



**GEORGIA DEPARTMENT
OF COMMUNITY HEALTH**

STATE OF GEORGIA

**GEORGIA FAMILIES FOR YOUTH IN FOSTER CARE, ADOPTION ASSISTANCE
AND JUVENILE JUSTICE**

**SECTION 1115 DEMONSTRATION PROPOSAL
WAIVER APPLICATION FOR PUBLIC COMMENT
PRELIMINARY DRAFT: JUNE 13, 2013**

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

Section I - Program Description

This section should contain information describing the goals and objectives of the Demonstration, as well as the hypotheses that the Demonstration will test. In accordance with 42 CFR 431.412(a)(i), (v) and (vii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

- 1) *Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act). (This summary will also be posted on Medicaid.gov after the application is submitted.)*

In 2011, the Georgia Department of Community Health (DCH) initiated a process to solicit input from an array of stakeholders within the State regarding needed reforms to the Medicaid program. DCH gathered feedback from more than 30 focus groups; three issue-specific task forces; online surveys; and several other mechanisms. DCH also researched and surveyed other states' programs for best practices and lessons learned when implementing delivery system reforms. The information gathered during this process revealed significant concerns with medical care coordination and fragmented systems for several Medicaid populations, particularly youth in foster care and adoption assistance. DCH and its partner agencies also identified concerns for selected youth in juvenile justice who are in community residential care. The stakeholder input process, as well as additional review of literature and data analyses, highlighted for DCH the complex social and medical needs of these populations – as well as the importance of designing a cohesive and responsive delivery system that had a specific focus on meeting the needs of these unique populations.

DCH is therefore seeking approval for this Section 1115 Research and Demonstration waiver to meet our goal of creating one seamless, integrated delivery system for youth in foster care and adoption assistance and selected youth in the juvenile justice system (“Demonstration Populations”) to improve care coordination, access to care, and health outcomes.¹ DCH designed this goal to be consistent with the CMS “triple aim” objectives to improve patient experience, improve health and reduce costs.

The Demonstration Populations represent an estimated 27,000 youth in foster care and adoption assistance and on average 250 youth in the juvenile justice system who are in community residential care. These members currently receive Medicaid or State Children's Health Insurance Program (SCHIP), PeachCare for Kids® services through the State's fee-for-service (FFS) delivery system. However, due to the complex needs of these individuals, which are well documented in national literature as well as by State stakeholders, DCH seeks to pursue an alternative strategy to delivering health care services to these populations. Under the Demonstration, DCH proposes to test the effectiveness of the

¹ The Demonstration Population will include youth in the juvenile justice system who are placed in community residential care.

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

following three strategies on improving care coordination, access to care and health outcomes for the Demonstration Populations:

1. Contracting with a single, statewide Care Management Organization (CMO) responsible for providing all State Plan medical services as well as enhanced assessment and care coordination
2. Utilizing electronic health information to better integrate care
3. Implementing value-based purchasing strategies to align care delivery with expected outcomes, as well as quality improvement goals

2) *Include the rationale for the Demonstration.*

The Demonstration goals focus on improving care coordination, access to care and health outcomes for youth who are in foster care and adoption assistance and selected youth in the juvenile justice system. Feedback from stakeholders throughout the State, as well as review of literature, indicates that a lack of care coordination for these Medicaid members who are often high risk and have multiple care needs is a significant issue. These findings, described in more detail below, compel consideration of alternative delivery system designs other than those that have traditionally been approved for Medicaid programs.

In September 2006, Georgia transitioned all of its PeachCare for Kids® members and select Medicaid populations from the FFS delivery system to a full-risk mandatory managed care Medicaid delivery system, Georgia Families.^{2,3} This effort improved care coordination for enrolled populations and allowed DCH to build the necessary expertise and internal administrative capacity required to effectively manage this type of delivery system for its Medicaid populations. Key program accomplishments include:

- Successful enrollment of 1.2 million lives for over five years

² Individuals in the following Medicaid eligibility categories must enroll in Georgia Families: Low-Income Medicaid (LIM) program, Transitional Medicaid, pregnant women and children in the Right from the Start Medicaid (RSM) program, newborns of Medicaid-covered women, refugees and women with breast and cervical cancer.

³ The Managed Care State Plan Amendment (SPA) identifies certain groups of members as those with “special health care needs.” These members are exempt from enrolling in the Georgia Families program and include:

- Medicaid and PeachCare for Kids® members enrolled in the Children’s Medical Services Program
- Children receiving services through the Georgia Pediatric Program (GAPP)
- Members residing in hospice or LTC facilities
- Individuals who are institutionalized
- Children 18 years of age or younger who are in foster care or another out-of-home placement
- Children 18 years of age or younger who are getting foster care or adoption assistance under Title IV-E of the Social Security Administration
- Individuals enrolled in Medicaid who qualify for Medicare
- Individuals who qualify for Supplemental Security Income (SSI)

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

- Cost-avoidance of between \$402 million and \$532 million in medical benefit expenditures for State Fiscal Years (SFYs) 2007 through 2011
- Improved quality and outcome reporting including:
 - Measurement of 54 HEDIS/NCQA Quality Metrics
 - 90th percentile for dental access
 - Recognition by HHS for innovative use of quality in our programs
 - Leading the nation in reporting of the initial core set of CHIPRA quality measures
- Developed a quality measurement infrastructure and are working to evolve quality measurement and performance improvement processes
- Enhanced oversight and monitoring of CMOs' performance through the expansion and accreditation of HEDIS®-based performance measurement, demonstrated improvement through PIPs and cross-state agency collaboration initiatives

This proposed Demonstration will permit DCH to build on the success of its efforts under Georgia Families by developing a comparable delivery system, via a single CMO, that has targeted expertise to effectively handle the unique and complex health care needs of youth in foster care and adoption assistance. DCH believes a single CMO will provide the best opportunity to achieve improvements in continuity of care, services and coordination which will in turn improve outcomes. Dividing such a small population over multiple plans would create a barrier to the development of the necessary infrastructure and processes that are needed to properly serve the child.

Stakeholder feedback substantiates the benefit of using a single CMO focused on improving health outcomes for the Demonstration Populations. Stakeholder concerns, particularly regarding the complex needs of these youth, are supported by the literature. For example, research notes that:

- Nearly 90 percent of youth entering child welfare have physical health problems, and more than half have two or more chronic conditions⁴
- One-quarter of youth entering foster care have three or more chronic conditions⁵
- Nearly half of youth entering foster care have significant emotional and behavioral

⁴ Testimony from John Landsverk, Ph.D. at Testimony to the Little Hoover Commission Children's Mental Health in Child Welfare and Juvenile Justice, a Public Hearing on Children's Mental Health Policy on October 26, 2000 in Sacramento, California.

⁵ L.K. Leslie, M.S. Hurlburt, J. Landsverk, K. Kelleher et al. "Comprehensive Assessments for Children Entering Foster Care: A National Perspective." *Pediatrics*, July 2003.

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

health conditions⁶

- Rates of psychotropic medication use for youth in foster care are significantly higher (ranging from 13 percent to 52 percent) than for the general youth population (four percent).⁷

At the same time, these youth face severe environmental instability and shifting guardianship between birth parents, foster parents, guardians or an adoptive family. This means they are often moved from household to household throughout the State. This environmental instability means that meeting their health care needs can be sporadic and disjointed, with frequent changes in health care providers and fragmented medical records.

Additionally, youth in the Demonstration Population are typically served by multiple entities, but are subject to “fragmented social services, including the involvement of multiple, often uncoordinated systems such as behavioral health, child welfare, juvenile justice, education, and primary care; and limited resources and competing demands on [health] plans, state Medicaid agencies and child welfare systems.”⁸ Youth in foster care must receive court ordered assessments from multiple provider types and EPSDT services within accelerated timeframes. Also, opportunities for integrated physical health and behavioral health care services under the FFS delivery system are limited. These issues result in less than optimal access to appropriate care, provision of duplicative services and assessments and limited coordination between physical health, behavioral health and other services.

