CARE-M Gap Analysis: Medicaid Managed Care Transition for ABD Population and Recommendations Regarding ABD Population State Plan Amendment Released by DCH October 10, 2013

SPA = State Plan Amendment

Y = specific task force recommendation adequately reflected in proposal

N = specific recommendation not adequately reflected in proposal

P = specific recommendation partially reflected in proposal

Note: Any references to federal legislation and regulations cited in SPA are italicized.

Task Force and Work Group Recommendations	**Included in SPA?** SPA Citation	**Comment**
Overarching CARE-M Goals for Medicaid Redesign		
1. The first priority is to revise and incorporate innovations into the health care delivery system for those who are currently managed by CMOs	**P** SPA Condition H.3.ii SPA Condition G	SPA does not give priority to incorporating innovations into current CMO delivery systems but will extend voluntary enrollment to those currently served by CMOs. SPA will bring ABD members not currently under managed care under a PCCM contract. Additionally, those currently in managed care who will be eligible to enroll in the Medical Coordination Program on a voluntary basis include: SSI, Public Laws, Institutionalized (nursing home, inpatient hospice, long-term hospital, etc), Home and Community Based Waiver, Deeming Waiver, and Medically Needy.
2. Phase in care management of populations in ABD who are not currently managed	**Y** SPA Condition H.3.ii	DCH will make its Medical Coordination Program services available to ABD eligible members currently in the fee-for-service system.
3. Delay requiring that the new contract manage the care for ABD participants in nursing homes and those Medicaid waiver participants that already have care coordination services	**N** SPA Condition G	Populations in nursing homes and waiver participants under managed care will be eligible for *voluntary* enrollment under the new contract. There is no specificity regarding the timeframe for enrollment of populations currently in managed care versus those in fee-for-service.
4. If the decision is made to include LTSS in managed care, the State should improve overall service and care coordination for those people receiving LTSS services and shift the focus	**P** SPA Condition H.2.i SPA Condition H.2.iii	SPA does not specify that it will bring any new services under managed care but will provide general coordination services for all members and intensive coordination services for

	and funding from institutional care to home and community based services. This should be done using one managed care entity.		members who qualify. This will be done using one contracted vendor.
A. Cross-Cutting Issues for All Medicaid Members in Managed Care			
1. State Oversight and Accountability	DCH must build and maintain adequate staff capacity and expertise at the state level to implement the plan, oversee operations, and diligently enforce contract requirements	**Y** SPA Condition C.5	*SPA Condition C.5 assures that all relevant requirements in 42 CFR Part 438 for PCCMs will be met. 42 CFR 438.1 on Basis and Scope cites that under Section 1902(a)(4) of SSA, the State must provide methods of administration for the proper and efficient operation of the plan*.
2. Medicaid Redesign Vehicle	CARE-M expected a Section 1115 waiver or a 1915(b)/1915(c) combination waiver.	**N** SPA Condition A	*DCH release is a State Plan Amendment granted under the authority of section 1932(a)(1)(A) of SSA.*
3. Stakeholder Participation	Each population included in the new contract must be fully engaged in designing, implementing, and monitoring the outcomes and effectiveness of the managed care program.	**P** SPA Condition B.4	SPA cites activities beginning in 2011 (statewide stakeholder focus groups, two public hearings, an online survey, and a "My Opinion" Mailbox) as well as 2012 activities (the convening of the ABD, Children & Families, and Provider Task Forces and the Mental Health and Substance Abuse Workgroup) as what composed the public process for program design. For roll-out and continued implementation, the inclusion of stakeholders and inclusion of Amendment-related topics in the agenda of the Medical Care Advisory Committee are cited as examples of methods that DCH will employ on an as-needed basis. Note: There are no assurances that there will be permanent public involvement after SPA approval in design or implementation.
	Each population included in managed care must be empowered to bring issues occurring in care delivery forward to the attention of the managed care entities and the Department of Community Health	**Y** SPA Condition C.5	*SPA Condition C.5 assures that all relevant requirements in 42 CFR Part 438 for PCCMs will be met. 42 CFR 438.400(a)(1) on Grievance Systems requires compliance under Section 1902(a)(3) of the SSA that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.* *Note: PCCM contracts are not subject to many of the requirements for grievance systems that specifically address*

