	35.9%	No contractual performance standard set
Immunization and Screening			
Childhood Immunization Status - Combination 2	76.6%	75.2%	72.0%
Lead Screening in Children	71.6%	66.0%	65.9%

concept is not. In fact, the PCP assignment for all CMO-enrolled members is an intentional effort to establish medical homes for participating children. However, researchers have documented how a systematic approach that includes advanced access to services, care coordination through a medical home, electronic health records, and tools for information and knowledge transfer is essential for ensuring children receive the quality of care they need.⁶³ DCH should take this opportunity to build on efforts already underway and adopt innovative approaches similar to those in place in Texas and Rhode Island.

MEDICAL HOMES ARE AN ESSENTIAL COMPONENT OF A QUALITY-DRIVEN DELIVERY SYSTEM

The National Strategy for Quality Improvement in Health Care (National Quality Strategy) required by ACA, was issued by HHS in March 2011 and sets priorities to guide improvements in health care, as well as, provides a strategic plan for how to achieve it. The National Quality Strategy identifies principles that address areas important to children's health care quality such as: increasing person-centeredness and family engagement; eliminating disparities in care; making primary care a bigger focus; enhancing coordination of care; and integrating care delivery.⁶⁴

Medical homes must serve as the primary vehicle for providing children's health care that:

- Ensures access and coordination of services;
- Integrates physical/behavioral health care; and
- Ensures accountability for quality through rigorous contractual obligations related to performance incentives/penalties, data collection, and public sharing of performance outcomes, among others.

ACCESSIBLE AND COORDINATED CARE THROUGH MEDICAL HOME APPROACHES

As previously stated, these medical home program design features could be implemented in a full-risk managed care or EPCCM program design model. Previous research conducted by Voices for Georgia's Children found features that support access to care and high quality are more important than full-risk managed care versus EPCCM distinctions.⁶⁵ For instance, North Carolina's EPCCM program, Community Care of North Carolina (CCNC), uses local non-profit community networks comprised of physicians, hospitals, social service agencies, and county health departments, to provide and manage care. Evaluators of the EPCCM programs like CCNC found they perform equal to or better than capitated MCOs on measures of access, cost, and quality, if sufficient resources are devoted to their design, implementation, management, and funding.⁶⁶

On the capitated managed care side, Care Oregon exemplifies a managed care plan approach to medical homes by using grants in their Care Coordination and Systems Integration (CCSI) program to help providers within their network implement specific projects that would improve health care delivery and outcomes in their practices.⁶⁷

This paper does not take a position on the best provider contracting or incentive payment model for Georgia. Instead, we provide examples of features of a medical home approach that are essential to ensuring high quality care through access and coordination; physical and behavioral health integration; and provider accountability. Establishing processes to share information between a child's medical home and other providers is a key feature to maintaining an accessible and coordinated system of care. The Texas Health Passport electronic health records (EHR) program provides an example of such an approach. Additionally, Rhode Island's provider-based Family Resource Specialist approach in its Pediatric Practice Enhancement Project exemplifies a model that ensures care is accessible, coordinated and integrated for all children, specifically children and youth with special health care needs.

INTEGRATED PHYSICAL AND BEHAVIORAL HEALTH CARE

Georgia is not alone in that many states must better manage the care of children with complex behavioral health conditions, particularly children and youth with special health care needs (CYSHCN) and those enrolled in the foster care system.

Some states have significant experience with full integration managed care include Arizona, Massachusetts, Minnesota, Texas, and Wisconsin.⁶⁸ Other states have used EPCCM approaches to promote integration of care. The most essential component of care management and integration for CYSHCN and children in foster care is that all aspects of care are accessible and coordinated within their medical home. In doing so, care givers have a familiar resource to assist in navigating the medical system and ensuring access to care in a comprehensive and coordinated manner.

ACCOUNTABILITY FOR QUALITY

Serving as an active purchaser is one of the key features of an effective care management delivery system for state Medicaid and CHIP programs – during each phase: request for proposal, setting contract expectations, and monitoring performance. This includes maximizing opportunities to purchase higher quality and better services, not just more services.⁶⁹ Rigorous contracting standards are critical for measuring what is working and identifying what needs to be fixed.

States should ensure their provider and/or health plan agreements include contractual terms that:

- Ensure states are getting the value for their money;
- Incentivize quality improvement and innovation; and
- Demand that plans and providers share clinical data to track quality and provide effective care for complex populations.

