

Contract No.: 282-98-0021  
MPR Reference No.: 8661-204



## **State of Georgia**

# **Improving Medicaid Participation for Pregnant Women and Children: Strategies and Challenges**

*Final Report*

*February 18, 2002*

*Kathleen A. Maloy\**

Submitted to:

Department of Health and Human Services  
Administration for Children and Families  
Office of Planning, Research and Evaluation  
370 L'Enfant Promenade, SW, 7<sup>th</sup> Floor  
Washington, DC 20447

Submitted by:

Mathematica Policy Research, Inc.  
600 Maryland Ave., SW, Suite 550  
Washington, DC 20024-2512  
Telephone: (202) 484-9220  
Facsimile: (202) 863-1763

Project Officer:

Michael Dubinsky

Project Director:

LaDonna Pavetti

\*Center for Health Services Research and Policy, The George Washington University School of Public Health and Health Services

***PAGE IS INTENTIONALLY LEFT BLANK TO ALLOW FOR DOUBLE-SIDED COPYING***

## ACKNOWLEDGMENTS

This report would not have been possible without the cooperation and support we received from staff at all levels in each of the study states. Program administrators fielded many questions from us about formal policies and procedures and local staff talked openly with us about how those policies and procedures play out in practice and let us observe them as they went about their daily routines. Clients shared both the benefits and costs of applying for public benefits. We would like to thank everyone who graciously shared their time with us for making this report possible.

We would also like to thank staff from the U.S. Departments of Health and Human Services and Agriculture for providing guidance and feedback throughout this project. As project officer, Michael Dubinsky, guided the project from beginning to end. Ann McCormick, Ann Burek, Penny Pine and Margaret Andrews also provided useful feedback throughout the project.

Stacy Dean, Dottie Rosenbaum and David Super from the Center on Budget and Policy Priorities helped us to gain a better understanding of the intricacies of the Food Stamp Program and the options available to states to simplify the application and recertification processes for families. Vicki Grant and Nancy Gantt from the Southern Institute for Children and Families worked with us to coordinate our work with the Robert Wood Johnson's project on Supporting Families After Welfare Reform.

The work for this project was completed as a team effort, involving staff from multiple organizations. At Mathematica Policy Research, LaDonna Pavetti directed the project. Robin Dion, Megan McHugh, Angela Merrill, Jessica Mittler, and Charles Nagatoshi conducted site visits and authored the state site visit summaries. As a consultant to MPR, Liz Schott contributed to virtually every aspect of the project. She conducted site visits, authored several of the site visit summaries and reviewed those she did not write. Her extensive knowledge of TANF and the Food Stamp and Medicaid programs helped all of us to do a better job on this project. Margaret Boeckmann, also a consultant to MPR, conducted several site visits and helped to synthesize the information collected. Julie Osnes of the Rushmore Group, Inc. helped us to identify potential sites and reviewed all of the reports. Ruchika Bajaj managed the project. Brianna Stanton helped us to prepare the data we collected for analysis. Daryl Hall coordinated the editing of the reports and Donna Dorsey provided ongoing and consistent administrative support. Staff from our survey division helped us to recruit clients for the focus groups.

Our subcontractors, George Washington University Center for Health Services Research (GWU) and American Management Services, Inc. (AMS) participated in all aspects of the project. Kathleen Maloy acted as project director at GWU, supervising project staff and reviewing all project reports. Her extensive knowledge of Medicaid for families helped everyone to better understand the intricacies of Medicaid enrollment and retention. Jennifer Stuber and Michelle Posner conducted site visits. Lea Nolan and Julie Darnell, a consultant to GWU from Northwestern University, conducted site visits and authored the state site visit summaries. Soeurette Cyprien provided administrative support. At AMS, Gary Hyzer acted as project director. Along with Allison Logie, Lara Petrou Green and Ben Marglin, he conducted

site visits and authored the state site visit summaries. AMS staff also helped to develop the methodology to document the case flow in each of the sites and to assess the use of automated systems.

# CONTENTS

Chapter	Page
I. CONTEXT .....	1
A. INTRODUCTION.....	1
B. RESEARCH METHODS.....	1
C. OVERVIEW OF STATE POLICIES AND PROGRAMS FOR PUBLIC BENEFITS PROGRAMS .....	2
1. TANF Program—Work First .....	3
2. Medicaid and SCHIP Programs for Families and Children .....	4
3. Food Stamp Program.....	6
D. STRUCTURE AND OPERATION OF THE DEKALB COUNTY DFCS OFFICE .....	7
II. FINDINGS .....	9
A. PROMISING PRACTICE: RSM INITIATIVE DESIGNED TO PROMOTE PARTICIPATION IN MEDICAID FOR PREGNANT WOMEN AND CHILDREN.....	9
1. RSM Created in Response to Georgia’s High Infant Mortality Rate.....	9
2. RSM Project Structure and Staff: State Employees Located in the Community Instead of in County DFCS Offices .....	9
3. RSM Program Operation — Emphasis on Creative Ongoing Community Outreach .....	10
4. RSM Project Intake and Enrollment .....	11
5. RSM Project Performance Linked to RSM Outreach and Staff Attributes.....	12
III. CONCLUSIONS AND RECOMMENDATIONS.....	15
A. RSM OUTREACH PROJECT.....	15