			MCO and PIHP contracts in 42 CFR 438 Subpart F.
	Stakeholders need access to performance data to measure progress on established benchmarks.	**N**	SPA does not contain assurances that quality assessment and performance improvement systems will be in place, nor does it refer to federal regulations requiring quality assessment and performance improvement systems of PCCM contracts. *Note: SPA Condition C.5 assures that all relevant requirements in 42 CFR Part 438 for PCCMs will be met. 42 CFR 438 Parts D and E list requirements for Quality Assessment and External Quality Review for MCO and PIHP contracts. Language does not specify that above requirements apply to PCCM contracts.*
	Task Forces should continue to be involved in the implementation process.	**P** SPA Condition B.4	SPA states that the three external task forces and the Mental Health and Substance Abuse Workgroup will continue to provide input "through and after implementation as needed." Note: There are no assurances that there will be standing advisory groups that guarantee continued public involvement in design after SPA approval or implementation.
	Consumers should be represented through continued implementation by standing advisory groups at both the state and local level.	**N** SPA Condition B.4	SPA does not reflect that it will create standing advisory groups. SPA assures that it will collect public input during and after implementation from providers, members, and advocates on an as-needed basis. Note: There are no assurances that there will be permanent public involvement after SPA approval in design or implementation.
	The managed care entity must convene meetings with a representative group of its members at least quarterly to fully document all grievances, keep comprehensive minutes of meetings made available to all members, and to provide written responses to all grievances prior to the next meeting. Members should	**P** SPA Condition C.5	Not reflected to this level of specificity. The State must provide opportunity for fair hearing, but SPA does not, nor do any federal regulations cited in SPA, require an internal grievance system for PCCM contracts. *SPA Condition C.5 assures that all relevant requirements in 42 CFR Part 438 for PCCMs will be met. 42 CFR 438.400(a)(1) requires compliance under Section 1902(a)(3) of the SSA that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon*

	be notified at least fifteen days prior to each meeting regarding its date and location. Transportation and remote access should be provided to accommodate special needs.		*promptly.* *Note: PCCM contracts are not subject to many of the requirements for grievance systems that specifically address MCO and PIHP contracts in 42 CFR 438 Subpart F on Grievance Systems.*
4. Definition of Medical Necessity	Definitions of medical necessity must be adjusted or amended to include those home and community-based services that are necessary to support individuals in a stable way in their homes, but which are not necessarily of a medical nature.	**N** SPA Condition C.5	There are no requirements in SPA or federal regulations cited in SPA for PCCM contracts to disclose definitions of medical necessity. *There are requirements in 42 CFR 438.210 on Coverage and authorization of services that MCO, PIHP, and PAHP contracts specify what constitutes "medically necessary services" in a manner that addresses to what extent the entity is responsible for covering services that help enrollees attain, maintain, or regain functional capacity. The language does not apply to PCCM contracts.*
5. Appeals and Independent Problem Resolution	Timely, adequate notice of adverse decisions in the principal language of the individual and in a comprehensible manner, including what action the managed care entity is taking	**P** SPA Condition C.5 SPA Condition K	SPA addresses information requirements for PCCM contracts that ensure effective communication. However, specific requirements on notices during the appeals process and disclosure of adverse decisions are not present. *SPA Condition C.5 assures that all relevant requirements in 42 CFR Part 438 for PCCMs will be met. 42 CFR 438.10 on Information Requirements requires that enrollees be given "written notice of any change (that the State defines as "significant") in [available providers, restrictions on freedom of choice among providers, grievance and fair hearing procedures, amount, duration, and scope of available benefits, procedures for obtaining benefits, the extent to which enrollees may obtain benefits] at least 30 days before the intended effective date of the change"* *This subpart also requires that oral interpretation be available for any language, and written information must be available in prevalent languages in easily understood language and format.*