A review of DCH's current CMO contract reveals a solid framework in place for ensuring states are getting the value for their money by establishing clear expectations for quality improvement, care coordination, and access to primary and preventive care. The terms include incentives for performance and penalties for non-performance. Public reporting of quality outcomes through the annual HEDIS findings and CMO-specific Performance Improvement Programs are other strengths in the current Quality Improvement Strategy for Georgia and should be continued.

DCH could enhance their quality standards in two ways. The current performance standards for Childhood Immunizations and Lead Screening are based on the 50th percentile national HEDIS Benchmark.⁷⁰ Increasing the standard to the 75th percentile would bring them in line with the well-child

SPOTLIGHT ON BEHAVIORAL HEALTH

A Commonwealth Fund State Scorecard on Child Health Performance reports that less than 50 percent of children in Georgia receive the mental health services they need.

Nationwide, the shortage of mental health providers for children, stigma attached to receiving mental health services, chronic underfunding of the public mental health system, decreased reimbursement to mental health providers, and inadequate insurance benefits contribute to underutilization of mental health services among children. While CHIPRA's mental health parity legislation may help to alleviate some financial barriers, other challenges remain related to care coordination and integration with physical health.

Policies that require state agencies to coordinate with each other for children receiving mental health care would mitigate the number of cases lost in the system or "dumped" on one agency's hands. Further integrating mental health with physical health screening and treatment would promote more timely identification of developmental problems, more efficient care planning and ultimately pre-empt the occurrence of more costly health conditions. Finally, the specifics of mental health services for children must be clearly delineated in managed care contracts to adequately measure quality and ensure compliance.

visit standards, currently at the 75th percentile. Additionally DCH could add more well-child visit measures for older age groups, beyond the first 15 months of life, to the performance standards. This change would send a signal to CMOs regarding the high priority DCH places on children's care, as well as, challenge CMOs to intensify their efforts to make needed improvements in these areas.

STATE EXAMPLES

Texas Health Passport

Implemented in 2007, the Texas Health and Human Services Commission's (HHSC) Health Passport program is an innovative approach to coordinating care for children in the foster care system. The Health Passport is a web-based EHR system used by state officials, managed care plans and providers to share medical history and ensure coordinated and unduplicated care for children transitioning in and out of the foster care system. The goal of the Health Passport is to improve health outcomes and care coordination for children by equipping parties involved in a child's care with consolidated medical information so they can better understand and meet the child's health care needs. Increased access to medical information may also help reduce provider errors caused by missing information, the delivery of duplicate immunizations, tests, and prescriptions, and costs associated with duplication of services. Funding for the development of the Health Passport came from a \$4 million Medicaid Transformation Grant from the Centers for Medicare and Medicaid Services (CMS).⁷¹ Ongoing operations costs for the Health Passport are included in the capitated rate paid to the managed care plan contracted to provide care for children enrolled in foster care.⁷² The Health Passport EHR website includes:

- Demographics: personal contact information of the child's physicians and other individuals involved in the child's care;
- Medical and Pharmacy History: Most recent two years of claims of each visit to a health care provider with date of service, diagnosis, and procedure(s) performed along with all prescriptions filled;
- Immunizations: Comprehensive list of a child's immunizations;
- Lab Results: Results of lab tests performed, if available;
- Electronic Documentation: Providers can document EPSDT visits, dental, and behavioral health assessments within the Passport;
- Vital Signs: Providers can record vital signs at the point of care;
- Allergies: Providers can record allergies at the point of care. Passport checks the medication interactions.⁷³

TEXAS

Texas Health and Human Services Commission's (HHSC) Health Passport program is a web-based electronic health record (EHR) system used by state officials, managed care plans and providers to share medical history and ensure coordinated and unduplicated care for children transitioning in and out of the foster care system. HHSC expects to go live in early 2012 with a new EHR system to transition Health Passport into serving the broader Medicaid and CHIP population.

Approved by CMS as modification and improvement costs for the state's Management Information System (MMIS), HHSC's EHR development receives a 90 percent federal match on state dollars.

