State: Georgia

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Georgia enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

____ i. MCO
_X__ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

____i. fee for service;
____ii. capitation;
_X__iii. a case management fee;
_X__iv. a bonus/incentive payment;
____ v. a supplemental payment, or
____vi. other. (Please provide a description below).

1905(t)
42 CFR 440.168

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's

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42 CFR 438.6(c)(5)(iii)(iv)	case management fee, if certain conditions are met. If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). __X__i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. __X__ii. Incentives will be based upon specific activities and targets. __X__iii. Incentives will be based upon a fixed period of time. __X__iv. Incentives will not be renewed automatically. __X__v. Incentives will be made available to both public and private PCCMs. __X__vi. Incentives will not be conditioned on intergovernmental transfer agreements. ____vii. Not applicable to this 1932 state plan amendment.

Citation		Condition or Requirement
CFR 438.50(b)(4)	4.	Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* Beginning in 2011, DCH conducted a very inclusive and transparent process in analyzing redesign options and designing the program specific to youth in foster care, juvenile justice and adoption assistance. DCH and its Agent facilitated public input through statewide stakeholder focus groups, two public hearings an online survey and task forces. DCH also allowed for submission of comments through a "My Opinion" Mailbox. Beginning in February 2012, DCH convened three external task forces (Provider, Children and Families and "ABD" task forces) and a Mental Health and Substance Abuse Workgroup to provide input into program design which will continue through and after implementation as needed. Information collected during these task forces has helped to define the program design. Examples of additional methods that DCH will employ to continue collecting public input during and after implementation are as follows: • Inclusion of stakeholders such as providers, members and advocates on an as needed basis • Requirement for the vendor to identify and work with DCH to resolve issues pertaining to access to health care services, to communicate and educate members, providers and caregivers and to regularly report findings to the Medicaid Agency • Inclusion of related topics in the agenda for the Medical Care Advisory Committee on an as needed basis
1932(a)(1)(A)	5.	The state plan program will___/will not_X__ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary__X___ enrollment will be implemented in the following county/area(s): i. county/counties (mandatory) _____ ii. county/counties (voluntary) Statewide_____X_____

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iii. area/areas (mandatory)_____

iv. area/areas (voluntary) Statewide_____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. ____The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

Not applicable.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. __X__The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. ____The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.

Not applicable.

1932(a)(1)(A
42 CFR 431.51
1905(a)(4)(C)

4. __X__The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.

1932(a)(1)(A)
42 CFR 438
42 CFR 438.50(c)(4)
1903(m)

5. __X__The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.

1932(a)(1)(A)
42 CFR 438.6(c)
42 CFR 438.50(c)(6)

6. ____The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.

Citation	Condition or Requirement
	Not applicable.
1932(a)(1)(A) for 42 CFR 447.362 42 CFR 438.50(c)(6)	7. __X__The state assures that all applicable requirements of 42 CFR 447.362 payments under any nonrisk contracts will be met.
45 CFR 74.40	8. __X__The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D. Eligible groups
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis. There will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services**.**
	2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.
1932(a)(2)(B) 42 CFR 438(d)(1)	i. _X___Recipients who are also eligible for Medicare. There will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services. If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. ____Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a

Citation	Condition or Requirement
	contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. _X___Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. _X___Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 438.50(3)(iii)	v. ____Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. ____Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. _X__Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

Children receiving services funded by Title V are enrolled in the Children's Medical Services Program administered by the Georgia Division of Public Health. This program provides comprehensive, coordinated, community-based, Title V services for children birth to age 21 with chronic medical conditions. Medical eligibility includes but is not limited to:

a. Burns
b. Cardiac conditions
c. Cystic fibrosis
d. Hearing disorders
e. Spina bifida

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f. Cerebral palsy
g. Diabetes mellitus
h. Vision disorders
i. Craniofacial anomalies (including cleft lip/palate)
j. Gastrointestinal disorders
k. Neurological and neurosurgical conditions including epilepsy and hydrocephalus
l. Orthopedic and/or neuromuscular disorders (scoliosis)
m. Congenital or traumatic amputations of limbs

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

____i. program participation,
____ii. special health care needs, or
_X__iii. both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

_X__i. yes
____ii. no

1932(a)(2)
42 CFR 438.50 (d)

4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self-identification)*

Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.

i. Children under 19 years of age who are eligible for SSI under title XVI;

Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.