			Note: PCCM contracts are not subject to the requirement for "Notice of adverse action" that addresses MCO, PIHP, and PAHP contracts in 42 CFR 438.210 on Coverage and authorization of services to ensure that enrollees and providers are notified of any decision that denies a service authorization request or authorizes a service in an amount, duration, or scope that is less than requested.
	Notices of adverse action must state how much time the member has to appeal and the method by which they must appeal, and the notice must be issued at least ten days prior to the adverse action taking place	**N** SPA Condition C.5	Specific requirements for appeals procedures for PCCM contracts are not laid out in SPA or any federal regulations cited in SPA. *Note: SPA Condition C.5 assures that all relevant requirements in 42 CFR Part 438 for PCCMs will be met. PCCM contracts are not subject to many of the requirements for grievance systems that specifically address MCO and PIHP contracts in 42 CFR 438 Subpart F on Grievance Systems. For example, 42 CFR 438.402(b)(2) states that an enrollee may file an appeal between 20 and 90 days after notice of action by an MCO or PIHP. Language does not include PCCM contracts.*
	The State must preserve the right to timely access of the individual's file with the contracted entity and all documents related to an appeals decision	**N** SPA Condition C.5	Specific requirements for appeals procedures are not laid out in SPA or any federal regulations cited in SPA for PCCM contracts. *Note: SPA Condition C.5 assures that all relevant requirements in 42 CFR Part 438 for PCCMs will be met. PCCM contracts are not subject to many of the requirements for grievance systems that specifically address MCO and PIHP contracts in 42 CFR 438 Subpart F on Grievance Systems. For example, 42 CFR 438.406(b)(3) on Handling of grievances and appeals requires that the State provide the enrollee to examine his or her case file, including medical records and any other documents considered during the appeals process. Language is unclear whether the statue applies to PCCM contracts.*
	The right to a fair hearing, including the right to bring witnesses, the opportunity to confront and cross-examine adverse witnesses, and the right to receive a written decision	**N** SPA Condition C.5	Specific requirements for appeals procedures are not laid out in SPA or any federal regulations cited in SPA for PCCM contracts. *Note: SPA Condition C.5 assures that all relevant requirements*

	that summarizes the facts and criteria supporting the decision.		*in 42 CFR Part 438 for PCCMs will be met. PCCM contracts are not subject to many of the requirements for grievance systems that specifically address MCO and PIHP contracts in 42 CFR 438 Subpart F on Grievance Systems. For example, 42 CFR 438.406(b)(2) on "Handling of grievances and appeals" requires that the State provide the enrollee a reasonable opportunity to present evidence. Language is unclear whether the statue applies to PCCM contracts.*
	Benefits paid pending final resolution of terminations or denials may not be limited to the current authorization period and must be provided until the matter is resolved.	**N**	Specific appeals procedures are not laid out in SPA or any federal regulations cited in SPA for PCCM contracts. *Note: SPA Condition C.5 assures that all relevant requirements in 42 CFR Part 438 for PCCMs will be met. PCCM contracts are not subject to many of the requirements for grievance systems that specifically address MCO and PIHP contracts in 42 CFR 438 Subpart F on Grievance Systems. For example, language in 42 CFR 438.420 on "Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending" does not apply to PCCM contracts.*
	Hearing officers must be impartial and independent, receive training regarding the delivery of Medicare and Medicaid benefits, including Long-Term Services and Supports and Behavioral Health services to seniors and persons with disabilities, and take non-medical goals into account e.g., independence and choice	**N**	There are no assurances for the provision of impartial, independent, and knowledgeable hearing officers for PCCM contracts in the SPA or any federal regulations cited in the SPA. *Note: SPA Condition C.5 assures that all relevant requirements in 42 CFR Part 438 for PCCMs will be met. PCCM contracts are not subject to many of the requirements for grievance systems that specifically address MCO and PIHP contracts in 42 CFR 438 Subpart F on Grievance Systems. For example, 42 CFR 438.406(b)(2) on "Handling of grievances and appeals" requires that the State ensure that the individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making. Language is unclear whether the statue applies to PCCM contracts.*
	The state must publicly share data on denial, termination, and reversal rates (including partial denials), the numbers of appeals and grievances	**N**	There are no relevant assurances for PCCM contracts in the SPA or any federal regulations cited in the SPA. *Note: SPA Condition C.5 assures that all relevant requirements*