HHSC staff and consumer advocates agree that the lack of interoperability with provider's office-based EMR systems is a weakness that needs to be addressed. Currently Providers cannot import Health Passport information into their systems nor can they transmit data electronically from their systems to the Health Passport. Instead, providers with their own electronic systems must manually enter data into two systems.⁷⁴

Expanding Health Passport to the broader Medicaid and CHIP child population

HHSC expects to go live in early 2012 with a new EHR system for the broader Medicaid and CHIP population. A future enhancement of the new EHR will allow the system to be interoperable with physician's office-based Electronic Medical Records (EMR) systems. Importantly, the EHR development has been approved by CMS as modification and improvement costs for the state's Medicaid Management Information System (MMIS). Therefore, HHSC receives a 90 percent federal match on all state dollars for the development costs.⁷⁵ The new EHR builds on momentum and works in concert with the Medicaid EMR incentive program established by CMS.⁷⁶ Since May of 2011, HHSC has distributed more than \$200 million to health care providers to assist in financing the development of their own EMRs.

Georgia has the potential to establish a similar statewide EHR for Medicaid and PeachCare enrollees by building on current efforts underway. Since Georgia's EHR incentive program launched on September 5, 2011, incentive payments totaling \$6.4 million have gone out to six hospitals and 12 health care professionals around the state who were among the first to qualify.⁷⁷ EHR tools like Health Passport are necessary components for both Medicaid and CHIP state purchasers and providers as they move to create efficient systems of care management and coordination, improved quality tracking, and effective monitoring of health outcomes.

Rhode Island Pediatric Practice Enhancement Project

The Rhode Island Pediatric Practice Enhancement Project (PPEP) began in 2003 by the Department of Health's Office of Special Health Care Needs in response to a state-administered needs assessment that identified physician and family concerns about obstacles to providing a medical home for CYSHCN and their families. The program uses specially trained parent consultants, called Family Resource Specialists, who work 20 hours per week in a participating medical practice. When a physician learns that a patient has needs beyond the medical scope of the practice that are not being addressed, a referral is made to the Family Resource Specialist.

Across the country, programs that use peer and parent-to-parent support have found success in helping families gain the comfort, knowledge, and skills to access appropriate services. Research indicates that parents who receive support from other parents who have faced similar situations with their own children with special health care needs, are better able to adjust to their child's disability and have better attitudes, increased coping abilities, and greater progress in solving problems.⁷⁸

PPEP parent consultants assist with:

- resource identification;
- community referrals for social, developmental or mental health services;
- links with the education system;
- eligibility or application assistance for health insurance, nutrition, or housing services;
- navigation across these services; and
- peer-to-peer support.

RHODE ISLAND

Patient Problem Resolution: 81 percent of the presenting problems were resolved, including long-term educational or behavioral health issues.

Lower Patient Costs: Annual healthcare costs were 39 percent lower for Pediatric Practice Enhancement Project (PPEP) participants compared to pre-PPEP and 27 percent lower compared to children and youth with special health care needs in standard care.

The PPEP program is realizing positive outcomes on multiple fronts. The most recent Rhode Island Department of Health evaluation of the PPEP program identified the following indicators of success:

- Patient Problem Resolution: 81 percent of the presenting problems were resolved. Many included long-term educational or behavioral health issues.
- Coordinated Care: When care was coordinated through the PPEP model, CYSHCN had fewer health care encounters than before care coordination occurred.
- Lower Inpatient Utilization: Inpatient utilization was 24 percent lower for PPEP participants compared to pre-PPEP and 34 percent lower compared to CYSHCN in standard care.
- Lower Patient Costs: Annual healthcare costs were 39 percent lower for PPEP participants compared to pre-PPEP and 27 percent lower compared to CYSHCN in standard care.
- Sustainability of PPEP: All participating sites (24) have chosen to support the PPEP model, utilizing Family Resource Specialists to varying degrees to suit their individual site needs.⁷⁹

Additionally, families served by PPEP report greater understanding and satisfaction regarding the health care service system, a sense of empowerment, and enhanced knowledge of available supports. Participating physicians report a tremendous value in having the Family Resource Specialist available to assist with the many coordination needs beyond medical care.⁸⁰

Since the New Freedom Grant ended in 2009,⁸¹ the RI Department of Health's Office of Special Health Care Needs has funded the PPEP through a shared commitment with participating practices. The majority of the participating PPEP sites bought into the project to support the Family Resource Specialist. Levels of funding vary from practice to practice depending on the available budget of the practice. The standard number of hours that a Family Resource Specialist's support is provided to a practice is 15 or 20 hours per week. The Office of Special Health Care Needs pays for five of the hours through Title V (Maternal and Child Health Services Block Grant) funding and the practice pays the rest.⁸²

DCH has the capacity to leverage relationships with providers either directly or through the CMO contracts to establish a similar program in Georgia. Developing patient-centered, care coordination in partnership with primary care providers that integrates all aspects of care (both physical and behavioral) and uses specific techniques such as peer-to-peer approaches is an innovative approach to developing tools for information and knowledge transfer between providers and parents.