***PAGE IS INTENTIONALLY LEFT BLANK TO ALLOW FOR DOUBLE-SIDED COPYING***

## TABLES

Table	Page
I.1	STATE MEDICAID AND SCHIP PROGRAM..... 5

***PAGE IS INTENTIONALLY LEFT BLANK TO ALLOW FOR DOUBLE-SIDED COPYING***

## I. CONTEXT

### A. INTRODUCTION

The 1996 federal welfare reform law, with its emphasis on time-limited benefits and sanctions for nonparticipation in work activities, was designed to encourage families to leave cash assistance for work, thereby substantially reducing the nation's welfare rolls. The delinking of Medicaid from welfare through the enactment of Section 1931 eligibility was intended to ensure that welfare reform would not also lead to reduced Medicaid enrollment. Nevertheless, since 1996, Medicaid participation has declined at a rate higher than expected, raising concerns among federal and state policy makers that changes in cash assistance programs have affected Medicaid enrollment. Similar concerns have been raised in regard to the dramatic participation declines in the Food Stamp Program (FSP). A recent analysis indicated that among the 10 states with the greatest welfare caseload declines, some had relatively large reductions in food stamp participation rates while others experienced moderate to relatively small reductions.<sup>1</sup> One explanation for such declines may be that entitlement programs such as the FSP and Medicaid that operate in the context of a nonentitlement block-granted program—the current cash assistance system is Temporary Assistance to Needy Families (TANF)—may present unique implementation challenges that can affect program participation.

To examine the barriers and enhancements to initial and continuous participation in the FSP, Medicaid, and new State Children's Health Insurance Program (SCHIP), the U.S. Department of Health and Human Services and the U.S. Department of Agriculture commissioned a research project calling for case studies of the operation of these programs at the state and county levels. This report describes findings from the Georgia case study

Georgia was selected as one of the study's promising practice sites because of increased Medicaid enrollment among pregnant woman and children in the Right from the Start Medicaid (RSM) expansion program in the years before and since welfare reform. DeKalb County was selected by state officials for its proximity to the state department offices and because the county has established decentralized RSM enrollment sites.

### B. RESEARCH METHODS

With the aim of documenting DeKalb County's experiences and lessons learned in implementing improved program access to and participation in benefits programs, the research team analyzed the county's general program approach and identified specific strategies for encouraging program participation.

---

<sup>1</sup> Schirm A., "Reaching Those in Need: State Food Stamp Participation Rates in 1998," Mathematica Policy Research, Inc., January 2001.

The Georgia site visit took place over three days in February 2001. One day was devoted to meeting with state policy officials with the remainder spent focusing on the county-based operation of the RSM program as a promising practice. Before the site visit, we conducted interviews with other state policy officials and representatives from community-based organizations. Data-collection methods included:

- Interviews with RSM program directors and supervisors as well as with outreach workers
- A group interview with division managers
- Interviews with caseworkers
- Interviews with automated system experts
- Case reviews with line caseworkers
- Interviews with Georgia Department of Community Health (GDCH) officials regarding policies and operational goals
- Interviews with representatives from community agencies

### **C. OVERVIEW OF STATE POLICIES AND PROGRAMS FOR PUBLIC BENEFITS PROGRAMS**

The Georgia Department of Human Resources (GDHR) is responsible for administering the Food Stamp and TANF programs. These programs, along with child support enforcement and collection and child welfare/social services, are lodged within the Division of Family and Children Services (DFCS) of GDHR. The Georgia Department of Community Health (GDCH) is responsible for administering the Medicaid program.<sup>2</sup> The Division of Medical Assistance (DMA) within GDCH sets eligibility policies and procedures for the range of benefits available under Medicaid. GDCH/DMA operates under an interagency agreement with GDHR/DFCS that grants GDHR the authority to determine eligibility for Medicaid.

Given that Georgia uses a state-supervised, county-administered approach to providing public benefits, the county departments of family and children services (county DFCS) assume front-line responsibility for determining eligibility and awarding benefits for individual applicants.<sup>3</sup> Each county convenes a board that participates in the appointment of the director of the county DFCS and ostensibly oversees the operation of the local offices. Although the county

---

<sup>2</sup> In 1998, Georgia consolidated the Departments of State Employee Insurance, Health, and Medical Assistance into one department called the Department of Community Health.

<sup>3</sup> To distinguish between the state Division of Family and Children Services and the county Department of Family and Children Services, the report uses the following acronyms, respectively: state GDHR/DFCS and county DFCS.

departments must take direction from the state departments in terms of policies and procedures, each county DFCS office organizes itself in the manner that its director deems most appropriate to serving its caseload given the resources allocated by the county. These organizational and operational circumstances pose a challenge to mediating among and working with many different players and stakeholders in the administration of public benefits in Georgia.

## **1. TANF Program—Work First**

Before passage of the 1996 welfare reform law, Georgia implemented its Work First program statewide as an Aid to Families with Dependent Children (AFDC) demonstration program that in turn became the state's TANF program. Georgia's cash assistance caseload declined by 59 percent between August 1996 and June 2000, whereas the national caseload declined by 44 percent for the same period.