	filed, and the number of appeals that result in a reversal of an initial decision.		*in 42 CFR Part 438 for PCCMs will be met. PCCM contracts are not subject to many of the requirements for grievance systems that specifically address MCO and PIHP contracts in 42 CFR 438 Subpart F on Grievance Systems. For example, 42 CFR 438.416 on "Recordkeeping and reporting requirements" specifies that MCOs and PIHPs must maintain records of grievances and appeals and must review the information as part of the State quality strategy. No such requirement is made of PCCM contracts.*
	The managed care system must include an **independent ombudsman** who has expertise in the delivery of Medicare and Medicaid benefits to seniors and persons with disabilities, including Long-Term Services and Supports and Behavioral Health services, will assist beneficiaries with appeals, and will identify systemic problems in the CMO and be able to bring those concerns to the agency authority.	**N**	There are no provisions for an independent ombudsman in the SPA or in the federal regulations cited in the SPA. *Note: SPA Condition C.5 assures that all relevant requirements in 42 CFR Part 438 for PCCMs will be met. PCCM contracts are not subject to 42 CFR 438.608 on Program integrity requirements, which mandate that an MCO or PIHP have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.*
	DCH should establish a **Medical Loss Ratio** (MLR) for CMOs, and should publish the MLRs for each CMO as well as the underlying components of the MLR.	**N**	There is no assurance in the SPA or any federal regulation cited in SPA that DCH will establish protocol to publish MLR under the contracting entity.
B. Focus on Issues for the Aged, Blind or Disabled Population			
1. Carve-Out	Populations in nursing facilities must be considered in redesign and cannot be carved out.	**Y** SPA Condition G	Populations in nursing facilities are listed as a group eligible for voluntary enrollment into the Medical Coordination Program.
	There must be financial consequences for a managed care organization if an individual selects a nursing facility as their service option so that high need individuals are discouraged from institutional placement.	**P** SPA Condition B.2	SPA assures that the contracting entity will pay providers bonus or incentive payments in addition to a case management fee, suggesting a reward structure for cost effective and appropriate use of care across the delivery system.

	All Medicaid resources must be managed under the same program umbrella to manage its resources effectively and flexibly, ensure that individuals are served in the most integrated setting, and extend services to individuals on waiting lists.	**P** SPA Condition H.2.iii SPA Condition C.2	DCH will contract with one vendor to provide services to eligible populations. The State assures that all requirements of section 1905(t) of SSA for PCCMs and PCCM contracts will be met: *Section 1905(t)(1) definition of primary care case management services includes locating, coordinating and monitoring health care services.* SPA provides no indication on the extension of services to individuals on waiting lists.
2. Phase-In	If the state determines to keep the nursing facility resources off the table in the plan to be released, then the ABD populations must be phased in gradually, over years, including the nursing home population.	**Not Applicable**	There is no mention in the SPA that nursing facility resources will or will not be reallocated. The Medical Coordination Program will be available to ABD eligibles currently under fee-for-service models and to populations listed in SPA Condition G in a voluntary opt out basis. There is no indication of a timeframe of enrollment for any of these populations.
	The enrollment of each ABD population should be preceded by a readiness assessment.	**N** SPA Condition H.2.iii	SPA does not address the intent to assess the program before roll-out for any population.
	Enrollment for persons with disability must be voluntary with strong opt-out mechanisms, and the appropriate appeals processes must be in place.	**Y** SPA Conditions D-G SPA Condition H.2.i SPA Condition H.2.iii	There will be no mandatory enrollment for any population. Members who qualify for intensive medical coordination services will be voluntarily select or be assigned to a medical home. The member may decline to receive or opt out of intensive coordination services.
3. Measurement	Enrollment of ABD populations utilizing home and community-based services will require a different set of measurement tools and indicators other than those most commonly used for assessing quality in Medicaid services (EQRO's, HEDIS, CAHPS, etc).	**N**	There are no assurances in SPA or cited federal regulations that the State will improve or even require quality measures under the new contract. *Note: SPA Condition C.5 assures that all relevant requirements in 42 CFR Part 438 for PCCMs will be met. 42 CFR 438 Parts D and E list requirements for Quality Assessment and External Quality Review for MCO and PIHP contracts. Language does not specify that above requirements apply to PCCM contracts.*
	Other useful quality measures include:	**N**	There are no assurances in SPA or cited federal regulations that the State will improve or even require quality measures

