Citation	Condition or Requirement

1932(a)(1)(A)

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

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

B. General Description of the Program and Public Process.

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

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

1. The State will contract with an

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

Georgia Better Health Care (GBHC) is a PCCM program for the State of Georgia. This program matches Medicaid aged, blind and disabled beneficiaries to a primary care provider (PCP). The PCP is responsible for coordinating health care services, including necessary referrals, and maintaining a 24-hour availability for beneficiaries. This SPA will incorporate a disease management component to GBHC, as an enhancement to the basic PCCM program. Through this enhanced PCCM program it is expected that health outcomes of the population will improve, while medical costs will decrease. The disease management program will include the following components:

- Patient and provider adherence to evidence-based clinical guidelines;
- Twenty –four hour call nurse;
- Provider education to improve adherence to clinical guidelines and total enrollee care;
- Enrollee education to improve self-management of their diseases/conditions

Citation	Condition or Requirement

- Claims analysis, including enrollee and provider profiling; and
- Clinical outcome measurements reporting and feedback to providers and enrollees on a scheduled basis.

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

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

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

Primary Care Providers participating in GBHC will be paid fee for service (FFS) for medical services provided. In addition, PCPs will be paid a monthly case management fee for performing the case management functions expected of the PCP.

As part of the enhanced PCCM program, the disease management entity will be paid a monthly fee for case management services for face-to-face and ancillary contact. This rate will be triggered by a submitted monthly claim, ie, upon member receipt of services the disease management entity will submit a claim for the monthly all-inclusive rate. The rate will not be paid unless and until services are rendered, unlike prepaid capitation payments, which are paid monthly regardless of whether any services are rendered. The disease management entity will not be "at-risk" for the provision of medical services. The rate will be based on all case management services to be performed by the disease management entity on a monthly basis. Services other than case management services will be rendered by Medicaid providers and paid according to the State's fee schedule.

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.

Citation	Condition or Requirement

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.

____ 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.)*

Georgia Better Health Care (GBHC) began on a limited basis in 1993. Throughout the design, initial implementation, and statewide expansion, the State has obtained and considered public comment from providers and recipients. As a PCCM program, GBHC operates concurrent with the CMO program Georgia Cares (GCS). An extensive public notice process, including numerous stakeholder meetings, was held in conjunction with the design of GCS and the resulting changes to the GBHC program, including the addition of a disease management component. The ongoing public input process established under GBHC will continue, including the Advisory Committee, staff liaisons and member surveys.

1932(a)(1)(A)

5. The state plan program will x /will not___ 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):

Citation	Condition or Requirement

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.

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

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

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

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

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

Citation	Condition or Requirement

1932(a)(1)(A)
42 CFR 447.362
42 CFR 438.50(c)(6)

7. __N/A__ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met. This section applies to nonrisk prepaid capitation plans. Under this contract the disease management entity will be paid on a FFS basis.

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.

- **SSI RECIPIENTS** - Aged, blind or disabled adults age 19 and above who receive Supplemental Security Insurance (SSI) benefits. This excludes residents of nursing homes, personal care homes, or mental health hospitals or other domiciliary facilities.

Previous eligibility groups listed for participation in GBHC PCCM will now be enrolled in Georgia Cares (GCS), according to the phased-in implementation schedule for GCS.

For the enhanced PCCM disease management component, enrollment will be 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.

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

i. ____ Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment.
(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)

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

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

Citation	Condition or Requirement
	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.
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.)* *Children receiving services funded by title V are enrolled in the Children's Medical Services program, administered by the Georgia Division of Public Health. This program provides comprehensive, coordinated, community-based, Title V services for children birth to age 21 with chronic medical conditions.*
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.

Citation	Condition or Requirement

__x__ i. yes
____ ii. no

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

4. Describe how the state identifies the following groups of children who are exempt 42 from mandatory enrollment: *(Examples: eligibility database, self- identification)*

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

Identification for purposes of exemption will be accomplished by reviewing the eligibility database for each aid category. Exempted aid categories have an identifying edit. For enrollees who should be exempt but are inadvertently enrolled in the PCCM program, notification by the enrollee, provider or other state agency of the exempt status will be processed by the State and the child will be disenrolled.

ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

Identification for purposes of exemption will be accomplished by reviewing the eligibility database for each aid category. Exempted aid categories have an identifying edit. For enrollees who should be exempt but are inadvertently enrolled in the PCCM program, notification by the enrollee, provider or other state agency of the exempt status will be processed by the State and the child will be disenrolled.

iii. Children under 19 years of age who are in foster care or other out-of-home placement;

Identification for purposes of exemption will be accomplished by reviewing the eligibility database for each aid category. Exempted aid categories have an identifying edit. For enrollees who should be exempt but are inadvertently enrolled in the PCCM program, notification by the enrollee, provider or other state agency of the exempt status will be processed by the State and the child will be disenrolled.

iv. Children under 19 years of age who are receiving foster care or adoption assistance.