Recommendations

Georgia's children need a system of care that ensures coverage, access, and quality. To make sure such a system is in place now and in the future, Georgia policy makers must take a modernized approach to program eligibility and health care delivery. A modernized system of care for children ensures coverage for all children through simplified eligibility policies and technology-driven solutions that automate administrative functions and reduces the burden for families and eligibility workers. This system of care must include features that hold providers accountable for quality, ensure access to care, and promote strategies that focus on the value of care provided by balancing cost and quality. The following recommendations center on features of program design options that will create a solid framework for managing the care of today's Medicaid and CHIP enrolled children, as well as, garner the infrastructure and capacity necessary to handle the program needs of the future.

1. Further simplify eligibility processes to ensure coverage for all children.

Children with continuous coverage have better health outcomes than those who do not. Also, a streamlined eligibility process not only has the potential to save administrative costs, but is essential for creating the capacity Georgia needs to accommodate the expansion of Medicaid in 2014.

Georgia should leverage, not just some, but all of these new program flexibilities and enhanced funding opportunities to accomplish the following:

- ▶ Continue the good progress with DCH's CHIPRA Outreach Grant, but take these efforts to the next level like Alabama and Louisiana by further simplifying the enrollment policies and creating electronic interfaces with multiple public program data sources for verification and ELE determination at application and renewal.
- ▶ Consider following Utah's lead in developing online capacity for families to access their eligibility information. Also, consider using email and text messaging to communicate with parents of enrolled children. This user-specific online access is currently available to PeachCare enrolled families. Its expansion to Medicaid, along with the email and text notifications for both PeachCare and Medicaid could potentially improve a family's experience in accessing and retaining coverage for their children, as well as, encourage administrative efficiencies.

2. Improve access to specialty care for children.

DCH should continue to attend to provider access issues, particularly in specialty care for children. Higher reimbursement for some Pediatric provider types may be necessary to fill network gaps particularly in the areas of Endocrinology, Infectious Disease, and Rheumatology. DCH should also monitor to ensure CMOs are complying with policies for establishing timely and appropriate out-of-network provider arrangements for children needing care. DCH and its contracted providers should explore technological approaches to addressing access barriers. For example, telemedicine, e-consultations, digital photography, and other applications of technology could help bridge gaps in specialist access.

3. Modernize program design features in medical home models to establish value-driven, high quality care for children in Medicaid and CHIP.

Establishing a comprehensive medical home that holds providers accountable for quality and ensures access to coordinated care is an integral aspect of any contractual arrangement Georgia opts to pursue. Regardless of the care management model, a medical home is indispensable to ensuring access and quality of children's health care. Georgia should consider modernized service delivery features such as:

- Using EHR, similar to Texas Health Passport, to enable medical home providers to coordinate access to care. EHR also allows for data-driven performance tracking to ensure timely and appropriate care is received, such as EPSDT.
- Developing patient-centered, care coordination in partnership with primary care providers that integrates all aspects of care (both physical and behavioral). Use specific techniques such as peer-to-peer approaches found in Rhode Island to ensure care is accessible and coordinated for all children.

4. Strengthen contract standards to hold providers and CMOs accountable for quality.

The state should intensify their efforts to hold plans accountable for performance on HEDIS measures.

- DCH could strengthen their quality standards by increasing the FY12 performance standard for Childhood Immunizations and Lead Screening from the 50th percentile to the 75th percentile. This would bring them in line with national well-child visit standards, currently at the 75th percentile.
- DCH could add more well-child visits for older age groups to the performance standards beyond the first 15 months of life. This change would signal to CMOs the priority DCH places on children's care, as well as, challenge CMOs to raise their efforts to increase quality in these areas.

5. Pursue public and private grants to achieve goals.

Alabama, Louisiana, Utah, Texas and Rhode Island, all used public and private sector grants, from HHS and the Robert Wood Johnson Foundation MaxEnroll Initiative, to obtain technical assistance and financing necessary to achieve their program goals. Georgia can and should follow this approach in garnering available resources to supplement expertise and financing.

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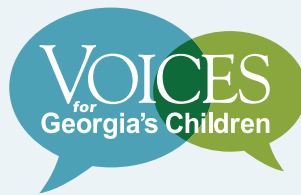
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Appendix A: State Study Contacts

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