	• Numbers of avoidable hospitalizations • Number of avoidable facility care • Depression screenings • Cholesterol measures after coronary events • Access to specialists • Access to equipment • Non-emergency transportation • Access to plan representatives • Timely and fair resolution of complaints		under the new contract. *Note: SPA Condition C.5 assures that all relevant requirements in 42 CFR Part 438 for PCCMs will be met. 42 CFR 438 Parts D and E list requirements for Quality Assessment and External Quality Review for MCO and PIHP contracts. Language does not specify that above requirements apply to PCCM contracts.* *42 CFR 438.416 on Recordkeeping and reporting requirements states does not include PCCM contracts under the requirement that contracted entities maintain records of grievances and appeals and must review the information as part of the State quality strategy.*
	EPSDT CMS-416 should be considered as an alternate or additional measurement tool to HEDIS for evaluating the quality of dental services in Medicaid.	**N**	There are no assurances in SPA or cited federal regulations that the State will improve or even require quality measures under the new contract. *Note: SPA Condition C.5 assures that all relevant requirements in 42 CFR Part 438 for PCCMs will be met. 42 CFR 438 Parts D and E list requirements for Quality Assessment and External Quality Review for MCO and PIHP contracts. Language does not specify that above requirements apply to PCCM contracts.*
4. DOJ Settlement	The new contract must include the deliverables of the DOJ Settlement	**N** SPA Condition C.5	Compliance with the DOJ Settlement is not assured in the SPA or enforced by any federal regulation cited in the SPA.
5. Provider Network – Choice, Capacity, Accessibility	There must be an adequate array of providers to meet the needs of any subgroup of the ABD population included in the managed care program including: • Health care providers • Behavioral health care providers • Home and Community-based supports • Long term supports and services	**Y** SPA Condition C.2 SPA Condition M.2 SPA Condition M.3	*SPA assures that all applicable requirements of Section 1905(t) of SSA for PCCMs will be met. Section 1905(t) requires that a PCCM contract must, by definition, provide for arrangements with or referrals to sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care.*
	Special attention needs to be paid to rural areas and to cultural and linguistic diversity.	**P** SPA Condition I.3 SPA Condition C.5	The SPA does not make specific considerations for rural areas. *SPA Condition I.3 cites 42 CFR 438.58, which requires MCO, PIHP, PAHP, and PCCM contracts to give enrollees a choice of*

			at least two provider entities. The proposed SPA is waived from this requirement under subheading (b), which allows a State to limit a rural area resident to a single PCCM system if the program is authorized by a plan amendment under section 1932(a) of SSA. However, the State will not be able to enroll any member, including those in rural areas who will have to travel unreasonable amount of time to access services. *SPA Condition C.5 assures that all relevant requirements in 42 CFR Part 438 for PCCMs will be met. 42 CFR 438.6 on Contract Requirements states that a PCCM contract must restrict enrollment to recipients who reside sufficiently near one of the manager's delivery sites to reach that site within a reasonable time using available and affordable modes of transportation.* The SPA does make specific considerations for cultural and linguistic diversity in relaying information to members. *42 CFR 438.10: Information Requirements requires that information be provided to enrollees in easily understood language and format. In addition, oral interpretation must be available for any language, and written information must be available in prevalent languages.* However, SPA, nor any federal regulation cited in SPA, does not require providers under PCCM contracts to be linguistically or culturally competent in providing services to members. *42 CFR 438.206 on Availability of services requires that contracts participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees. This requirement applies only to MCO, PIHP, and PAHP contracts.*