A family of three may initially qualify for TANF if its net income is below \$765 per month (approximately 64 percent of the federal poverty level [FPL]) and its assets are less than \$1,000. After four months, qualifying net income drops to \$544 per month, or 46 percent of FPL. The maximum TANF grant for a family of three is \$280 per month, which is approximately 25 percent of FPL. The average monthly cash benefit through February 2000 was \$223 per month.

Georgia's TANF program focuses primarily on employment and self-sufficiency by offering substantial services to help applicants secure jobs. Applicants are required to participate in a job search as a condition of eligibility. GDHR reports that the percentage of people leaving welfare from 1997 to 1998 as a result of employment was 63 percent and that, one year later, 59 percent of those persons were still working.

### **a. Mandatory Applicant Job Search**

Generally, all TANF applicants with children over the age of one year are required to participate in job search activities as a condition of approval of their TANF application. If applicants have no visible barriers to employment, they receive an orientation to Work First and a referral to the Department of Labor for assistance in finding a job. The number and type of job contacts that an applicant must make to meet the job search requirement vary by county DFCS office but generally range between 25 and 30.

### **b. Time Limits**

Georgia established 48 months as the life-time limit for receipt of cash assistance rather than the federally imposed time limit of 60 months. Cases approaching the time limit undergo review at the 44<sup>th</sup> and 47<sup>th</sup> months of benefit receipt. The 47<sup>th</sup>-month review requires a face-to-face interview with the client. If the family is in compliance with their Personal Responsibility (PRA) and has no other source of support, then the case is considered for a hardship extension for three months. Families began reaching the time limit on December 31, 2000.

### **c. Sanctions**

Georgia has instituted a “two strikes and you are out” sanction policy. After the first instance of failure to comply with the PRA, the family grant is reduced by 25 percent. A second instance of noncompliance results in a permanent loss of all benefits. A face-to-face interview is conducted with the client before case closure to make sure that the sanction is not placing the family at risk. Families do not lose Medicaid or food stamps as a result of sanctions, but they cannot use food stamp benefits to offset the reduction in cash benefits until six months have elapsed. Informants consistently reported that caseworkers are particularly reluctant to impose Georgia’s severe sanctions; instead, the informal policy is to encourage clients to close their cases voluntarily. Currently, the sanction rate in Georgia is approximately 2 percent (e.g., in 2000, 890 households out of 54,091 received the first sanction for failure to participate in a work activity, and 25 families received the second sanction).

## **2. Medicaid and SCHIP Programs for Families and Children**

This section describes the eligibility policies for the Medicaid and SCHIP programs targeted to nondisabled individuals, families, women, and children, including 1931 Medicaid or Low Income Medicaid (LIM), Right from the Start Medicaid (RSM), and the State Children’s Health Insurance Program (SCHIP) known as PeachCare, which is a separate state program (see Table I.1). Between fiscal year (FY) 1996 and 2000, state data show that the number of Medicaid recipients grew by 1.7 percent.<sup>4</sup> In the face of national declines in Medicaid enrollment for families, state informants attributed Georgia’s relatively stable number of Medicaid recipients to enrollment growth among the aged, blind, and disabled (ABD) and, to a lesser extent, to enrollment growth in RSM. In 2000, 27 percent of Georgia’s Medicaid recipients received ABD coverage, 38 percent RSM coverage, and 34 percent LIM coverage.

### **a. Section 1931 Medicaid for Low-Income Families**

Georgia’s 1931 Medicaid program is known as Low Income Medicaid or LIM. An earned income disregard of \$120 plus one-third of remaining income is available to applicants. With the disregard, a family of three that is eligible for LIM must have income that is less than 64 percent of FPL (i.e., \$756 per month) and assets less than \$1,000.<sup>5</sup> Recipients receive the earned income disregard for four months, after which time it drops to \$90 plus \$30 for the next eight months. At this point, a family of three with a net income greater than \$544 per month (46 percent of FPL) loses its eligibility for LIM. Thereafter, the disregard drops to \$90, and families of three with a net income greater than \$514 per month (44 percent of FPL) lose their eligibility for LIM.

---

<sup>4</sup> From June 1996 through June 2000, Health Care Financing Administration (HCFA) data for Medicaid enrollees in Georgia indicate that the number of Medicaid enrollees declined by 13 percent. These differences may be attributable to the definition of recipients versus enrollees (e.g., in 2000, Georgia reported 1.2 million Medicaid recipients, whereas HCFA reported 841,900 enrollees).

<sup>5</sup> The eligibility criteria for 1931 Medicaid and TANF in Georgia are aligned and represent the eligibility criteria in place for AFDC in Georgia as of July 1996.

