Citation	Condition or Requirement

1932(a)(1)(A)

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

The State of Georgia enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to provide a statewide Disease Management Program through Enhanced Primary Care Case Management to Medicaid beneficiaries who meet nursing home level of care requirements and who have chronic illnesses, to help them better manage their diseases without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

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

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

1. The State will contract with an

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

Georgia Better Health Care (GBHC) is a PCCM program for the State of Georgia. This program matches Medicaid recipients to a primary care provider (PCP) who, through an on-going provider/patient relationship, coordinates health care services, including referrals for necessary specialty services, and maintains 24-hour availability to members. GBHC also has an enhanced PCCM disease management component.

This SPA builds on the basic GBHC program and the enhanced PCCM disease management program by incorporating an additional enhanced PCCM (E-PCCM) program targeted to beneficiaries who meet nursing home level of care criteria.

Citation	Condition or Requirement

Under this additional E-PCCM program, called the SOURCE program, the E-PCCM provider manages the enrolled member's health by working directly with the member and their physicians on their treatment plan regarding diet, adherence to medicine schedules and other self-management techniques by:

1. *Increasing the member and/or their caregivers' understanding of their disease so they are:*

   - *Better able to understand their disease(s);*
   - *Better able to access regular preventative healthcare by improving their self management skills;*
   - *Better able to understand the appropriate use of resources needed to care for their disease; and*
   - *Improve members quality of life by assisting them in self-managing their disease and in accessing regular preventative health care.*

2. *Providing coordination between case manager and health care providers.*

3 *Improving adherence to national, evidence-based guidelines to improve member's health status*

4. *Reducing the need for long-term institutional placement and increasing options for aged and disabled members.*

5. *Preventing the level of disability and disease from increasing in chronically ill members.*

6. *Eliminating fragmented service delivery through managed care principles and outcome-based case management..*

7. *Increasing the cost-efficiency and value of Medicaid LTC funding by reducing inappropriate emergency room use, multiple hospitalizations and nursing home placement caused by preventable medical complications; also by promoting self-care and informal support when possible for individual members.*

The Department contracts with SOURCE E-PCCM Organizations throughout the State that engage a network of credentialed primary care physicians, medical personnel, service providers and hospitals to work closely with the case manager to meet program goals for enrolled members. This effective enhanced case management model requires a commitment of time, energy and focus from all

Citation	Condition or Requirement

providers and a standardized set of expected outcomes for the member, with an individualized plan to achieve each outcome.

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

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

___ i. fee for service;
___ ii. capitation;
__x__ iii. a case management fee;
___ iv. a bonus/incentive payment;
___ v. a supplemental payment, or
___ vi. other. (Please provide a description below).

The E-PCCM entity receives a standard per member per month case management fee. Providers that render services to Members will continue to receive payment for services under the current Georgia fee for service methodology.

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

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

If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

___ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

___ ii. Incentives will be based upon specific activities and targets.

___ iii. Incentives will be based upon a fixed period of time.

___ iv. Incentives will not be renewed automatically.

___ v. Incentives will be made available to both public and private PCCMs.

Citation	Condition or Requirement

____ vi. Incentives will not be conditioned on intergovernmental transfer agreements.

__x__ vii. Not applicable to this 1932 state plan amendment.

CFR 438.50(b)(4)

4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

During the design and development of the SOURCE E-PCCM program, the state involved numerous interested parties, such as healthcare systems that coordinate primary physician care and acute care with other services. The department continues to have public meetings, and the Georgia State Health Policy Center at the local university has also conducted several meetings with providers. The department's nursing facility transitions grant conducted a pilot project in eighteen north and south/central Georgia counties to transition members out of area nursing facilities enrolling them in EPCCM

1932(a)(1)(A)

5. The state plan program will ____ / will not __x__ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory ____ / voluntary ____ enrollment will be implemented in the following county/area(s):

i. county/counties (mandatory) _____

ii. county/counties (voluntary)_____

iii. area/areas (mandatory)_____

iv. area/areas (voluntary)_____

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

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

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

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

Citation		Condition or Requirement
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2.	_x_ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3.	N/A The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4.	N/A The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5.	_x_ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6.	N/A The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7.	_x_ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.
45 CFR 74.40	8.	_x_ The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D.	Eligible groups
1932(a)(1)(A)(i)	1.	List all eligible groups that will be enrolled on a mandatory basis. *Enrollment in the SOURCE E-PCCM is voluntary.*
	2.	Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

Citation	Condition or Requirement

1932(a)(2)(B)
42 CFR 438(d)(1)

i. _X_ Recipients who are also eligible for Medicare.
If enrollment is voluntary, describe the circumstances of enrollment.

Recipients who are also eligible for Medicare may voluntarily enroll into the SOURCE E-PCCM if they meet the nursing home level of care and are not being served in another case management service.

1932(a)(2)(C)
42 CFR 438(d)(2)

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

1932(a)(2)(A)(i)
42 CFR 438.50(d)(3)(i)

iii. _X_ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.

Children in this group can voluntarily enroll in the SOURCE E-PCCM program when they meet nursing home level of care.