The single CMO would also best serve selected youth in the juvenile justice system, as they have complex health care needs and social challenges similar to youth in foster care and adoption assistance. These youth may have prior offenses and often have social, safety and developmental needs. These youth sometime await community residential placement at home, while some await placement in one of the State’s Regional Youth Detention Centers (RYDCs), which are designed for short term placement for youth awaiting court hearings or placement. Youth who are awaiting community residential placement are moved from the RYDC and placed in a community residential setting after they are assessed and an appropriate placement is identified and obtained. These multiple transfers and placement in a variety of settings contribute to instability in meeting their health care needs, even more so when their enrollment in a CMO may also have to change.

⁶ B.J. Burns, S.D. Phillips, R. Wagner, R.P. Barth, D.J. Kolko, Y. Campbell, et al. “Mental Health Need and Access to Mental Health Services by Youths Involved with Child Welfare: A National Survey.” *Journal of the American Academy of Child and Adolescent Psychiatry*, v43, n8, August 2004.

⁷ L.K. Leslie and C. Bellonci. “Multistate Study on Psychotropic Medication Oversight in Foster Care.” Tufts University: Tufts Clinical and Translational Science Institute, September 2010.

⁸ Allen, K., Pires, S., Mahadevan, R., “Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit” Center for Health Care Strategies, Inc. February 2012. Available at: http://www.chcs.org/usr_doc/Child_Welfare_Quality_Improvement_Collaborative_Toolkit.pdf

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

These youth, in many of the same foster care settings as youth in the custody of the State's Division of Family and Child Services, would therefore benefit from the specialized care delivered by one CMO.

Furthermore, serving a small population of members with special needs through one CMO may lead to more focused efforts and less burden for providers and members:

- While Maryland contracts with multiple health plans for its Medicaid managed care program, one health plan has been identified as the “MCO of choice” for youth in foster care in Baltimore. The MCO of choice was identified due to initiatives to coordinate with foster care case workers that have resulted in a 20 percent increase over three years in the youth receiving a comprehensive health risk screening upon enrollment. The MCO's efforts are being used as a model to expand statewide.⁹
- The Georgia-based Coalition to Assure Redesign Effectiveness for Medicaid recommended that members should have availability of the same or similar access to services, eligibility requirements and service arrays regardless of provider or location in the state; and providers should have uniform processes for authorizations, credentialing and billing/payments.¹⁰ Provider burden is minimized through contracting with one CMO and members will remain in one CMO regardless of transition. Therefore, they will not be burdened with new enrollment processes, paperwork and CMO processes and procedures upon transitions throughout the state.
- Researchers with the University of South Florida's *Health Care Reform Tracking Project* tracked and analyzed the impact of managed care initiatives on youth with emotional and substance abuse disorders and their families. They concluded:
 - Provider choice is more important to consumers than choice of managed care organization
 - Use of multiple MCOs either statewide or within regions creates more challenges and administrative complexities than advantages¹¹

Enrollment with one consistent CMO will result in continuity of care and better coordination. Based on a recommendation by the State's Pediatric Healthcare

⁹ Allen, K., Pires, S., Mahadevan, R., “Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit” Center for Health Care Strategies, Inc. February 2012. Available at: http://www.chcs.org/usr_doc/Child_Welfare_Quality_Improvement_Collaborative_Toolkit.pdf

¹⁰ CARE-M. Inclusion of Children in Foster Care in Medicaid Managed Care. September 2012. Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions. GAO-12-270T. December 1, 2011. <http://www.gao.gov/products/GAO-12-270T>.

¹¹ Pires, S.A., Armstrong, M.I, & Stroul, B.A. (1999). Health Care Reform Tracking Project: 1999 Impact Analysis. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida.

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

Improvement Coalition, DCH is contractually requiring the CMO to assign a Care Coordination Team to each member tailored to his or her individual needs. The Care Coordination Teams will assist members in navigating the health care system and will be the primary contact between the CMO and State agencies, members, foster parent(s) and caregivers.¹² The CMO will be required to coordinate all necessary health assessments within specified timeframes and the Care Coordination Teams will attain provider appointments to meet timeliness requirements. Through this approach, the fragmentation of care received by these populations will decrease. Youth in foster care and adoption assistance will maintain the same CMO and Care Coordination Team to help them navigate the healthcare system through transitions in custody and residential placement.

In December 2011, the United States Government Accountability Office (GAO) released a report indicating that youth in foster care in the five studied states were prescribed psychotropic drugs at higher rates than other youth.^{13,14} This emphasizes the vulnerability of the Demonstration Populations and the importance of designing a system that minimizes the risks of poor care coordination and inappropriate utilization. Inappropriate psychotropic prescribing highlights one of many opportunities to improve care through the single accountability of one CMO. An exclusive CMO for the Demonstration Populations will also facilitate stable coordination patterns between physical health and behavioral health providers, as well as the multiple child-serving public systems in which the member may be involved.

DCH understands the vulnerability of the Demonstration Populations and is developing additional reporting requirements for the selected CMO. Given the unique challenges associated with these populations, a single CMO is more accountable for ensuring continuity of care and consistency of access and coverage for both physical and behavioral health services. It will also centralize service coordination and management of health care data and information. For example, Texas reported the following results between 2004 and 2012 for youth in foster care who are enrolled in a single Medicaid managed care program:

- A 34 percent decrease in psychotropic medication use 60 days plus
- A 66 percent decrease in polypharmacy class drug prescription
- A 71 percent decrease of five or more polypharmacy drug prescriptions¹⁵

¹² The Pediatric Healthcare Improvement Coalition, "Strategies for Medicaid & CHIP Redesign: Better Managing the Health of Georgia's Foster Children. September 2012

¹³ Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions. GAO-12-270T. December 1, 2011. <http://www.gao.gov/products/GAO-12-270T>.

¹⁴ The GAO report acknowledged that the greater utilization could be due in part to greater behavioral health needs of children in foster care and challenges of coordinating their care. However, GAO also noted that some of this difference in utilization may be inappropriate as many children were on treatment regimens that had little or no supporting evidence.

¹⁵ Texas Health and Human Services Commission. Update on the Use of Psychotropic Medications for Children in Texas Foster Care: Fiscal Years 2002-2012. Available at: <http://www.hhsc.state.tx.us/medicaid/OCC/Psych-Medications.pdf>

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

DCH is also enhancing the ability of the CMO and providers to provide more coordinated integrated care for members by developing a Virtual Health Record (VHR) specifically for managing the health information of the Demonstration Population. The VHR will be available 24 hours, 7 days per week, and improve timeliness of information available to support care management and continuity of care. The VHR will capture a more complete medical history for the Demonstration Populations even through varying custody arrangements and transitions among living arrangements throughout the State. This is consistent with the view of the American Academy of Pediatrics, which notes that “Coordinated behavioral and medical care for children in child welfare requires a cross-system approach – including effective mechanisms for data-sharing and communication – to ensure successful health care delivery that is tailored to this population’s unique needs.”¹⁶

The VHR will provide secure data connectivity between various state agencies and programs serving the Demonstration Population in Georgia. This solution will decrease duplication of effort, provide data sharing capability, and enable providers to receive data from the electronic health records systems. Specific functionality will allow authorized clinicians and other authorized individuals to access various data sources connected to the statewide Georgia Health Information Network and query for relevant health information for the purpose of treatment and relevant specialized services. The VHR will be capable of presenting queried health information to a variety of end-use applications to efficiently meet information needs for the total care team. The information will be gathered, tailored to and compatible with the needs of DFCS case workers, foster care service providers, legal guardians, and health care providers.

While DCH’s primary motivation for moving the Demonstration Populations into a single CMO is to improve services and health outcomes, DCH recognizes that this transition may also decrease costs to the state in the long-term. For example, increased access to PCPs and health assessments may increase needed access to specialized care. This would increase costs in the short-term; however, if health outcomes improve over time, the State could possibly decrease the rate of growth of costs to care for the Demonstration Populations.¹⁷ Dividing such a small population over multiple plans would create a barrier to the development of the necessary infrastructure and processes that are needed to properly serve the child. This model allows the single CMO to have the fiscal ability to build the necessary infrastructure and investment to serve these populations. The State believes that this customized program with a robust care coordination component will be successful in improving critical health outcomes while also decreasing costs.