TABLE I.1

## STATE MEDICAID AND SCHIP PROGRAM

Type of Program	Eligibility	Coverage	Redetermination Period
Section 1931 Medicaid for Low-Income Families (LIM)	Families with incomes up to 64 percent of FPL for four months, then 46 percent for eight months, and 44 percent of FPL thereafter	Provides full Medicaid benefits	Six months alternating in person and mail-in
Right from the Start Medicaid (RSM) — Medicaid Expansion for Pregnant Women and Children	Pregnant women and infants up to one year of age  Up to 235 percent of FPL Children one through six years of age with family income up to 133 percent of FPL  Children seven through 19 years of age with family income up to 100 percent of FPL	Provides full Medicaid benefits for children and coverage for pregnant women	Six months alternating in person and mail-in
PeachCare — Separate State SCHIP Program	Children up to 19 years of age with family income up to 235 percent of FPL and who are ineligible for RSM	Requires premiums Full Medicaid benefits	12 months Mail-in

**Effective Extension of Transitional Medicaid Assistance (TMA) Benefits.** In July 2000, Georgia adopted a policy change that in effect extended Transitional Medicaid Assistance (TMA) for families losing LIM coverage as a consequence of increased income. As long as the family has received one month of LIM coverage, it can receive a 12-month disregard of all earned income at the point at which it is about to lose LIM coverage. The additional LIM coverage is known as Work Transitional Medicaid (WTM). Once the 12-month period of WTM expires, the family becomes eligible for 12 months of TMA. The policy change also effectively expanded access to TMA; that is, when a family finds a job quickly, WTM helps the household meet the “three-out-of-six-month rule” and thus qualify for TMA.

Application procedures for LIM include completion of the generic public benefits form, a face-to-face interview, and verification procedures. Georgia has recently implemented a policy allowing self-declaration of income for 1931 Medicaid applicants. The policy built on the self-declaration policy in effect for the RSM program. State informants noted, however, that procedures for self-declaration vary by county and depend on the discretion of the caseworker (e.g., caseworkers can request more verification on questionable items) and that rural counties consistently seem to make the declaration process more difficult for applicants.

## **b. Right From the Start Medicaid (RSM)—Medicaid Expansion Coverage**

Congressionally mandated Medicaid expansions enacted during the late 1980s required states to expand Medicaid coverage to pregnant women and children under age six by up to 133 percent of FPL; in 1990, the final federal expansion required states to phase in coverage of children ages six through 18 by up to 100 percent of FPL. Georgia's program for these poverty-level Medicaid expansions is known as Right from the Start Medicaid (RSM).

The Right from the Start Medicaid Project began in 1993 as a response to the state's high infant mortality rate, which was among the highest in the nation. The RSM Project, the product of an interagency agreement between the former state Departments of Medical Assistance (currently GDCH) and Human Resources, was designed to promote enrollment in RSM for pregnant women and children through enhanced and aggressive outreach and education, thereby ensuring that all eligible pregnant women and children would receive coverage. The RSM application process involves a simplified two-page application that can be completed at numerous community-based locations, simplified verification procedures, and no asset test.

It is important to understand that (1) RSM Medicaid does not represent expanded Medicaid eligibility beyond what is required by federal law except for pregnant women and infants up to one year of age (i.e., Georgia recently expanded Medicaid coverage for pregnant woman and infants under age one year from 200 percent of FPL to 235 percent of FPL) and that (2) RSM Medicaid coverage for pregnant women and children is not the 1931 Medicaid coverage category for families that was created as a result of welfare reform. As noted above, 1931 Medicaid coverage for families in Georgia is available only up to 64 percent of FPL during the first four months, 46 percent of FPL during the next eight months, and 44 percent of FPL thereafter.

## **c. PeachCare—Separate State SCHIP**

Georgia established its SCHIP, called PeachCare, as a separate state program; PeachCare is not Medicaid. Children under 19 years of age who are ineligible for RSM and have incomes below 235 percent of FPL can be eligible for PeachCare. Parents pay \$7.50 per child per month in premiums. A private firm, Dental Health Administration and Consulting Services (DHACS), administers the program. Prospect Associates has a contract with DCH to conduct an extensive advertising campaign. The application and redetermination process is completed by mail. While the Georgia legislature did not want to make PeachCare an entitlement program, it did make PeachCare comparable to Medicaid in terms of benefits.

## **3. Food Stamp Program**

Unlike the Medicaid program, the federal government determines nationwide eligibility criteria for the Food Stamp Program. In general, eligible households must have a gross income of less than 130 percent of FPL, demonstrate a net income of less than 100 percent of FPL and no more than \$2,000 in assets, and meet other procedural requirements. States can, however, determine their certification periods (i.e., the length of time a household can receive food stamps before it must reapply). States can also determine the type of reporting that is required during the certification periods.

For families/households with earned and/or fluctuating income, Georgia uses a 3-month certification period with change reporting. In other words, families must reapply for food stamps during a face-to-face interview every 3 months and, for the preceding three months, report all changes in income greater than \$25 as well as all changes in circumstances. For households with more stable income (e.g., disability benefits), certification periods range from 6 to 12 months.

In four of the last five years, Georgia has been sanctioned for its food stamp error rate. As a result, state officials have been extremely concerned about food stamp quality control procedures and less focused on policies designed to increase participation in the program. Given the emphasis on the error rate, one state official noted that “in each case where the state had flexibility, it took the most restrictive path.” From June 1996 through June 2000, food stamp households declined by 28 percent. From June 2000 through July 2001, however, food stamp households increased by about 8 percent.