1932(a)(2)(A)(iii)
42 CFR 438.50(d)(3)(ii)

iv. ___ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.

1932(a)(2)(A)(v)
42 CFR 438.50(3)(iii)

v. ___ Children under the age of 19 years who are in foster care or other out-of-the-home placement.

1932(a)(2)(A)(iv)
42 CFR 438.50(3)(iv)

vi. ___ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.

1932(a)(2)(A)(ii)
42 CFR 438.50(3)(v)

vii. ___ Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

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

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

Citation	Condition or Requirement
	Children receiving services funded by title V are enrolled in the Children's Medical Services program, administered by the Georgia Division of Public Health. This program provides comprehensive, coordinated, Title V services for children birth to age 21 with chronic medical conditions.
1932(a)(2) 42 CFR 438.50(d)	2. Place a check mark to affirm if the state's definition of title V children is determined by: ___ i. program participation, ___ ii. special health care needs, or __x__ iii. both
1932(a)(2) 42 CFR 438.50(d)	3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system. __x__ i. yes ___ ii. no
1932(a)(2) 42 CFR 438.50 (d)	4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)* i. Children under 19 years of age who are eligible for SSI under title XVI; *There is no mandatory enrollment in SOURCE E-PCCM.* ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; *There is no mandatory enrollment in SOURCE E-PCCM.* iii. Children under 19 years of age who are in foster care or other out-of-home placement; *There is no mandatory enrollment in SOURCE E-PCCM.* iv. Children under 19 years of age who are receiving foster care or adoption assistance. *There is no mandatory enrollment in SOURCE E-PCCM.*

Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* *There is no mandatory enrollment in the SOURCE E-PCCM.*
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)* i. Recipients who are also eligible for Medicare. *There is no mandatory enrollment in SOURCE E-PCCM.* ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. *There are no federally recognized Indian Tribes in Georgia.*
42 CFR 438.50	F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment *There is no mandatory enrollment into SOURCE E-PCCM.*
42 CFR 438.50	G. List all other eligible groups who will be permitted to enroll on a volnntary basis *The SOURCE E-PCCM will be offered statewide on a voluntary basis to Medicaid SSI recipients that meet nursing home level of care criteria. SSI Recipients include aged, blind or disabled adults age 19 and above who receive Supplemental Security Income (SSI) benefits, as well as those below age 19 years.*
	H. Enrollment process.
1932(a)(4) 42 CFR 438.50	1. Definitions

Citation	Condition or Requirement

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

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

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

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

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

The SOURCE E-PCCM is voluntary and will not utilize default enrollment.

Members may self refer or be referred by their PCP or other treating medical professional. Members are screened by the SOURCE E-PCCM entity to determine if they meet the nursing home level of care, and to gather data for the Department on persons seeking long term care services to help them better understand and manage their disease states.

The Case Management staff using a standard assessment form assesses members enrolling in SOURCE E-PCCM. The purposes of the assessment are:

- *To determine program eligibility*
- *To build a personal profile, including gathering medical, functional and psychosocial information, which will serve as the basis for case management interaction, level of care determination, care path development and delivery of service.*
- *To identify urgent problems requiring prompt attention.*
- *To gather data regarding the population served by the project, for the department's review and to develop a protocol for care.*
- *To see firsthand the living environment of members (assessing the physical structure and safety, meeting caregivers or family members as indicated to assess their informal support system, etc.).*
- *To determine the amount and level of service needed*

SOURCE E-PCCM admission occurs with three steps following assessment:

Citation	Condition or Requirement

- *The new member is reviewed by a multi-disciplinary team;*
- *The new member receives a level of care assignment; and*
- *The new member information is provided to Georgia Health Partnership for enrollment.*

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

The SOURCE E-PCCM is voluntary and will not utilize default enrollment.

iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

The SOURCE E-PCCM is voluntary and will not utilize default enrollment.

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

i. The state will ___/will not _x_ use a lock-in for EPCCM enrollment once the members has selected a participating provider.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be _N/A_.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

N/A

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

N/A

Citation	Condition or Requirement

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

N/A

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

N/A.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

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

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

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

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

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

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

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

Citation	Condition or Requirement

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

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

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will___/will not _x_ use lock-in for managed care.

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

3. Place a check mark to affirm state compliance.

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

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

Members may disenroll at any time. Members will be automatically disenrolled in the following circumstances:

- *Enrollment in a Hospice service;*
- *Medicaid eligibility ends;*
- *Enrolled in another case management program;*
- *Death; and*
- *Enter a nursing facility due to increased impairment or illness*

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

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

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

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

Enrollees obtain referrals from their PCP for all ambulatory and facility services, with the exception of behavioral health services.

Citation	Condition or Requirement

1932 (a)(1)(A)(ii) M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will__X__/will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. __X__ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

SOURCE E-PCCM entities are selected based on the following criteria:

- *A network of primary care physicians, medical personnel, service providers, and hospital affiliations within the state, credentialed by the Department;*
- *A minimum of two years experience providing case management and disease management monitoring;*
- *A history of working with enhanced primary care case management programs; and*
- *The ability to meet the State's electronic data reporting requirements.*

4. _____ The selective contracting provision in not applicable to this state plan.