¹⁶ American Academy of Pediatrics Guidelines for Foster Care. Available at: <http://aappolicy.aappublications.org/cgi/reprint/pediatrics;109/3/536.pdf>.

¹⁷ Center for Public Policy Priorities. Medicaid Managed Care for Foster Children: An Early Report. November 2008. Available at: <http://library.cppp.org/files/4/351%20Medicaid%20Managed%20Care%20for%20Foster%20Care.pdf>.

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

- 3) *Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them.*

The State will test the following hypotheses through the proposed Section 1115 Demonstration Program:

1. Enrolling the Demonstration Populations into a single, statewide CMO will improve overall continuity of care evidenced by increased preventive and primary care visit rates and more stable primary care physician-patient contact over time
2. Providing physical, behavioral and social/ emotional health care services coordinated via an integrated care management structure will result in improved health outcomes when compared with the outcomes recorded for service delivery via a FFS delivery system
3. The inappropriate use of psychotropic medications and polypharmacy among the Demonstration Populations will decline as a result of establishing individual Care Coordination Teams familiar with member history and special needs coupled with improved appropriate use of medications, care monitoring, and follow-up to care
4. Timely access to health care data and information via the use of the Virtual Health Record for the target populations will improve continuity and coordination of care across physical and behavioral health services
5. Improving access to care and health outcomes will result in overall cost containment in the long-term for these high-risk, high-cost Demonstration Populations

The State's evaluation design for the Demonstration will:

1. Detail applicable research questions and methodologies so that Georgia's evaluation of the planned Demonstration gathers the appropriate data to evaluate outcomes.
2. Test the hypotheses described above.
3. Detail the study design, data sources and collection methods, sampling methodologies, and data analysis strategies for assessing these measures.
4. Establish baseline and trending rates and appropriate performance benchmarks (e.g., available national performance benchmarks or guidelines-based "gold standards") for each measure to be evaluated.
5. Describe how the effects of the Demonstration-related activities will be isolated from other initiatives occurring across the State.
6. Discuss the State's plan for reporting to CMS on the hypothesis testing, the outcome measures, and the desired content of the intended reports.

**State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment**

The State will submit to CMS for approval an evaluation design for the Demonstration no later than 120 days after CMS approval of the Demonstration. After receiving comments about the draft evaluation design from CMS, DCH will submit the final design to CMS. DCH will include progress updates in quarterly and annual Demonstration reports and will submit a final draft evaluation report prior to the expiration of the Demonstration.

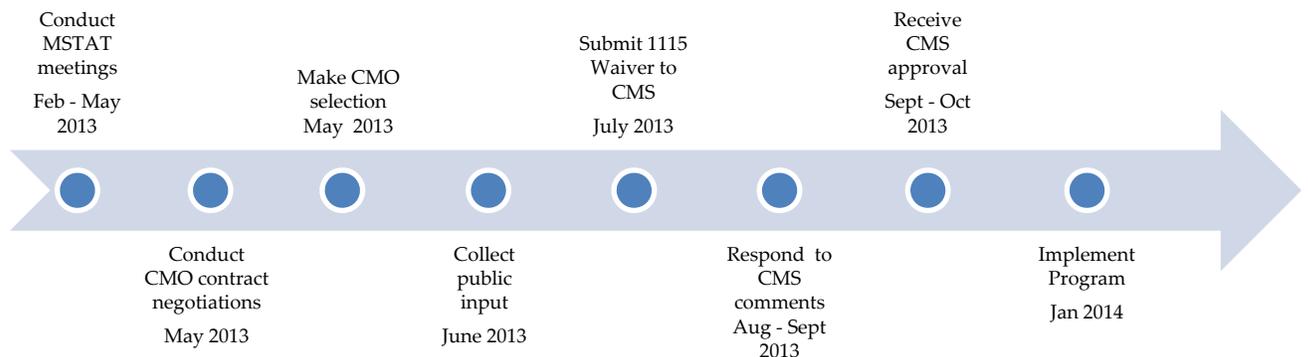
- 4) *Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate.*

The Demonstration will operate statewide.

- 5) *Include the proposed timeframe for the Demonstration.*

The target implementation date for this Demonstration is January 1, 2014. All Demonstration Populations will be enrolled on this date. Figure 1 shows the anticipated timeline and approach for implementation. To permit sufficient time for planning to meet the target implementation date, DCH is seeking federal approval by October 2013.

Figure 1: 1115 Waiver Demonstration Implementation Timeline



- 6) *Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.*

The Demonstration will not affect and/or modify other components of the State's current Medicaid program or CHIP.

Section II – Demonstration Eligibility

This section should include information on the populations that will participate in the Demonstration, including income level. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

**State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment**

- 1) *Include a chart identifying any populations whose eligibility will be affected by the Demonstration (an example is provided below; note that populations whose eligibility is not proposed to be changed by the Demonstration do not need to be included).*

The Demonstration will include youth in foster care and adoption assistance and selected youth in the juvenile justice system. The applicable Medicaid eligibility categories for these Demonstration Populations are detailed in Figure 2 below.

Figure 2: Eligibility Chart for Mandatory State Plan Groups

Eligibility Group Name	Social Security Act and CFR Citations
Youth less than twenty-six (26) years of age who are receiving foster care or who are less than twenty-one (21) years of age who are receiving other adoption assistance under Title IV-E or Title IV-B of the Social Security Act	1902(a)(10)(A)(i)(I) 473(b)(3) 42 CFR 435.145
Youth less than twenty-six (26) years of age who are receiving foster care under Title IV-E or Title IV-B of the Social Security Act and are eligible for Supplemental Security Income	1902(a)(10)(A)(i)(I) 473(b)(3) 42 CFR 435.145 1902(a)(10)(A)(i)(II)(aa) 42 CFR 435.120
Youth less than twenty-six (26) years of age who are receiving foster care or who are less than twenty-one (21) years of age and are receiving other adoption assistance under Title IV-E or Title IV-B of the Social Security Act and are enrolled in SCHIP, PeachCare for Kids®	1902(a)(10)(A)(i)(I) 473(b)(3) 42 CFR 435.145
Youth less than eighteen (18) years of age eligible for Right from the Start Medicaid in the juvenile justice system and who are placed in community residential care	1902(a)(10)(A)(i)(III) ¹⁸ 1902(a)(10)(A)(i)(IV) 1902(a)(10)(A)(i)(VI) 1902(a)(10)(A)(i)(VII) 1902(a)(10)(A)(ii)(IX) 42 CFR 435.118 Section 1931 (<18) 42 CFR 435.110

Members of the Demonstration Populations who are enrolled in the home- and community based services (HCBS) 1915(c) waiver programs described in Figure 3 will be included in this Demonstration.

¹⁸ 1902(a)(10)(A)(i)(III) is RSM covers pregnant women and newborns. The assumption is that newborns would not be in juvenile justice and will not be part of the Demonstration, so this reference applies specifically to pregnant women.

**State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment**

Figure 3: HCBS 1915(c) Waiver Programs Included in the Demonstration

HCBS Waiver	Description
Elderly and Disabled Waiver Program	Provides services to people who are functionally impaired or disabled, helping members to remain in their own homes, the homes of caregivers or in other community settings as long as possible.
Independent Care Waiver Program	Offers services that help a limited number of adult Medicaid members with severe physical disabilities live in their own homes or in the community instead of a hospital or nursing facility.
New Options Waiver Program (NOW) and Comprehensive Supports Waiver Program (COMP)	Offers HCBS for people with mental retardation or developmental disabilities.
Community-Based Alternatives for Youth (CBAY)	Provides intensive behavioral health supports to youth who have been diagnosed with a serious emotional and behavioral disturbance.

HCBS waiver programs will continue to be administered by DCH or a DCH partner agency. The CMO will coordinate with DCH, partner agencies and HCBS providers to provide medical services to this population.

- 2) *Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan.*

The eligibility determination process will not be modified under the Demonstration. The State of Georgia will have the sole authority granted under this waiver for determining eligibility for the Medicaid program and whether Medicaid beneficiaries are eligible for enrollment in the Georgia Families program. Medicaid eligibility is determined within forty-eight (48) hours of a child entering foster care. Enrollment into the CMO will occur within forty-eight (48) hours of the member’s Medicaid eligibility determination.