In view of the potential to increase program accuracy and participation through the simplification of program rules, state officials have recently started to think about adopting changes in food stamp regulations. At the time of the site visit (February 2001), the state was considering (1) a request for a change reporting waiver from the Food and Nutrition Service (FNS) that would increase from \$25 to \$100 the change amount that must be reported and (2) implementation of the new six-month reporting option offered by FNS. In November 2001, FNS informed state officials that it had approved the state’s request to implement the six-month reporting option; state officials planned to implement the change by March 2002.

#### **D. STRUCTURE AND OPERATION OF THE DEKALB COUNTY DFCS OFFICE**

The DeKalb County DFCS office is organized into 10 teams of approximately 21 staff members, including two supervisors, two child care workers, two clerical workers, and 15 public benefits caseworkers. The team structure was established in 1997 for several purposes: (1) to create a more manageable staff structure; (2) to provide a vehicle for some limited specialization, e.g., two teams handle cases involving, respectively, immigrants and elderly/blind/disabled (ABD); and (3) to create a more manageable environment and “home” for clients who would always be assigned to workers on their team. County DFCS workers described the team approach as a “big improvement” over the past organizational structure because it permitted more effective service delivery. It is important to note that because Georgia counties can choose how to organize their county DFCS office, the description of the DeKalb County DFCS office should not be understood to suggest how other county DFCS offices are structured.

Caseworkers on the teams are not categorized by intake and ongoing functions or by specialty area. While caseworkers are generally viewed as generic workers, they include four types of staff: (1) workers responsible for prescreening clients; (2) program associates who handle relatively simple Medicaid cases; (3) Family Independence Case Managers I (FICM I) who handle food stamp and Medicaid cases for clients not enrolled in TANF; and (4) Family Independence Case Managers II (FICM II) who handle TANF clients, including their food stamp and Medicaid cases. The foregoing description of staff types is ordered from least to most senior.

Public benefits application procedures require the applicant to check in with the front-desk receptionist, who checks SUCCESS (the state's automated information system) to see whether the applicant has an open case. In the instance of an open case, the client is sent to his or her current team's waiting area; in the case of no existing case, the new applicant is assigned in rotation to a team. In the team waiting area, the applicant completes a four- to six-page generic application and is screened by a designated caseworker for potential eligibility for expedited food stamps. The applicant has an intake interview with a program associate, FICM I, or FICM II depending on the benefits requested and/or potential eligibility for RSM, food stamps and Medicaid, or TANF, respectively; in general, the caseworker who conducts the interview will also manage the ongoing case. As the client's program eligibility changes, the client may be reassigned to a different worker. For example, when a client leaves TANF, his or her food stamp and Medicaid cases are transferred from an FICM II worker to an FICM I worker.

**SUCCESS—Georgia's Automated Eligibility and Management Information System.** Georgia began installing SUCCESS (i.e., System for the Uniform Calculation and Consolidation of Economic Support Services) in 1998 and completed statewide implementation by February 1999. SUCCESS is described as a fully automated interactive system with the following features: (1) provides a single system for eligibility determinations and case management for all public benefits; (2) requires no paper application, thereby permitting caseworkers to enter application information directly into the system; (3) presents an interactive system program to prompt workers to provide complete and correct information for all programs; (4) automatically calculates eligibility based on information entered; (5) cascades/trickles through benefits programs to find an optimum match with client's eligibility information (i.e., best-case-scenario hierarchy); (6) can incorporate policy changes into the eligibility program; and (7) facilitates linkages to other databases that the eligibility worker can use to verify client information, including the Department of Labor, W-4/new hires, and the Social Security Administration.<sup>6</sup>

County DFCS staff reported generally positive experiences with SUCCESS, noting that the relatively new system (1) allows caseworkers to manage all of their clients' cases more effectively; (2) automatically makes a change in all of a client's cases when a change is made in one case; and (3) alerts caseworkers to any changes made in their clients' cases by another caseworker. County staff also acknowledged that many caseworkers erroneously perceived that SUCCESS requires much more work than a paper-based system because of the need to key in a considerable volume of information. In addition, the system generates more information than the caseworkers can sometimes handle.

The introduction of SUCCESS reportedly prompted some counties to shift from caseworkers specialized by program to caseworkers who can handle all programs. Staff turnover and shortages have also motivated counties to move from intake and ongoing caseworkers to generic caseworkers who can handle all cases from start to finish. County DFCS officials expected that the shift to generic workers would be feasible because SUCCESS would expedite case management and integrate information from the Food Stamp, TANF, and Medicaid programs.

---

<sup>6</sup> In 10 counties, a small number of caseworkers can access the Department of Motor Vehicles database through SUCCESS to verify motor vehicle information.

## II. FINDINGS

### A. PROMISING PRACTICE: RSM INITIATIVE DESIGNED TO PROMOTE PARTICIPATION IN MEDICAID FOR PREGNANT WOMEN AND CHILDREN

#### 1. RSM Created in Response to Georgia's High Infant Mortality Rate

In response to the publicity surrounding Georgia's inordinately high infant mortality rate (i.e., in 1990, Georgia recorded the second-highest infant mortality rate in the United States), state officials and legislators initiated the Right from the Start Medicaid Outreach Project in January 1993. The goal of the project was to increase the enrollment of low-income pregnant women and children in the poverty-level expansion of Medicaid programs that provided coverage for pregnant women and children at higher levels than family coverage.