Citation	Condition or Requirement
	ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.
	iii. Children under 19 years of age who are in foster care or other out-of-home placement; Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.
	iv. Children under 19 years of age who are receiving foster care or adoption assistance. Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)*

Citation	Condition or Requirement

Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.

i. Recipients who are also eligible for Medicare.

Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.

ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.

42 CFR 438.50 F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

Not applicable as there will not be mandatory enrollment into the program. Additionally, members who are identified to receive intensive medical coordination may decline to receive, or opt out, of services.

42 CFR 438.50 G. List all other eligible groups who will be permitted to enroll on a voluntary basis

- SSI
- Public Laws
- Institutionalized (Nursing facility, inpatient hospice, long-term hospital, etc.)
- Home and Community Based Waiver
- Deeming Waiver
- Medically Needy

Citation	Condition or Requirement

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.i).

All members will receive provider services through the fee-for-service delivery system and so existing provider-recipient relationships may continue at the member's option.

Members identified to receive intensive medical coordination services will be formally assigned to a medical home. Members may voluntarily select or the vendor may assign members to a medical home. The vendor will determine if the member has a primary source of care that is participating in the Medical Coordination Program, and if so, assign the member to that provider.

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

The provider networks for Medicaid members are limited to Medicaid-participating providers.

iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4));

Citation	Condition or Requirement
	and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)* DCH is contracting with one vendor to provide services to eligible populations. All members will have access to a minimum set of general coordination services and be subject to predictive modeling and other analyses by the vendor to identify the need for intensive medical coordination services. Members identified by the vendor as high-risk and impactable will be eligible to receive intensive medical coordination services. The vendor must have a process for individuals to decline to receive, or opt out of, Intensive Medical Coordination services.
1932(a)(4) 42 CFR 438.50	3. As part of the state's discussion on the default enrollment process, include the following information: i. The state will____/will not__X__ use a lock-in for managed care. ii. The time frame for recipients to choose a health plan before being auto-assigned will be_____. Medical Coordination program services will be available to Medicaid members in the fee-for-service delivery system at the time that they are determined eligible under an aged, blind and disabled eligibility category. The vendor will conduct regular analyses to identify eligible members who may be in need of intensive medical coordination services, and contact those members to enroll in those services. The vendor must have a process for individuals to decline to receive, or opt out of, Intensive Medical Coordination services. iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)* DCH has a process in place to mail notification to the member of the availability of services the vendor will provide. iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the

Citation | Condition or Requirement

first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

Not applicable.

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

Not applicable.

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

Not applicable.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. X The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. ____The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

Not applicable.

3. ____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

_X_This provision is not applicable to this 1932 State Plan Amendment.

Citation	Condition or Requirement

4. ____The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

_X_ This provision is not applicable to this 1932 State Plan Amendment.

5. __X_ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

___This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will___/will not_X__ use lock-in for managed care.

2. The lock-in will apply for ____ months (up to 12 months).

Not applicable.

3. Place a check mark to affirm state compliance.

_X_The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

Members may opt out of receiving intensive care management services at any time for any reason.

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

_X___The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

Citation		Condition or Requirement
1932(a)(5)(D) 1905(t)	L.	List all services that are excluded for each model (MCO & PCCM) Services will continue to be provided through the fee-for-service delivery system.
1932 (a)(1)(A)(ii)	M.	Selective contracting under a 1932 state plan option To respond to items #1 and #2, place a check mark. The third item requires a brief narrative. 1. The state will__X___/will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option. 2. ___X__ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services. 3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)* DCH has elected to contract with a single vendor that has targeted expertise to effectively provide intensive medical coordination for members who are aged, blind and disabled and have unique and complex health care needs. This program is meant to provide additional coordination to meet the needs of eligible members who remain in the fee-for-service delivery system, and DCH believes that one vendor is sufficient to meet the requirements of the contract and the population being served. 4. ____ The selective contracting provision in not applicable to this state plan.