

MEMORANDUM

To: Dan McCarthy  
HCFA

From: Fran Ellington, CHIP Coordinator  
Georgia Department of Medical Assistance

Re: CHIP State Plan

Date: August 16, 1998

Attached are the answers to the questions forwarded to us regarding Georgia's Child Health Insurance Plan.

Please let me know if there is any other information we can provide.

Thank you.

### Section 4.1.7

**How often will periodic checks of the DOL files and eligibility information occur? Who will conduct these checks?**

The application process is designed to be a self-declaration process. The checks of the state= Department of Labor files are designed to be a validation of client information, not verification of client information. The Department of Labor files will be checked at the time of initial application and at six month intervals thereafter. Any discrepancies found between the applicant/enrollee=s statement and the Labor file information that indicates the family has countable income greater than the CHIP income limit will be flagged. The client will be contacted and given the opportunity to provide information to resolve the discrepancy (pay stubs, employer statement etc). If the client is unable to resolve the discrepancy or affirms that the Labor information is correct, the child(ren) will be denied participation in the program due to family income in excess of the CHIP limit.

The Third Party Administrator will be responsible for checking the DOL files at application and at six month intervals.

### Section 4.3

**The state may not require a SS# as a condition of eligibility. How will the state obtain the documentation needed in order to verify eligibility if the applicant chooses not to provide their SS#?**

**Please provide an assurance that the Title XXI State plan will be conducted in compliance with all civil rights requirements. This assurance is necessary for all programs involving Federal financial assistance.**

While we are requesting that the applicant provide social security numbers for applicant children and their parents on the application. These will not be required fields. For applicants who do not have a social security number a Apsuedo@ number will be assigned for systems purposes.

Eligibility for the CHIP program is based on self-declaration of income. The client=s statement will be accepted as to source and amount of income. In questionable situations, the client may be asked to provide verification in the form of pay stubs or a written statement from the employer.

The CHIP program in Georgia will be conducted in compliance with Title VI of the Civil Rights Act of 1964, as amended. Title VI provides that no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving

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federal financial assistance.

**Section 9 - Strategic Objectives and Performance Goals for the Plan administration**

**Section 9.2 Please include measurable and time framed outcome terms for performance goals. For example, how does the State define an acceptable time frame - on or about - for measures related to immunization and well child screens? Can current baseline information be provided?**

We believe we have included measurable outcome terms for each performance goal. These outcomes are delineated for each objective as follows:

Objective 1 - Increase insurance coverage of Georgia's low-income children

**Measurable outcomes:**

- Percent of eligible children enrolled
- Enrollment motivations

Objective 2 - Increase the percentage of low-income children with a regular source of care.

**Measurable outcomes:**

- Percent of children who selected PCP or HMO at enrollment
- Percent of children who see the same provider for at least 75% of their visits
- Percent of enrollees who stay with their PCP one year

Objective 3 - Promote utilization of Health Check (EPSDT) services to achieve targets set by the Health Care Financing Administration and GBHC. These are 80% for screening and 90% for immunizations.

**Measurable outcomes:**

- Percent of enrolled children receiving each screening on or about the recommended schedule
- Percent of enrolled children receiving each immunization on or about the recommended schedule
- Percent of PCP panels with improved screening rates in subsequent years

Objective 4 - Decrease unnecessary use of emergency departments for non-emergency services. A non-emergency service is one that does not meet the prudent layperson definition of emergency.

**Measurable outcomes:**

- Rate of non-emergency ED visits per year for the population enrolled
- Number of repeat ED visits by the same child and by the same family
- Rate of ED visits per 100 patients
- Rate of ED referral by provider

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Rate of ED referral by provider for the same child for the same condition

Objective 5 - Reduce preventable hospitalizations

**Measurable outcomes:**

Number of preventable hospitalizations, based on an existing screening methodology  
Percent of PCPs showing improvement in preventable hospitalization rates in subsequent years

Objective 6 - Promote the appropriate use of health care services by children with asthma (as defined by standards of the National Heart Lung and Blood Institute of the National Institutes of Health).

**Measurable outcomes:**

Percent of children seeing PCP within two weeks of ER or hospital visit  
Percent of children receiving drug regimen consistent with national guidelines  
Percent of children for whom appropriate asthma management tools (such as nebulizers, spacers, and mattress bags etc) are prescribed  
Percent of children and parents receiving education  
Percent of parents responding to a survey who say they are reasonably confident they know how to care for their child with asthma  
Percent of PCPs whose performance on above indicators improves in subsequent years.

As noted above, for immunization the target is 90% and for screening the target is 80%. Both activities are a part of EPSDT (Early and Periodic Screening Diagnosis and Treatment) and follow the HCFA approved schedule for these activities.

We have set up specific timeframes for:

Objective 1 - Percent of children enrolled:

By the end of the second year, enroll 60 percent of uninsured, non Medicaid-eligible children with family income below 200 percent of poverty in the new program

Objective 5 - Reduce preventable hospitalizations

Reduce preventable hospitalizations in the second year of the program  
Percent of PCPs showing improvement in preventable hospitalizations rates in subsequent years

Objective 6 - Assess the number of children whose asthma is managed through appropriate outpatient care

Percent of PCPs whose performance on above indicators

improves in subsequent years

For other measures the timeframes for measuring impact will depend on how long it takes before we have enough children enrolled for a sufficient duration that they will be receiving primary preventive care (especially screening and immunizations). The earliest utilization may be sick care. Some children may cycle in and out of the program depending on when the family can afford the premiums. We would want to measure outcomes at the earliest point at which it would yield data. The latest point at which we would measure outcomes is starting March 2000, at which point we will have claims data for all of 1999. Only about 5,000 children are expected to have had coverage for all of 1999. About 30,000 children may have been enrolled six months.