The clearly stated mission/vision of the RSM Project is to identify and enroll pregnant women and children in Medicaid, and to do so at increasingly higher levels. RSM works toward its goal by promoting an aggressive outreach and enrollment campaign. The expected outcomes of expanded enrollment include improved access to prenatal and health care services, thereby lowering the infant mortality rate. The GDHR administers the RSM Outreach Project as part of its interagency agreement with GDCH; the agreement delegates administration of the Medicaid program to GDHR. Originally funded for three years, the RSM Outreach Project has continued for an additional five years.

#### 2. RSM Project Structure and Staff: State Employees Located in the Community Instead of in County DFCS Offices

A major element of the RSM Project structure is that all RSM staff are state employees who are supervised by and accountable to GDHR staff. The RSM program director reports to the director of the Economic Support Services Section in the Division of Family and Children Services within GDHR. This structure provides the basis for more stable and consistent program administration as the potential for substantial variation resulting from county administration is acknowledged by state officials.

RSM program staff include a director, 4 managers, 20 supervisors, and 143 RSM outreach workers (i.e., caseworkers). RSM outreach workers are organized into 20 teams responsible for covering Georgia's 159 counties. Each team typically ranges in size from five to nine outreach workers, and each has a supervisor and administrative support. As of 1999, one team specializes in assisting families that have applied for PeachCare and were determined eligible for RSM. Another specialty team, known as the floater team, assists the other 18 RSM teams around the state as needed. Given the ethnic diversity of RSM clients, the project employs 11 bilingual staff members, including nine Spanish-speakers.

Many RSM workers are former county DFCS caseworkers who have knowledge of both Medicaid program rules and the procedures followed by the county DFCS offices. Workers are hired to conduct outreach in the communities in which they live. Accordingly, they know where

to locate potential clients and how to use community resources to best advantage. Most RSM workers are well integrated into their communities; many are already involved with local agencies and task forces.

### **3. RSM Program Operation—Emphasis on Creative Ongoing Community Outreach**

RSM program operation is designed to ensure a community-based focus on outreach and enrollment and to make certain that RSM workers are easily accessible to potential applicants. RSM workers are placed in the community rather than in county DFCS offices. Because the RSM program budget has limited funds for rent, RSM workers establish enrollment sites wherever they can find inexpensive but appropriate accommodations in the community. Most workers establish enrollment sites in health departments (45 percent) and hospitals or medical centers (32 percent). Another 10 percent locate enrollment sites in government buildings. The remaining RSM workers are housed in schools, churches, and other agencies.

RSM workers are required to conduct outreach and to process Medicaid applications during eight nontraditional hours per week (i.e., outside 8:00 a.m. and 5:00 p.m. Monday through Friday, including Saturdays and Sundays). To ensure further that RSM workers have the time to focus on outreach activities, they do not maintain a Medicaid caseload. Within 30 days of determining a client eligible for Medicaid, the RSM worker transfers the client's case to the county DFCS offices.<sup>7</sup>

RSM workers are expected to take the initiative to create outreach events to educate potential clients about RSM. Presentations and outreach events occur in places frequented by potential clients, such as hospitals, health departments, churches, and departments of labor. RSM workers also make presentations to organizations that can assist in identifying persons who may be eligible for Medicaid. Such organizations include community groups, medical providers, schools, and employers. Each RSM worker is required to make 48 presentations per year, including presentations at 12 major events, which are defined as events that bring together 30 or more people. Major events can include health fairs, community yard sales, the local Kmart, arts festivals, PTA meetings, holiday events, and county fairs. RSM staff gave 8,225 presentations during FY 1999-2000.

Each RSM worker sets his or her individual outreach goals. Goals can vary by county and by the worker's particular circumstances in his or her outreach area. The worker's team supervisor discusses and evaluates the goals. RSM workers enjoy substantial flexibility in designing their outreach activities. Such activities include (1) providing literature and applications at job sites; (2) attaching brochures to paychecks; (3) certifying employees for

---

<sup>7</sup> Although RSM workers sometimes also assist clients in applying for other benefits such as food stamps and Medicaid for low-income families, these workers can determine eligibility for and enroll clients only in Medicaid for pregnant women and children. RSM workers must refer applicants to the county DFCS office for eligibility determinations for other benefits. At the time of the site visit, however, the RSM program director expected that the authority to enroll families in 1931 Medicaid might be granted to RSM workers.

Medicaid at local chicken processing plants; (4) distributing bookmarks that promote RSM; and (5) coordinating with schools to allow literature about the project to be sent home with report cards. The development of RSM outreach initiatives was described by RSM senior staff as coming from the “bottom up and from the top down,” meaning that administrative staff, outreach workers, and caseworkers constantly communicate with one another and share ideas. A quarterly RSM report and bimonthly newsletter describe past and upcoming outreach events and ideas. Within teams, workers are in constant communication with each other and their team supervisor about new ideas and each other’s achievements.