- 3) *Specify any enrollment limits that apply for expansion populations under the Demonstration.*

Enrollment limits will not be applied under the Demonstration.

- 4) *Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.*

DCH estimates that 27,000 youth in foster care and adoption assistance will be included in

**State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment**

the Demonstration, including approximately 53 members who are enrolled in a HCBS 1915(c) waiver program. Additionally, on average 250 youth in the juvenile justice system receive Medicaid services and are included in the Demonstration Population. DCH and its partner agencies will continue to administer the HCBS 1915(c) waiver programs. The CMO will coordinate with DCH, partner agencies and HCBS providers to provide services to these Demonstration Populations. Figure 4 below provides a breakout of the proposed Demonstration Populations and the corresponding number of members.

Figure 4: Projected Number of Members by Eligibility Group (FY12 Monthly Members)

Population	Estimated Number of Members
Youth less than twenty-six (26) years of age who are receiving foster care under Title IV-E or Title IV-B of the Social Security Act	11,335
Youth less than twenty-one (21) years of age who are receiving other adoption assistance under Title IV-E or Title IV-B of the Social Security Act	15,155
Youth less than twenty-six (26) years of age who are receiving foster care under Title IV-E or Title IV-B of the Social Security Act and are eligible for Supplemental Security Income	121
Youth less than twenty-six (26) years of age who are receiving foster care or other adoption assistance under Title IV-E or Title IV-B of the Social Security Act and are enrolled in the SCHIP, PeachCare for Kids®	247
Youth less than twenty-one (21) years of age who are receiving adoption assistance under Title IV-E or Title IV-B of the Social Security Act and are enrolled in the SCHIP, PeachCare for Kids®	0
Youth less than eighteen (18) years of age eligible for Right from the Start Medicaid in the juvenile justice system and who are placed in community residential care	250

- 5) *To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State).*

DCH will require the CMO to coordinate with HCBS waiver providers for members enrolled in the Elderly and Disabled, NOW, COMP, CBAY or Independent Care HCBS 1915(c) waiver programs. HCBS waiver services will continue to be managed and paid for via a FFS environment. Individuals in long-term care facilities are not included in the waivers. Institutional long-term services and supports are not included in this Demonstration.

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

- 6) *Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013).*

Eligibility procedures will not change for populations under the Demonstration.

- 7) *If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.*

This is not applicable to this Demonstration.

Section III – Demonstration Benefits and Cost Sharing Requirements

This section should include information on the benefits provided under the Demonstration as well as any cost sharing requirements. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state’s application in order to be determined complete. Specifically, this section should:

DCH must demonstrate budget neutrality for the Demonstration Project. Budget neutrality means that Georgia may not receive more federal dollars under the Demonstration than it would have received without it over the five year demonstration period. The DCH methodology for assessing budget neutrality uses a set of specified annual per capita costs multiplied by the estimated enrollment for each year of the five year demonstration. This is DCH’s best estimate of cost and enrollment at the time of the Demonstration Proposal submission. For detail on the budget neutrality calculation please refer to Appendices A and B.

Section IV – Delivery System and Payment Rates for Services

This section should include information on the means by which benefits will be provided to Demonstration participants. In accordance with 42 CFR 431.412(a)(ii), a description of the proposed healthcare delivery system must be included in a state’s application in order to be determined complete. Specifically, this section should:

- 1) *Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan.*

Yes, the delivery system will differ and is described below.

- 2) *Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration’s expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by*

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.

The Demonstration goals focus on improving care coordination, access to care and health outcomes for youth who are in foster care and adoption assistance and selected youth in the juvenile justice system. Feedback from stakeholders throughout the State, as well as review of literature, indicates that a lack of care coordination for these Medicaid members who are often high risk and have multiple care needs is a significant issue. These findings, described in more detail below, compel consideration of alternative delivery system designs other than those that have traditionally been approved for Medicaid programs.

In September 2006, Georgia transitioned all of its PeachCare for Kids® members and select Medicaid populations from the FFS delivery system to a full-risk mandatory managed care Medicaid delivery system, Georgia Families.^{19,20} This effort improved care coordination for enrolled populations and allowed DCH to build the necessary expertise and internal administrative capacity required to effectively manage this type of delivery system for its Medicaid populations. Key program accomplishments include:

- Successful enrollment of 1.2 million lives for over five years
- Cost-avoidance of between \$402 million and \$532 million in medical benefit expenditures for SFYs 2007 through 2011
- Improved quality and outcome reporting including:
 - Measurement of 54 HEDIS/NCQA Quality Metrics
 - 90th percentile for dental access
 - Recognition by HHS for innovative use of quality in our programs

¹⁹ Individuals in the following Medicaid eligibility categories must enroll in Georgia Families: Low-Income Medicaid (LIM) program, Transitional Medicaid, pregnant women and children in the Right from the Start Medicaid (RSM) program, newborns of Medicaid-covered women, refugees and women with breast and cervical cancer.

²⁰ The Managed Care State Plan Amendment (SPA) identifies certain groups of members as those with “special health care needs.” These members are exempt from enrolling in the Georgia Families program and include:

- Medicaid and PeachCare for Kids® members enrolled in the Children’s Medical Services Program
- Children receiving services through the Georgia Pediatric Program (GAPP)
- Members residing in hospice or LTC facilities
- Individuals who are institutionalized
- Children 18 years of age or younger who are in foster care or another out-of-home placement
- Children 18 years of age or younger who are getting foster care or adoption assistance under Title IV-E of the Social Security Administration
- Individuals enrolled in Medicaid who qualify for Medicare
- Individuals who qualify for Supplemental Security Income (SSI)

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

- Leading the nation in reporting of the initial core set of CHIPRA quality measures
- Developed a quality measurement infrastructure and are working to evolve quality measurement and performance improvement processes
- Enhanced oversight and monitoring of CMOs’ performance through the expansion and accreditation of HEDIS®-based performance measurement, demonstrated improvement through PIPs and cross-state agency collaboration initiatives

This proposed Demonstration will permit DCH to build on the success of its efforts under Georgia Families by developing a comparable delivery system, via a single CMO, that has targeted expertise to effectively handle the unique and complex health care needs of youth in foster care and adoption assistance. DCH believes a single CMO will provide the best opportunity to achieve improvements in continuity of care, services and coordination which will in turn improve outcomes. Dividing such a small population over multiple plans would create a barrier to the development of the necessary infrastructure and processes that are needed to properly serve the child.

Stakeholder feedback substantiates the benefit of using a single CMO focused on improving health outcomes for the Demonstration Populations. Stakeholder concerns, particularly regarding the complex needs of these youth, are supported by the literature. For example, research notes that:

- Nearly 90 percent of youth entering child welfare have physical health problems, and more than half have two or more chronic conditions²¹
- One-quarter of youth entering foster care have three or more chronic conditions²²
- Nearly half of youth entering foster care have significant emotional and behavioral health conditions²³
- Rates of psychotropic medication use for youth in foster care are significantly higher (ranging from 13 percent to 52 percent) than for the general youth population (four percent).²⁴

²¹ Testimony from John Landsverk, Ph.D. at Testimony to the Little Hoover Commission Children’s Mental Health in Child Welfare and Juvenile Justice, a Public Hearing on Children’s Mental Health Policy on October 26, 2000 in Sacramento, California.

²² L.K. Leslie, M.S. Hurlburt, J. Landsverk, K. Kelleher et al. “Comprehensive Assessments for Children Entering Foster Care: A National Perspective.” *Pediatrics*, July 2003.

²³ B.J. Burns, S.D. Phillips, R. Wagner, R.P. Barth, D.J. Kolko, Y. Campbell, et al. “Mental Health Need and Access to Mental Health Services by Youths Involved with Child Welfare: A National Survey.” *Journal of the American Academy of Child and Adolescent Psychiatry*, v43, n8, August 2004.

²⁴ L.K. Leslie and C. Bellonci. “Multistate Study on Psychotropic Medication Oversight in Foster Care.” Tufts University: Tufts Clinical and Translational Science Institute, September 2010.