Other measures could be measured earlier than March 2000. We've attached a chart giving anticipated time frames. (Attachment 1)

We also have not included target levels for most of our measures because we have no baseline data. PeachCare children will not have been insured previously, so we have no record of their baseline utilization. We will be measuring baseline utilization for a similar population of Medicaid children. We won't have data on this comparison group until April 1999, because we intend to look at 1998 as the baseline year. For some of our measures, we have indicated we will look at the second year of data relative to the first.

#### Section 9.9

The plan states that the American Academy of Pediatrics schedule for screening will be covered, but does not specify which immunizations will be covered. Will the State follow the ACIP guidelines for vaccinations?

The state will follow the American Academy of Pediatrics and EPSDT guidelines for immunizations. We will measure access to all immunizations recommended for children ages 0 through 18.

#### Section 9.10

The correct FMAP rates to be used in the calculations are **72.59%** for FY 98 and **72.33%** for FY 99. Please revise your budget to reflect these rates.

Please provide a more detailed budget, including a breakdown of administrative expenditures, as well as budgets for FYs **2000** and **2001**.

Please provide an assurance confirming our understanding that the origin of the general fund revenues used to fund the non-Federal share of these plan expenditures is not based on a provider tax(es) or donation(s).

Our budget figures have been revised to reflect the correct match rates.

The chart below provides a detailed budget for the program and includes a breakdown of administrative expenditures.

**Title XXI Budget**

<b>Object Class</b>	<b>FY 99</b>	<b>FY00</b>	<b>FY01</b>
<b>Personal Services</b>	\$ 410,607	\$ 544,178	\$ 555,138
<b>Regular Operating Expense</b>	\$ 407,634	\$ 153,528	\$ 158,715
<b>Travel</b>	\$ 50,000	\$ 63,835	\$ 63,835
<b>Equipment</b>	\$ 12,000	0	0
<b>Per Diem, Fees &amp; Contracts (Includes Marketing and TPA contractors)</b>	\$ 824,84	\$ 6,286,466	\$ 6,286,466
<b>Computer</b>	\$ 271,700	\$ 319,175	\$ 319,175
<b>Telecommunications</b>	\$ 14,950	\$ 15,767	\$ 15,767
<b>Total Administrative</b>	\$ 1,991,732	\$ 7,382,949	\$ 7,399,096
<b>Title XXI Benefit costs</b>	\$17,925,586	\$52,045,544	\$61,315,235
<b>Total Costs</b>	\$19,917,318	\$57,828,382	\$68,128,038
<b>Federal Funds XXI</b>	\$14,406,196	\$41,827,269	\$49,277,010
<b>State Funds</b>	\$ 5,511,122	\$16,001,113	\$18,851,028
<b>Total</b>	\$19,917,318	\$57,828,382	\$68,128,038

Assurance: The origin of the general fund revenues used to fund the non-federal share of these plan expenditures is not based on a provider tax(es) or donation(s).

## Attachment 1

Measure	Time Frame to be Measured	Proposed Date of Measurement
1.1 Percent of eligible children enrolled	Measure each quarter. Goal is 60% by end of year two	Begin 4/1/99. Measure against goal on 4/1/01
1.2 Learn what motivated enrollment and apply to further marketing and outreach	Need time for marketing efforts to reach people	July 1999
2.1 Percent of children who selected PCP or HMO on enrollment	Measure each quarter. Goal is continuous improvement. No target available	Begin 4/1/99
2.2 Percent of children who see the same PCP for at least 75% of their visits	Measure annually	Begin 4/1/00
2.3 Percent of enrollees who stay with their PCP at least one year	Measure annually	Begin 4/1/00
3.1 Percent of children receiving each EPSDT screening on or about recommended schedule	Measure annually	Begin 4/1/00
Percent of children immunized on or about recommended schedule	Measure annually	Begin 4/1/00
3.3 Percent of PCP panels with improved EPSDT rates in subsequent years	Measure annually	Begin 4/1/01
4.1 Rate of non-emergency ED visits by same child/same family	Measure annually	Begin 4/1/00
4.2 Rate of ED visits per 100 patients for a PCP panel	Measure annually	Begin 4/1/00
4.3 Rate of ED referral by provider for the same child for the same condition	Measure annually	Begin 4/1/00
Number of preventable hospitalizations (PH)	Measure annually	Begin 4/1/00
5.2 Percent of PCPs showing improvement in PH rate in subsequent years	Measure annually	Begin 4/1/01

Measure	Time Frame to be Measured	Proposed Date of Measurement
<p><b>6.1</b> For children with asthma: Percent of children seeing PCP within 2 weeks of ER or hospital visit. Percent of children receiving correct drug regimen. Percent of children and parents receiving education. Percent of parents confident about managing asthma.</p>	Measure annually	Begin 4/1/01
<p>6.2 Percent of PCPs whose performance on asthma indicators improves in subsequent years</p>	Measured annually	Begin 4/1/01