Each RSM worker receives \$100 per month to cover travel, printing fees, and any other costs associated with the worker’s outreach activities. In view of the project’s limited budget, the ability of RSM workers to form collaborative arrangements within the community and thus solicit donations and recruit volunteers is a major factor in the success of RSM outreach and enrollment efforts.

RSM project staff attend a yearly conference that offers training in a variety of areas, including policy, programs, and practice. In addition, each RSM worker receives training in any updates to the SUCCESS system.

#### **4. RSM Project Intake and Enrollment**

We visited two RSM enrollment sites in DeKalb and Rockdale counties to observe the RSM intake and enrollment procedures. The two sites were located, respectively, in a residential building in a housing building and a public health clinic operated by the county. At both enrollment sites, each RSM worker has a computer and access to the SUCCESS system. Applications taken in the office or at enrollment sites are entered directly into SUCCESS. Applications are taken by hand with a simple two-page application at outreach events and then entered into SUCCESS at the enrollment sites. SUCCESS is programmed to bring up only those screens needed to determine RSM eligibility.

An RSM applicant must provide information about income and family size and verify pregnancy (when appropriate), alien status, and “anything that looks questionable” in the opinion of the RSM worker. To verify pregnancy, the applicant needs documentation from a medical provider either in writing or over the telephone. The applicant signs a form stating that he or she is a U.S. citizen and then must provide his or her social security number or verify his or her residency status with documentation from the Immigration and Naturalization Service. The “anything that looks questionable” verification category covers instances when a client reports employment or income that does not match with information in the employment and income databases available to the worker through SUCCESS. For example, even though income is self-reported, if the Unemployment Insurance (UI) wage data show a higher-than-usual income that went unreported by a client in the last quarter, the RSM worker may ask that client to produce pay stubs to verify current income.

Once an RSM worker has completed the intake process in SUCCESS, he or she knows whether the client is eligible for RSM. The client receives an approval letter and a Medicaid card by mail within a few days. The RSM worker can also issue a “temporary” Medicaid card on the day the case becomes active if the client is in need of immediate medical treatment. The

supervisor of each outreach team is responsible for quality control. Supervisors typically review a sample of cases each month to determine whether the necessary verifications have been obtained from the client. Within 30 days, the RSM case is transferred manually and electronically via SUCCESS to the county DFCS office.

Although individuals do not have to go to the county DFCS office to enroll in RSM, they do have to visit the office for eligibility redeterminations and ongoing case management. Recertification interviews are conducted twice a year—once in person at the county DFCS office and once by mail. According to one RSM worker, his clients’ dislike of visiting the county DFCS office is so intense that some clients allow their RSM case to close so that the caseworker can reopen it and the clients themselves can avoid a trip to the DFCS office. When asked whether the RSM program should take on the additional responsibility of maintaining RSM cases, RSM senior staff responded that the assumption of additional responsibility would detract from the simplicity and effectiveness of RSM’s mission (i.e., to identify and certify/enroll RSM eligibles).

RSM workers reported few problems in working with SUCCESS and noted that they received adequate initial and ongoing training in Medicaid policies and procedures. These same workers did note an occasional desire to know “what happened” to their RSM clients, particularly if the clients dropped off the rolls and then re-enrolled at other locations. Continuing unresolved concerns involve occasional problems with transferring a case through SUCCESS to the county and the inability of RSM workers to open RSM cases in SUCCESS in more than one county. Although RSM workers also pointed to the occasional instance of a lack of cooperation on the part of their colleagues in the county DFCS office, they were generally satisfied with the communication and collaboration with county DFCS staff.

## 5. RSM Project Performance Linked to RSM Outreach and Staff Attributes

Between 1993 and 2000, RSM workers took 431,073 applications; in fact, the number of applications processed by RSM workers has increased every year (see table below). RSM workers recently have started to track the number of approved RSM applications relative to the number of applications filed. Of the 109,793 applications taken in FY 2000, 73,077 were approved (80 percent). Application approval rates were 70 percent for FY 1997, 84 percent for FY 1998, and 81 percent for FY 1999. Since June 1996, the RSM caseload has increased by 16 percent.

RSM Approved Applications					Percent Change			
1996	1997	1998	1999	2000	1986-97	1997-98	1998-99	1999-2000
37,234	45,004	49,821	52,804	73,077	17%	10%	6%	28%

It is difficult, however, to say how much of the increased enrollment in RSM Medicaid is attributable to the expanded eligibility for pregnant women and children and how much is the

result of the RSM Project's outreach efforts.<sup>8</sup> State officials noted, however, that much of the substantial growth occurred during the early 1990s following program inception. State reports describing enrollment in the Medicaid program during 1990 to 2000 attribute RSM's overall growth almost entirely to federally mandated expansions. On the other hand, the concerted efforts of the RSM staff to promote RSM Medicaid coverage and to expedite the application process have no doubt contributed to a significant increase in enrollment among pregnant women and children.

Focus group participants were extremely positive about the RSM Project and indicated that it was much easier to apply for Medicaid through RSM workers rather than through the county DFCS office. Focus group participants singled out one RSM worker as "very helpful," "sweet," "nice," "fabulous," "professional," and somebody who "loves to do his job well." In fact, focus group participants indicated that they had told friends and neighbors about him. The RSM worker in question does not schedule appointments; rather, he sees client on a walk-in basis. His supervisor reported that he is the most productive of her outreach workers and enrolls approximately 200 pregnant women and children in RSM Medicaid each month.