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

At the same time, these youth face severe environmental instability and shifting guardianship between birth parents, foster parents, guardians or an adoptive family. This means they are often moved from household to household throughout the State. This environmental instability means that meeting their health care needs can be sporadic and disjointed, with frequent changes in health care providers and fragmented medical records.

Additionally, youth in the Demonstration Population are typically served by multiple entities, but are subject to “fragmented social services, including the involvement of multiple, often uncoordinated systems such as behavioral health, child welfare, juvenile justice, education, and primary care; and limited resources and competing demands on [health] plans, state Medicaid agencies and child welfare systems.”²⁵ Youth in foster care must receive court ordered assessments from multiple provider types and EPSDT services within accelerated timeframes. Also, opportunities for integrated physical health and behavioral health care services under the FFS delivery system are limited. These issues result in less than optimal access to appropriate care, provision of duplicative services and assessments and limited coordination between physical health, behavioral health and other services.

The single CMO would also best serve selected youth in the juvenile justice system, as they have complex health care needs and social challenges similar to youth in foster care and adoption assistance. These youth may have prior offenses and often have social, safety and developmental needs. These youth sometime await community residential placement at home, while some await placement in one of the State’s Regional Youth Detention Centers (RYDCs), which are designed for short term placement for youth awaiting court hearings or placement. Youth who are awaiting community residential placement are moved from the RYDC and placed in a community residential setting after they are assessed and an appropriate placement is identified and obtained. These multiple transfers and placement in a variety of settings contribute to instability in meeting their health care needs, even more so when their enrollment in a CMO may also have to change.

These youth, in many of the same foster care settings as youth in the custody of the State’s Division of Family and Child Services, would therefore benefit from the specialized care delivered by one CMO.

Furthermore, serving a small population of members with special needs through one CMO may lead to more focused efforts and less burden for providers and members:

- While Maryland contracts with multiple health plans for its Medicaid managed care program, one health plan has been identified as the “MCO of choice” for youth in foster care in Baltimore. The MCO of choice was identified due to initiatives to

²⁵ Allen, K., Pires, S., Mahadevan, R., “Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit” Center for Health Care Strategies, Inc. February 2012. Available at: http://www.chcs.org/usr_doc/Child_Welfare_Quality_Improvement_Collaborative_Toolkit.pdf

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

coordinate with foster care case workers that have resulted in a 20 percent increase over three years in the youth receiving a comprehensive health risk screening upon enrollment. The MCO's efforts are being used as a model to expand statewide.²⁶

- The Georgia-based Coalition to Assure Redesign Effectiveness for Medicaid recommended that members should have availability of the same or similar access to services, eligibility requirements and service arrays regardless of provider or location in the state; and providers should have uniform processes for authorizations, credentialing and billing/payments.²⁷ Provider burden is minimized through contracting with one CMO and members will remain in one CMO regardless of transition. Therefore, they will not be burdened with new enrollment processes, paperwork and CMO processes and procedures upon transitions throughout the state.
- Researchers with the University of South Florida's *Health Care Reform Tracking Project* tracked and analyzed the impact of managed care initiatives on youth with emotional and substance abuse disorders and their families. They concluded:
 - Provider choice is more important to consumers than choice of managed care organization
 - Use of multiple MCOs either statewide or within regions creates more challenges and administrative complexities than advantages²⁸

Enrollment with one consistent CMO will result in continuity of care and better coordination. Based on a recommendation by the State's Pediatric Healthcare Improvement Coalition, DCH is contractually requiring the CMO to assign a Care Coordination Team to each member tailored to his or her individual needs. The Care Coordination Teams will assist members in navigating the health care system and will be the primary contact between the CMO and State agencies, members, foster parent(s) and caregivers.²⁹ The CMO will be required to coordinate all necessary health assessments within specified timeframes and the Care Coordination Teams will attain provider appointments to meet timeliness requirements. Through this approach, the fragmentation of care received by these populations will decrease. Youth in foster care and adoption

²⁶ Allen, K., Pires, S., Mahadevan, R., "Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit" Center for Health Care Strategies, Inc. February 2012. Available at: http://www.chcs.org/usr_doc/Child_Welfare_Quality_Improvement_Collaborative_Toolkit.pdf

²⁷ CARE-M. Inclusion of Children in Foster Care in Medicaid Managed Care. September 2012. Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions. GAO-12-270T. December 1, 2011. <http://www.gao.gov/products/GAO-12-270T>.

²⁸ Pires, S.A., Armstrong, M.I., & Stroul, B.A. (1999). Health Care Reform Tracking Project: 1999 Impact Analysis. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida.

²⁹ The Pediatric Healthcare Improvement Coalition, "Strategies for Medicaid & CHIP Redesign: Better Managing the Health of Georgia's Foster Children. September 2012

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

assistance will maintain the same CMO and Care Coordination Team to help them navigate the healthcare system through transitions in custody and residential placement.

In December 2011, the United States Government Accountability Office (GAO) released a report indicating that youth in foster care in the five studied states were prescribed psychotropic drugs at higher rates than other youth.^{30,31} This emphasizes the vulnerability of the Demonstration Populations and the importance of designing a system that minimizes the risks of poor care coordination and inappropriate utilization. Inappropriate psychotropic prescribing highlights one of many opportunities to improve care through the single accountability of one CMO. An exclusive CMO for the Demonstration Populations will also facilitate stable coordination patterns between physical health and behavioral health providers, as well as the multiple child-serving public systems in which the member may be involved.

DCH understands the vulnerability of the Demonstration Populations and is developing additional reporting requirements for the selected CMO. Given the unique challenges associated with these populations, a single CMO is more accountable for ensuring continuity of care and consistency of access and coverage for both physical and behavioral health services. It will also centralize service coordination and management of health care data and information. For example, Texas reported the following results between 2004 and 2012 for youth in foster care who are enrolled in a single Medicaid managed care program:

- A 34 percent decrease in psychotropic medication use 60 days plus
- A 66 percent decrease in polypharmacy class drug prescription
- A 71 percent decrease of five or more polypharmacy drug prescriptions³²

DCH is also enhancing the ability of the CMO and providers to provide more coordinated integrated care for members by developing a Virtual Health Record (VHR) specifically for managing the health information of the Demonstration Population. The VHR will be available 24 hours, 7 days per week, and improve timeliness of information available to support care management and continuity of care. The VHR will capture a more complete medical history for the Demonstration Populations even through varying custody arrangements and transitions among living arrangements throughout the State. This is consistent with the view of the American Academy of Pediatrics, which notes that

³⁰ Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions. GAO-12-270T. December 1, 2011. <http://www.gao.gov/products/GAO-12-270T>.

³¹ The GAO report acknowledged that the greater utilization could be due in part to greater behavioral health needs of children in foster care and challenges of coordinating their care. However, GAO also noted that some of this difference in utilization may be inappropriate as many children were on treatment regimens that had little or no supporting evidence.

³² Texas Health and Human Services Commission. Update on the Use of Psychotropic Medications for Children in Texas Foster Care: Fiscal Years 2002-2012. Available at: <http://www.hhsc.state.tx.us/medicaid/OCC/Psych-Medications.pdf>

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

“Coordinated behavioral and medical care for children in child welfare requires a cross-system approach – including effective mechanisms for data-sharing and communication – to ensure successful health care delivery that is tailored to this population’s unique needs.”³³

The VHR will provide secure data connectivity between various state agencies and programs serving the Demonstration Population in Georgia. This solution will decrease duplication of effort, provide data sharing capability, and enable providers to receive data from the electronic health records systems. Specific functionality will allow authorized clinicians and other authorized individuals to access various data sources connected to the statewide Georgia Health Information Network and query for relevant health information for the purpose of treatment and relevant specialized services. The VHR will be capable of presenting queried health information to a variety of end-use applications to efficiently meet information needs for the total care team. The information will be gathered, tailored to and compatible with the needs of DFCS case workers, foster care service providers, legal guardians, and health care providers.