	Individuals should be enabled to go out of network if they need a particular type of provider that is not available in network.	**Y** SPA Condition C.5	*SPA Condition C.5 assures that all relevant requirements in 42 CFR Part 438 for PCCMs will be met. 42 CFR 438.10 on Information Requirements states that the State must provide detailed information, upon request, on how enrollees may obtain benefits from out-of-network providers.*
	Health care services and supports must be provided in ADA-compliant settings.	**Y** SPA Condition C.5	*SPA Condition C.5 assures that all relevant requirements in 42 CFR Part 438 for PCCMs will be met. 42 CFR 438.6 on Contract Requirements states that contracts must comply with all applicable Federal and State laws and regulations including…the Americans with Disabilities Act of 1990 as amended.*
	The managed care program must preserve the existing service array as much as possible, allowing individuals to keep their existing practitioners if they prefer.	**Y** SPA Condition H.2	SPA assures that all members will receive services through FFS, existing provider-recipient relationships may continue at the member's option. The provider networks for Medicaid members are limited to Medicaid-participating providers.
	Durable medical equipment providers must be brought into the provider network.	**N**	There are no assurances in SPA that the State will provide DME coverage under the new contract.
	The managed care network must retain and support providers in the Developmental Disability and the Intellectual Disability subpopulations.	**N**	There are no assurances in SPA that the State will retain or support providers of DD or ID services under the new contract.
	Providers should not be excluded for lack of administrative and/or billing capacity.	**N**	Provider discrimination by PCCM contracts is not prohibited by any assurance made in SPA or any federal regulation cited in SPA. *Note: Prohibitions against provider discrimination in 42 CFR 438.12 apply to MCO, PIHP, and PAHP contracts and do not address PCCM contracts.*
	The managed care network must be required to include local providers.	**P** SPA Condition C.5	SPA assures that all enrollees must have reasonable access to delivery services. However, there is no requirement for inclusion of local providers and no prohibition against discrimination against local providers. *SPA Condition C.5 assures that all relevant requirements in 42*

			CFR Part 438 for PCCMs will be met. 42 CFR 438.6 on Contract Requirements states that a PCCM contract must "restrict enrollment to recipients who reside sufficiently near one of the manager's delivery sites to reach that site within a reasonable time using available and affordable modes of transportation." *Note: Prohibitions against provider discrimination in 42 CFR 438.12 apply to MCO, PIHP, and PAHP contracts and do not address PCCM contracts.*
	The rate structure needs to be adequate to maintain the participation of providers in the network.	**N**	The adequacy of any fee-for-service payment to providers is not addressed.
	A percentage of any savings achieved through coordination or administrative efficiencies should be returned to the system of care to enhance or extend programs or services.	**N**	SPA and federal regulations cited in SPA make no assurances on how the State will allocate any new funds from program savings.
	The investment that the state has made in self-directed, family-directed, and consumer-directed models must be preserved.	**N**	SPA expresses intent to adopt a PCCM model; patient self-direction and family support is not addressed in SPA.
6. Dental Services	A carve-out of dental services to one CMO would eliminate the confusions and administrative hassles for both the patients and providers as currently exists.	**N**	SPA does not specifically address dental services.
	Uniform, standardized, quarterly dental utilization reports should be required.	**N**	SPA does not specifically address dental services. SPA does not assure that the State will require quality measures under a PCCM contract.
C. Focus on Issues for Children			
7. Children with Disabilities Reaching Adulthood	Aging out of EPSDT-covered services should never result in the person's being placed in a nursing facility or hospital.	**N**	SPA does not make specific assurances for enrollees aging out of EPSDT services.
D. Focus on Issues for Behavioral Health			