The RSM workers we met during the site visit radiated energy and enthusiasm. When asked what they liked about the RSM Project, the workers listed the following: (1) a customer service orientation, (2) the simplicity of their mission, (3) the opportunity to be creative and flexible, (4) access to the RSM project director, (5) the nontraditional work hours, (6) the positive attitude of coworkers, and (7) the cooperation of the lead agencies. The RSM program reportedly has substantially lower staff turnover rates than many of the county DFCS offices (i.e., 15 versus 50 percent). RSM workers and supervisors attribute staff retention to their ability to be creative and flexible as well as to the camaraderie and support of other workers.

We found that all levels of state and county staff continue to view the RSM Project favorably. At the same time, clients experience the program as highly accessible. The emphasis on self-initiated and flexible outreach strategies tailored to the particular needs of communities is a major element of program success. It is not surprising that state officials are considering use of the RSM Project outreach approach to expand enrollment in LIM, although it is not clear whether additional resources will be available to supplement the RSM Project's already spare budget so that RSM workers can enroll families in LIM.

---

<sup>8</sup> Federal law enacted in 1990 required states to phase in, one year at a time, coverage of children up to 18 years of age with incomes up to 100 percent of FPL so that phase-in would be completed by 2002. Georgia accomplished most of its expansion in the early 1990s and, by May 1998, covered children up to age 18 with income up to 100 percent of FPL under Medicaid. As noted above, Georgia now covers pregnant women and children under one year of age with income up to 235 percent of FPL.

***PAGE IS INTENTIONALLY LEFT BLANK TO ALLOW FOR DOUBLE-SIDED COPYING***

### **III. CONCLUSIONS AND RECOMMENDATIONS**

Georgia state officials undertook an admittedly aggressive approach to welfare reform and achieved substantial reductions in the state's cash assistance caseload during the six years following the introduction of welfare reform. County officials understood that, for Georgia, the main priorities of welfare reform were a reduction in cash assistance enrollment and a reduction in the state's high food stamp error rate. Despite Georgia's emphasis on reducing participation in public benefits, the apparent legacy of the RSM Project, initiated a few years before the advent of national welfare reform, was the institutionalization of a policy and program focus on expanding the enrollment of pregnant women and children in Medicaid and thereby indirectly promoting the value of health insurance for families. The evident success of the RSM Project supported the growing awareness that continued participation in Medicaid for families leaving cash assistance meant continued health insurance coverage and access to care for low-income working families.

In this concluding section, we briefly review our findings, about the RSM Project, and provide a few policy and practice recommendations designed to promote participation in the programs.

#### **A. RSM OUTREACH PROJECT**

The Georgia site visit was primarily motivated by a desire to gain familiarity with the RSM Project as a promising practice in the area of increased and creative outreach efforts that had presumably resulted in expanded enrollment. The evidence indeed suggests that the RSM Project has succeeded in increasing enrollment for children in households at the poverty level and slightly above the poverty level and for pregnant women up to 235 percent of FPL.

Salient characteristics of the RSM Program include (1) a substantial presence in the community, (2) the opportunity to apply at several locations, (3) a simple application form with simple requirements, (4) minimal recertification requirements, and (5) aggressive outreach and community-based enrollment efforts. It is also important to remember that the RSM Project began in 1993, well before welfare reform, and that the target population does not receive the category of Medicaid (i.e., LIM or 1931 Medicaid) that was most affected by the changes (i.e., delinking) associated with welfare reform.

Nonetheless, the characteristics and practices of the RSM Project have been a catalyst for change in Georgia's overall Medicaid program. For example, RSM's reliance on the self-declaration of income shows little evidence of applicant fraud and thus provided the basis for permitting self-declaration of income for 1931 Medicaid applicants. State informants reported that the state is deciding whether to allow the RSM Project to handle outreach and enrollment for LIM applicants and that one of the conditions for expanding RSM is elimination of the asset test and vehicle test (i.e., effectively making the application process for LIM simpler while expanding program eligibility). State officials noted, however, that it was difficult to predict if and when the state might decide to introduce such changes.

**Recommendations for Improving the RSM Project.** Despite the apparent success of the RSM Project and the evident support for and popularity of the project among state officials and Georgia residents, areas recommended for improvement include (1) providing more funding to underwrite expanded outreach for RSM that would include outreach for other programs such as LIM; (2) addressing the problems with SUCCESS that prevent RSM workers from dealing with cases across counties as well as tracking referrals to other counties; (3) allowing RSM workers to assume responsibility for outreach and community-based enrollment for LIM; and (4) making the appropriate policy and resource decisions to support a decision to allow RSM workers to enroll LIM families.

Although many types of informants told us that clients and ongoing case management would benefit if RSM workers followed cases after client enrollment, the RSM director stated firmly that he does not want RSM workers engaged in monitoring and case management once a family or child is enrolled. He believes that the monitoring function would distract workers from successfully carrying out RSM's main mission, that is, to identify and to certify eligibility for all RSM eligibles.