While DCH’s primary motivation for moving the Demonstration Populations into a single CMO is to improve services and health outcomes, DCH recognizes that this transition may also decrease costs to the state in the long-term. For example, increased access to PCPs and health assessments may increase needed access to specialized care. This would increase costs in the short-term; however, if health outcomes improve over time, the State could possibly decrease the rate of growth of costs to care for the Demonstration Populations.³⁴ Dividing such a small population over multiple plans would create a barrier to the development of the necessary infrastructure and processes that are needed to properly serve the child. This model allows the single CMO to have the fiscal ability to build the necessary infrastructure and investment to serve these populations. The State believes that this customized program with a robust care coordination component will be successful in improving critical health outcomes while also decreasing costs.

3) *Indicate the delivery system that will be used in the Demonstration.*

DCH will use a managed care delivery system for the Demonstration and will contract with one managed care organization (or CMO as referred to in Georgia’s Medicaid program) to serve the Demonstration Population.

4) *If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration. Please also include the appropriate authority if the Demonstration will use a*

³³ American Academy of Pediatrics Guidelines for Foster Care. Available at: <http://aappolicy.aappublications.org/cgi/reprint/pediatrics;109/3/536.pdf>.

³⁴ Center for Public Policy Priorities. Medicaid Managed Care for Foster Children: An Early Report. November 2008. Available at: <http://library.cppp.org/files/4/351%20Medicaid%20Managed%20Care%20for%20Foster%20Care.pdf>.

**State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment**

delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option.

Figure 5. Delivery System Chart

Eligibility Group	Delivery System	Authority
All Demonstration Populations	Managed Care - CMO	1115

5) *If the Demonstration will utilize a managed care delivery system:*

a. *Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations?*

Enrollment of the Demonstration Populations into the single CMO will be mandatory. Youth in foster care or adoption assistance who are enrolled in the Georgia Pediatric Program (GAPP) will be excluded from participation. Participants of other HCBS Waiver programs who are also in the Demonstration Populations will be enrolled.

b. *Indicate whether managed care will be statewide, or will operate in specific areas of the state.*

The single CMO will operate statewide.

c. *Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state.).*

DCH plans to enroll all Demonstration Population members with the selected CMO upon the anticipated program effective date of January 1, 2014. However, DCH may consider a phased approach if discussions with the selected CMO about initial enrollment indicate a phased approach would be more appropriate given the complexities of these youth with special needs.

d. *Describe how will the state assure choice of MCOs, access to care and provider network adequacy.*

Although enrollment for the Demonstration Populations will be limited to a single CMO, members will have provider choice within the CMO. Providing services through one CMO will facilitate efficient care coordination between providers and stakeholders and increase stability.

To address the unique needs of the Demonstration populations, DCH will require that the contracted CMO demonstrate that the provider networks include primary care and specialist providers who are trained and experienced in treating youth represented by the Demonstration Populations. The CMO will assign members to a medical home and a dental home. The CMO's provider network must meet the geographic access standards outlined in Figure 6.

**State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment**

Figure 6: Geographic Access Standards

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

Additionally, if the provider network does not include a health care provider with appropriate training and experience in its panel or network meeting geographic access requirements, the CMO will be contractually required to make a referral to an appropriate out-of-network provider.

- e. *Describe how the managed care providers will be selected/procured.*

DCH will invite the three currently contracted CMOs participating in Georgia Families to present their approaches to serving the Demonstration Populations. Based on the preferred approach and negotiations, DCH will select a single CMO to provide services for the Demonstration Populations.

- 6) *Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.*

The Demonstration will not include the provision of HCBS waiver services for members of the Demonstration Population who are also enrolled in the State’s HCBS 1915(c) waiver programs. DCH and its partner agencies will continue the

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

administration of HCBS waiver services, and the CMO will be required to coordinate with DCH, partner agencies and HCBS providers. Members of the Demonstration Populations represent a small percent of each waiver's total enrollment; therefore, DCH believes it would be inefficient to require the CMO to develop a separate administrative process to provide HCBS waiver services for the Demonstration Populations. Also, any members in Georgia Pediatric Program within the same eligibility categories of members in the Demonstration Populations will be excluded from the Demonstration and remain in a FFS environment for all services (State Plan and waiver).

7) *If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration.*

The Demonstration will not provide personal care and/or long-term services and supports.

8) *If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.*

This is not applicable to this Demonstration.

9) *If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.*

There will be no deviations from the payment and contracting requirements of 42 CFR 438. DCH actuaries will use detailed FFS enrollment, medical, dental and prescription drug claims data to develop capitation rate ranges for Demonstration Populations. The source of the data will be two years of enrollment and claims data pulled from the Georgia MMIS. All expenditures for the Demonstration Population will be included in the MMIS claims data with adjustments for pharmacy rebates and third party liability recoveries.

Based on the two years of enrollment and claims data, DCH actuaries will apply the following adjustments to develop the CY 2014 per member per month capitation rate ranges:

- Completion factors for claims incurred in the base period but not actually paid
- Trend factors for the expected utilization and unit cost difference between the base period and the contract period (CY 2014)
- Managed care savings factors for the expected utilization difference and provider contracting difference between a FFS environment and a Managed care environment

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

- Adjustments for any program changes between the base period and the contract period
- FFS Provider reimbursement adjustment between the base period and the contract period
- Pharmacy claim adjustment for the rebate expected to be received by the CMO

10) *If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.*

DCH is implementing value-based purchasing (VBP) for its Medicaid program. A VBP model is an enhanced approach to purchasing and program management that focuses on value over volume. It is part of a cohesive strategy that aligns incentives for Members, Providers, the Contractor and the State to achieve the program's overarching goals. DCH will use a phased approach to implementing VBP. DCH's contract with the one CMO selected to administer services for this Demonstration will incorporate value-based purchasing that aligns established improvement goals with specific payment mechanisms. DCH will withhold a percentage of funds that will be paid to the CMO only upon meeting agreed upon performance targets.

In Year One of the program, DCH will focus on transactional (operational) measures and related targets that the CMO must meet. In subsequent years, DCH will work collaboratively with the contracted CMO to identify performance-based improvements and outcomes-based goals and will require that the contracted CMO share incentive payments with providers. The CMO will develop the provider incentive strategy which will be reviewed and approved by DCH. Additionally, DCH may incorporate requirements for member incentive programs.

Section V – Implementation of Demonstration

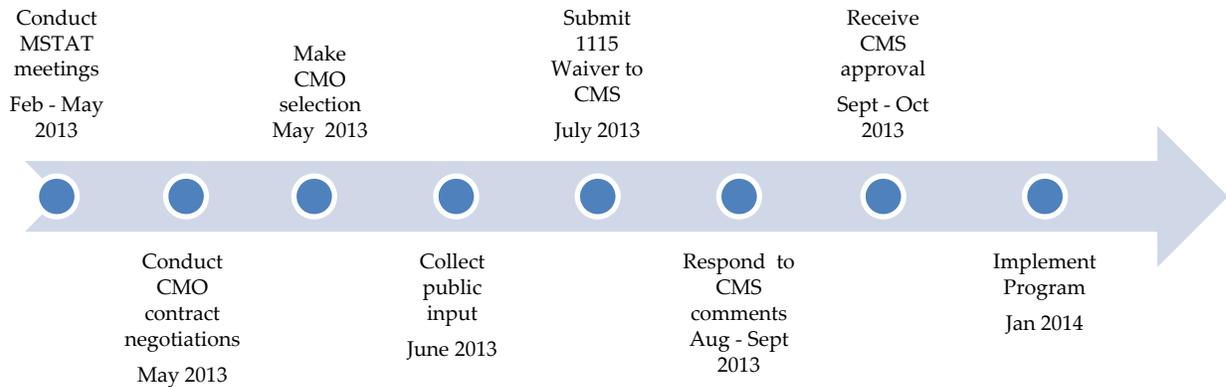
This section should include the anticipated implementation date, as well as the approach that the State will use to implement the Demonstration. Specifically, this section should:

- 1) *Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.*

The targeted implementation date for this Demonstration is January 1, 2014. Figure 7 shows the anticipated timeline and phased approach for implementation. To permit sufficient time for contract negotiations to meet this implementation deadline, DCH is seeking federal approval by October 2013.