1. General Expectations	The preferred method of design is a single non-profit or governmental Behavioral Health carve-out	**N**	SPA will not create a Behavioral Health Carve-out. All services will remain in the fee-for-service delivery system.
	Create a locus of accountability to prevent the inefficient use of resources	**Y** SPA Condition B.1	SPA proposes a PCCM contract to provide primary care case management intended to direct members to appropriate care.
	The contracted vendor should partner with local indigent services organizations	**N**	SPA cites DCH intention to solicit public input during design, roll-out, and continued implementation. However, no specific intent to partner with indigent services is mentioned.
	If the state chooses to carve-in behavioral health, a thorough analysis should be completed to determine the risk to the DBHDD institutional system and to the state regarding referrals to or out of emergency treatment, and involuntary commitment.	**N**	There is no specific assurance that the State will assess the new program for risk.
	The state shall ensure that the contract adheres to expectations set forth in Georgia's DOJ Settlement, the ADA, and the Olmstead Act.	**P** SPA Condition C.5	SPA assures that the contract will comply with all applicable Federal and State laws and regulations. Compliance with the DOJ Settlement has not been assured in the SPA. *SPA Condition C.5 assures that all relevant requirements in 42 CFR Part 438 for PCCMs will be met. 42 CFR 438.6 on Contract Requirements states that contracts must comply with all applicable Federal and State laws and regulations including…the Americans with Disabilities Act of 1990 as amended.*
	Consumer-Run Organizations and Family Support Organizations should be engaged through contract in advising the state, providers, and consumers of their rights and obligations and to assist individuals in navigating services.	**N** SPA Condition B.4	SPA assures that stakeholder groups will be involved with implementation on an as-needed basis. There is no assurance that Consumer-Run Organizations or Family Support Organizations will be fully and permanently engaged through contract to advise the design and implementation of the PCCM contract.
2. Outreach, Access, and Screening	The contracted vendor should demonstrate both experience and effectiveness of activities that support timely access to	**N** SPA Condition C.8	*SPA Condition C.8 assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met. These requirements do not directly mandate that the contracted vendor demonstrate experience and effectiveness in delivering*

	appropriate care and support services.		*appropriate care and support.*
	The contracted vendor should promote the effective integration of the general medical care sector with the behavioral care sector.	**N**	There is no specific assurance that primary care case management will effectively integrate general medical care with behavioral care.
	The vendor shall have written policies and procedures that permit members to seek in-network behavioral health services and substance abuse services without a referral or authorization from the primary care provider.	**N**	"Direct access to specialist" requirement does not preclude the necessity of referral or approval by a health care professional and does not apply to PCCM contracts. *SPA Condition C.5 assures that all applicable requirements in 42 CFR Part 438 for PCCMs will be met. 42 CFR .208 on Coordination and Continuity of care requires that enrollees determined to need a course of treatment be allowed to directly access a specialist through a standing referral or an approved number of visits.*
	Definitions of medical necessity must be completely and publicly transparent.	**N** SPA Condition C.5	There are no requirements in SPA or federal regulations cited in SPA for PCCM contracts to disclose definitions of medical necessity. *SPA Condition C.5 assures that all applicable requirements in 42 CFR Part 438 for PCCMs will be met. There are requirements in 42 CFR 438.210 on Coverage and authorization of services that MCO, PIHP, and PAHP contracts specify what constitutes "medically necessary services" in a manner that addresses to what extent the entity is responsible for covering services that help enrollees attain, maintain, or regain functional capacity. The language does not apply to PCCM contracts.*
	Medical Necessity criteria should be set broadly and be utilized to promote early intervention, prevention, resiliency, and recovery.	**N** SPA Condition C.5	There are no requirements in SPA or federal regulations cited in SPA for PCCM contracts to disclose definitions of medical necessity. *SPA Condition C.5 assures that all applicable requirements in 42 CFR Part 438 for PCCMs will be met. There are requirements in 42 CFR 438.210 on Coverage and authorization of services that MCO, PIHP, and PAHP contracts specify what constitutes "medically necessary services" in a*

			manner that addresses to what extent the entity is responsible for covering services that help enrollees attain, maintain, or regain functional capacity. The language does not apply to PCCM contracts.
3. Benefits and Services	For all vendors and providers, there shall be a recovery orientation in all policy, practice, and contracting	**N**	Not reflected to this level of specificity.
4. Treatment Planning and Care Coordination	The system should be stratified by risk/need of the users of services and supports	**Y** SPA Condition H.2.iii	Members will be assessed for need of intensive coordination services versus general coordination services.
	Payment model should incentivize coordination among general medical and behavioral health providers.	**N**	There is no specific assurance that primary care case management with incentive payments will effectively coordinate general medical care with behavioral care.
5. Consumer Involvement in Policy Making and Service Delivery	The vendor should include and be responsive to representatives with "lived experience" at all levels of planning and monitoring.	**N**	There is no specific assurance that stakeholder groups will be permanently or fully engaged in program design or implementation.
6. Contracts	The provider network should recognize as preferred providers CSBs, FQHCs, RHCs, and those currently licensed by the State of Georgia as Drug Abuse Treatment and Education Programs.	**N**	SPA does not guarantee the selection of preferred providers in behavioral health care. The requirement for nondiscrimination against certain health care licenses does not apply to PCCM contracts. *SPA Condition C.5 assures that all applicable requirements in 42 CFR Part 438 will be met. 42CFR 438.12 states that MCO, PIHP, and PAHP contracts may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. The requirement does not apply to PCCM contracts.*
E. Focus on Long Term Services and Supports			
1. Enrollment	There must be a process for individuals to receive individualized counseling about the options they have in choosing a plan.	**N** SPA Condition H.3.iii SPA Condition H.3.iv SPA Conditions D-G	SPA does not assure that members will be counseled on enrollment into the Medical Coordination Program. SPA Condition H.3.iii answers that the state will notify members by mail that they have been auto-enrolled into the program and what services will be available to them.