**State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment**

Figure 7: 1115 Waiver Demonstration Timeline



- 2) *Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.*

Members of the Demonstration Populations have complex health care needs that often require attention immediately upon entering state custody. Expedited enrollment is crucial for these Populations. Because this Demonstration includes one exclusive CMO, DCH will be able to enroll members into Georgia Families within forty-eight (48) hours of a member entering foster care. DCH will provide a daily eligibility file to the CMO.

The CMO will be required to submit electronically via secure methods information packets to Georgia's Division of Family and Children Services Case Managers for newly enrolled youth in foster care and adoption assistance and to Juvenile Probation and Parole Specialists for youth in the juvenile justice system within five calendar days of receipt of the eligibility file from DCH. Information packets will be used to notify the Member of enrollment with the CMO and to provide detailed information about available services:

- A welcome letter that includes the name and contact information for the Member's assigned CMO Care Coordinator
- A Member Handbook
- A new member ID card
- A PCP change form and a Dentist change form
- A form requesting information about any special health care needs and specific services for which the CMO may need to coordinate services

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

- Information for Members about the roles of the Care Coordination Team and how to seek help in scheduling appointments, and accessing Care Coordination services
- Information for Members about the role of the CMO Call Center and how to access the Call Center
- Information about 72-hour emergency prescription drug supply
- Information about the Ombudsman Liaison

If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action.

DCH invited the three currently contracted CMOs participating in Georgia Families to present their approaches to serving the Demonstration Populations. Based on the preferred approach and negotiations, DCH will select a single CMO to provide services for the Demonstration Populations. This selection process was endorsed by the State Department of Administrative Services.

Section VI – Demonstration Financing and Budget Neutrality

This section should include a narrative of how the Demonstration will be financed as well as the expenditure data that accompanies this application. The State must include 5 years of historical data, as well as projections on member month enrollment. In accordance with 42 CFR 431.412(a)(iii) and (iv), historical and projected expenditures as well as projected enrollment for the proposed demonstration project must be included in a state's application in order to be determined complete. The additional information requested will be needed before the application can be acted upon.

DCH must demonstrate budget neutrality for the Demonstration Project. Budget neutrality means that Georgia may not receive more federal dollars under the Demonstration than it would have received without it over the five year demonstration period. The DCH methodology for assessing budget neutrality uses a set of specified annual per capita costs multiplied by the estimated enrollment for each year of the five year Demonstration. This is DCH's best estimate of cost and enrollment at the time of the Demonstration Proposal submission. For detail on the budget neutrality calculation please refer to Appendix A: Description of Budget Neutrality Calculation and Appendix B: Budget Neutrality Estimates.

Section VII – List of Proposed Waivers and Expenditure Authorities

This section should include a preliminary list of waivers and expenditures authorities related to title XIX and XXI authority that the State believes it will need to operate its Demonstration. In accordance with 42 CFR 431.412(a)(vi), this section must be included in a state's application in order to be determined complete. Specifically, this section should:

- 1) Provide a list of proposed waivers and expenditure authorities; and

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

- 2) *Describe why the state is requesting the waiver or expenditure authority, and how it will be used.*

DCH is requesting the following waivers to test the goals and objectives of the Demonstration to improve care coordination and health outcomes:

- Amount, Duration, Scope – Section 1902(a)(10)(B)

Rationale for Authority: To permit the State to provide enhanced case management services to Demonstration Populations that are not otherwise available to state plan populations.

- Comparability – Section 1902(a)(17)

Rationale for Authority: To permit the State to exclude from the Demonstration:

- 1) Members within the same eligibility categories as the Demonstration Populations who are eligible and enrolled in the Georgia Pediatric Program (GAPP). GAPP members will remain in FFS delivery for all State Plan and HCBS waiver services.
- 2) Members who are enrolled in Right from the Start Medicaid, with the exception of youth less than 18 years of age who are in the juvenile justice system and placed in community residential care.

- Rate-Setting/Payment Methodologies – Section 1902(a)(13) and (a)(30)

Rationale for Authority: To permit the State to implement a value-based purchasing strategy with the single CMO, based on the use of withholds and incentives as well as the creation of an escrow account.

- Freedom of Choice – Section 1902(a)(23)(A)) and Section 1932(a)(2)(A)

Rationale for Authority: To permit the State to use selective contracting to limit enrollment and freedom of choice for Demonstration Populations to a single, risk-based CMO that will operate statewide. The State also seeks to mandatorily enroll in risk-based managed care youth in foster care and adoption assistance and selected youth in the juvenile justice system.

Additionally, DCH is requesting the following expenditure authorities:

- To permit expenditures under contracts with the single CMO that do not meet the requirements in section 1903(m)(2)(A)(vi) but only insofar as it requires compliance with section 1932(a)(4) of the Act regarding the ability of enrollees to disenroll from a managed care entity.

**State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment**

- To permit expenditures under contracts with the single CMO that do not meet the requirements of section 1903(m)(2)(A)(xii) but only insofar as it requires compliance with section 1932(a)(3)(A) regarding choice of at least two managed care organizations.

Section VIII – Public Notice

This section should include information on how the state solicited public comment during the development of the application in accordance with the requirements under 42 CFR 431.408. For specific information regarding the provision of state public notice and comment process, please click on the following link to view the section 1115 Transparency final rule and corresponding State Health Official Letter: <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>

DCH conducted a very inclusive and transparent process in analyzing redesign options and developing the Demonstration. DCH and its Agent have facilitated public input, examples of which are included in Figure 8.

Twenty-five focus groups were conducted in 12 locations throughout the State of Georgia between October 11, 2011 and November 2, 2011. As shown in Figure 8, 213 providers, consumers and consumer advocates participated. Focus group participants were selected through a combination of personal applications and randomly from lists of providers.

Figure 8. Examples of Public Input Processes Conducted by Department of Community Health

Public Input Process	Description
Focus Groups	In Fall 2011, Navigant conducted 30 focus groups in 12 unique locations in the State <ul style="list-style-type: none"> • Member and Advocate Focus Groups: Four focus groups conducted with 23 attendees • Provider Focus Groups: Nineteen focus groups conducted with 190 attendees • Vendor Focus Groups: Two focus groups conducted, including currently contracted vendors and others • Legislative Focus Groups: Two focus groups conducted
Online Surveys	To provide another forum for stakeholders who were unable to attend focus groups, in Fall 2011, Navigant published online surveys focused on member, advocate and provider stakeholders. This survey was available for completion for three months, and Navigant received more than 1,300 responses.
“MyOpinion” Mailbox	In September 2011, DCH established an e-mail address for stakeholders to submit input. DCH has received and reviewed hundreds of emails and proposals from a variety of stakeholder types through this mailbox.

**State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment**

Public Input Process	Description
Task Forces	<p>Beginning in February 2012, DCH convened the below three task forces to provide ongoing input into program design and that will continue through implementation. Each task force includes approximately 22 members.</p> <ul style="list-style-type: none"> • Provider Task Force: Includes members who represent a variety of provider types, including hospitals, nursing homes, physicians, home health, hospice, provider associations, among others • Children and Families Task Force: Includes members with representation including, parents of members, advocacy organizations and provider groups • “ABD” Task Force: Includes members with representation including parents of members with disabilities, advocacy organizations and provider groups
Mental Health and Substance Abuse Workgroup	<p>DCH convened this workgroup in April 2012 to provide ongoing input into the design and that will continue through implementation. This workgroup includes members with representation including parents of members, advocacy organizations and provider groups.</p>

Additionally, DCH has formed a Foster Care and Adoption Assistance Joint Task Force which is an interagency team that includes representatives from DCH and the following agencies:

- Department of Behavioral Health and Developmental Disabilities (DBHDD)
- Department of Juvenile Justice (DJJ)
- Department of Human Services (DHS)
- Department of Public Health (DPH)
- Department of Education (DOE)
- Department of Early Care and Learning (DECAL)

The Joint Task Force is advisory in nature and its goal is to provide input into the transition of youth in foster care and adoption assistance into the Georgia Families program. Input from Joint Task Force members has helped to ensure a program that is child-centric and focused on coordination of care.

DCH also conducted a public comment period to receive input about this 1115 demonstration as described in response to the below questions.

1) *Start and end dates of the state’s public comment period.*

DCH conducted a public comment period from June 13, 2013 through July 14, 2013.

2) *Certification that the state provided public notice of the application, along with a link to the state’s*

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

DCH provided public notices about the 1115 waiver demonstration as follows:

- Posted the public notice on the DCH website on June 13, 2013 at the following link: <http://dch.georgia.gov/public-notices>
 - Provided the public notice in the Department of Community Health Board Meeting on June 13, 2013
 - Provided the abbreviated public notice in the *Atlanta Journal Constitution* during the week of June 17, 2013
 - Provided copies for review at the office locations of Department of Community Health in Atlanta, Georgia
 - Provided copies for review at each county Department of Family and Children Services office
- 3) *Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.*

DCH is convening two hearings:

- Macon, Georgia on June 24, 2013 in the office of the Professional Licensing Boards.
- Atlanta, Georgia on June 25, 2013 in the office location for the Georgia Department of Community Health. As a courtesy, the State is making teleconference access available for this hearing.

PLACEHOLDER: Descriptions from the hearings will be added after they occur.

- 4) *Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used.)*

PLACEHOLDER: DCH will send the public hearing notice through an e-newsletter, DCH-I that is sent to an estimated 15,000 stakeholders, providers and consumers.

- 5) *Comments received by the state during the 30-day public notice period.*

PLACEHOLDER: A summary of comments will be added after conduct of Public Input Process.

- 6) *Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.*

**State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment**

PLACEHOLDER: A summary of responses to submitted comments will be added after conduct of Public Input Process.

- 7) *Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.*

There are no Federally recognized Tribes in the State of Georgia.

Section IX – Demonstration Administration

Please provide the contact information for the state's point of contact for the Demonstration application.

Name and Title: Jerry Dubberly, Chief Medicaid Division

Telephone Number: 404.651.8681

Email Address: jdubberly@dch.ga.gov

Appendix A: Description of Budget Neutrality Calculation

The purpose of this document is to describe the development of the budget neutrality calculations for the Georgia 1115 Demonstration Proposal. Per CMS guidance, budget neutrality consists of the following three worksheets: Historical Data, Without Waiver, and With Waiver. The methodology used to complete these worksheets is detailed below and assumes the effective date for the five year Demonstration project is January 1, 2014.

Components of Budget Neutrality Methodology

1. Historical Data

The Department of Community Health (DCH) developed the budget neutrality demonstration using FFS claims and enrollment data for Medicaid and PeachCare for Kids ® members in foster care, adoption assistance and selected youth in the juvenile justice system. The data covers incurred costs for the required five year period from State Fiscal Year (SFY) 2008 through SFY 2012. The State Fiscal Year runs from July 1 through June 30. This data was queried from the Georgia Medicaid Management Information System.

2. Without Waiver

The Without Waiver calculation uses the historical data to project the enrollment and per member per month expenditure trends to Demonstration Year 00 (DY 00), which equates to Calendar Year 2013 (CY 13). The DY 00 enrollment and per member per month (PMPM) cost is then projected to DY 01 through DY 05 or CY 14 to CY 18.

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

Enrollment Projection

The enrollment projection was developed by analyzing historical member month changes between SFY 2008 to SFY 2012. This time period showed a significant decrease in members at -4% over the five year period. However, this trend was due in part to changes in the Department of Human Services foster care enrollment policy. In addition, foster care program enrollment actually increased between SFY 2011 and SFY 2012. Therefore, DCH opted for a conservative approach in estimating demonstration population enrollment. For both the With Waiver and Without Waiver estimates, the trended enrollment for the five year demonstration is based on the Georgia Office of Planning and Budget's Residential Population Projection by Age for 2012 – 2020 and does not assume any changes in foster care policy that would result in a decline in membership. The annual enrollment trend is 0.845%.

PMPM Trends

The PMPM trend was developed by analyzing historical FFS expenditures between SFY 2008 to SFY 2012 at the category of service level of detail with costs associated with nursing home care and the Georgia Pediatric Program adjusted out as these services are not included in the Demonstration. These services were then projected forward for DY 01 to DY 05 based on a historical trend rate of 8.56%.

3. With Waiver

Similar to the Without Waiver component, the With Waiver calculations use historical data to project to Demonstration Year 00 (DY00) or CY 13. DY 00 PMPMs are then projected to DY 01 to DY05 or CY 14 to CY 18.

Enrollment Projection

The enrollment projection is the same as in the Without Waiver projection.

PMPM Trends

As in the Without Waiver calculation, the PMPM trend was developed using historical fee-for-service expenditures between SFY 2008 to SFY 2012 at the category of service level of detail with costs associated with nursing home care and the Georgia Pediatric Program adjusted out as these services are not included in the Demonstration. The With Waiver estimate for the five year demonstration period assumes increased costs in year one of the program due to pent up demand for services for the demonstration population. However, beginning in DY 02 and based on input from DCH actuaries, the expenditure trend is assumed to be 6% annually in order to reflect medical trends under a managed care environment.

Appendix B contains the Budget Neutrality worksheets for the Historical Data, Without Waiver, and With Waiver.

State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment

Appendix B: Budget Neutrality Estimates

5 YEARS OF HISTORIC DATA

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:

Medicaid Pop 1	HY 1	HY 2	HY 3	HY 4	HY 5	5-YEARS
TOTAL EXPENDITURES	\$129,478,625	\$132,088,989	\$134,749,406	\$140,203,778	\$152,032,430	\$688,553,228
ELIGIBLE MEMBER MONTHS	378,782	353,282	319,479	312,161	320,251	
PMPM COST	\$341.83	\$373.89	\$421.78	\$449.14	\$474.73	
TREND RATES	ANNUAL CHANGE					5-YEAR AVERAGE
TOTAL EXPENDITURE		2.02%	2.01%	4.05%	8.44%	4.10%
ELIGIBLE MEMBER MONTHS		-6.73%	-9.57%	-2.29%	2.59%	-4.11%
PMPM COST		9.38%	12.81%	6.49%	5.70%	8.56%

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS										
ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	DEMONSTRATION YEARS (DY)					TOTAL WOW
					DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Pop 1 using historic trends										
Pop Type: Medicaid										
Eligible Member Months	0.8%	18	324,319	0.8%	327,059	329,823	332,610	335,420	338,255	
PMPM Cost	8.56%	18	\$536.97	8.6%	\$582.93	\$632.83	\$687.00	\$745.81	\$809.65	
Total Expenditure					\$190,652,639	\$208,721,816	\$228,502,993	\$250,159,919	\$273,867,953	\$1,151,905,319

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS										
ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW		
			DY 01	DY 02	DY 03	DY 04	DY 05			
Medicaid Pop 1										
Pop Type: Medicaid										
Eligible Member Months	324,319	0.8%	327,059	329,823	332,610	335,420	338,255			
PMPM Cost	\$536.97		\$599.07	\$635.02	\$673.12	\$713.51	\$756.32			
Total Expenditure			\$195,931,866	\$209,444,128	\$223,886,367	\$239,325,839	\$255,828,828	\$1,124,417,027		

**State of Georgia Department of Community Health
Section 1115 Demonstration Proposal
Draft for Public Comment**

Budget Neutrality Summary						
Without-Waiver Total Expenditures						
	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Medicaid Pop 1 using historic trends	\$ 190,652,639	\$ 208,721,816	\$ 228,502,993	\$ 250,159,919	\$ 273,867,953	\$ 1,151,905,319
TOTAL	\$ 190,652,639	\$ 208,721,816	\$ 228,502,993	\$ 250,159,919	\$ 273,867,953	\$ 1,151,905,319
With-Waiver Total Expenditures						
	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Medicaid Pop 1	\$ 195,931,866	\$ 209,444,128	\$ 223,886,367	\$ 239,325,839	\$ 255,828,828	\$ 1,124,417,027
TOTAL	\$ 195,931,866	\$ 209,444,128	\$ 223,886,367	\$ 239,325,839	\$ 255,828,828	\$ 1,124,417,027
VARIANCE	\$ (5,279,227)	\$ (722,312)	\$ 4,616,625	\$ 10,834,080	\$ 18,039,125	\$ 27,488,292