			However, SPA Condition H.3.iv states that the requirement to describe the State's process for notifying auto-assigned members of their right to disenroll without cause during the first 90 days of their enrollment is not applicable to the proposed PCCM contract. SPA Conditions D through G assure that enrollment will be voluntary for all eligible members.
	The state may follow the good efforts of other states and conduct pre-enrollment assessments to ensure that enrollee's needs are known to new health plans and providers.	**P** SPA Condition H.2.iii	SPA states that "all members will…be subject to predictive modeling and other analyses by the vendor to identify the need for intensive medical coordination services." There are no assurances that there will be pre-enrollment assessments for the purposes of program design and preparation.
	Oversight and monitoring should be a coordinated and complementary effort by CMS, state agencies, and independent advocate for enrollees, and stakeholder committees.	**P** SPA Condition C.5 SPA Condition B.4	SPA assures that CMS will be notified whenever it sanctions the contracting entity for violating any applicable requirements of sections 1932 or 1905(t)(3) of the Act and any implementing regulations. However, the establishment of sanctions is optional for PCCM contracts. *SPA Condition C.5 assures that all relevant requirements in 42 CFR Part 438 for PCCMs will be met. 42 CFR 438.700 states that each State that contracts with a PCCM may establish sanctions that it may impose if it makes the determination that a PCCM violated any applicable federal requirements. 42 CFR 438.724 states that the State must give the CMS Regional Office written notice whenever it imposes a sanction on its contracting entity.* SPA assures that DCH will continue collecting public input during and after implementation from stakeholders including providers, members, and advocates.
2. State and Federal Oversight and Monitoring	Where the CMO is also providing Medicare benefits, Medicare must be involved in oversight and monitoring procedures.	**N**	SPA does not specifically refer to Medicare benefits or oversight by Medicare.
	Agencies involved in the delivery of LTSS should be involved in oversight	**N**	The SPA cites regulations in 42 CFR 438 that require oversight and monitoring but does not provide detail in allocating

	and monitoring. Roles among these agencies must be delineated, and a clear lead agency must be identified.		responsibilities to agencies.
	Specific activities for overseeing and monitoring delivery of LTSS must be developed.	**N**	Intent for oversight is present, but no specific activities are cited.
	A no-wrong door entry point system.	**P**	It is implied that members will have access to and be screened for all appropriate services.
3. Alignment with Balancing Incentives Payment Program	Conflict-free screening, enrollment, and case management across the entire long term care system and employ a standardized assessment tool.	**P** SPA Condition H.2	DCH has expressed intent to "conduct regular analyses to identify eligible members who may be in need to intensive medical coordination services." SPA contains no assurances of a standardized assessment tool.
	Divert and transition individuals from high cost institutional care to lower cost home and community-based services.	**P**	Not specifically mentioned, but is an implied intent under the PCCM framework
	Coordinate Medicaid services with services provided by private resources.	**N**	Intent to coordinate with private resources is not mentioned in SPA.
	Standardized instruments to determine eligibility and appropriate services.	**P** SPA Condition H.2	DCH has expressed intent to "conduct regular analyses to identify eligible members who may be in need to intensive medical coordination services"

Note: Analysis was conducted using assurances directly present in the proposed State Plan Amendment and federal laws and regulations directly cited in the proposed State Plan Amendment. Federal and state laws and regulations not directly cited in the State Plan Amendment were not considered in the analysis but may apply to the proposed PCCM contract.