Identification for purposes of exemption will be accomplished by reviewing the eligibility database for each aid category. Exempted aid categories have an identifying edit. For enrollees who should be exempt but are inadvertently enrolled in the PCCM program, notification by the enrollee, provider or other state agency of the exempt status will be processed by the State and the child will be disenrolled.

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)* *If the eligibility match does not initially identify those enrollees exempt from enrollment in the PCCM program, the enrollee, or their provider or another state agency, may notify the State of the error and the child will be exempted from mandatory enrollment.*
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. *Identification for purposes of exemption will be accomplished by reviewing the eligibility database for each aid category. Exempted aid categories have an identifying edit. For enrollees who should be exempt but are inadvertently enrolled in the PCCM program, notification by the enrollee, provider or other state agency of the exempt status will be processed by the State.* 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 *Children enrolled in the Georgia Pediatric Program (GAPP) who are eligible under another aid category in addition to section 1902(e)(3) will be exempted from enrollment. In addition, children with severe emotional disturbance who need mental health treatment in residential settings are exempted from enrollment into the PCCM program. Their care is coordinated under the Multi-Agency Team for Children (MATCH) program. For both of these groups of children, eligibility files will be matched, as will category of service files, to exempt these children from mandatory enrollment. In the case of inadvertent enrollment into the PCCM, the enrollee, provider or another state agency may request disenrollment*

Citation	Condition or Requirement

based upon the enrollee's participation in GAPP or MATCH and the child will be disenrolled.

42 CFR 438.50

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

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

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

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

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

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

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

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

The State assures that default enrollment will be based on maintaining existing, as well as historical, provider/enrollee relationships to the extent possible. Enrollees are auto-assigned to a PCP provider based on enrollee and family history, as well as sex, age and geographic proximity. If no enrollee history with a PCP exists, a search is done for a family member's history with a PCP for assignment. Lacking any historical or family history, enrollees are assigned to PCPs using an algorithm based on age, sex, geographic proximity, and in a manner that equitably distributes enrollees among qualified PCCMs available. Enrollees are notified of the auto-assignment and provided with a list of providers within the enrollee's service area. If unhappy with an auto-assigned provider, an enrollee may contact Member Services within the first 90-day period to request a change.

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

Citation	Condition or Requirement

PCP providers in the GBHC PCCM are those providers that have traditionally served the Medicaid population. Enrollees participating in the enhanced PCCM disease management component will continue to receive services from their PCP.

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.)*

GBHC is operational statewide. Individuals in every county have a choice of two (2) Georgia Better Health Care providers offering primary care case management services within their county of residence or adjacent counties. In rural areas, if only one PCCM group exists within the enrollee service area, enrollees will be given a choice between two providers within the PCCM group. The auto-assignment process includes mechanisms for monitoring PCP enrollment and enrollees are distributed equitably among PCCM groups and PCPs.

For the disease management component of the program enrollees will be auto-assigned to disease management entity operating in the geographic region in which the enrollee resides. Because participation in the disease management component is voluntary, enrollees may disenroll from the enhanced PCCM disease management program at any time.

1932(a)(4)
42 CFR 438.50

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

i. The state will__x__/will not____ use a lock-in for enrollment into the PCCM.

ii. The State will____/will not__x__ use a lock-in for enrollment into the enhanced PCCM disease management component.

iii. The time frame for recipients to choose a PCCM before being auto-assigned will be __15 days__.

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

Once eligibility is determined, beneficiaries are mailed informational materials regarding GBHC. In addition to information on the auto-assignment process, the

Citation	Condition or Requirement

materials include information on: eligibility requirements and exclusions, provider and member rights and responsibilities, grievance, fair hearing and appeal procedures and timeframes, covered services and those services that are not covered by Georgia Better Health Care, Primary Care Case Managers available, cost sharing (if applicable), non-English languages of service area providers, how to obtain services not provided by the PCP (including referrals to specialists) and, to the extent available, quality and performance indicators and member satisfaction information. Also included is a list of 2 or more primary care providers located geographically convenient to the recipient. Additionally, enrollees will receive information about the enhanced PCCM disease management program.

If the beneficiary does not choose a PCP, assignment is completed through the auto-assignment process and enrollees are notified by mail of the auto-assignment. Enrollees have access to a toll-free number for Member Services to assist with PCP selection, PCP changes and access issues that may occur. Periodic surveys are done to assess enrollee satisfaction including travel time to the primary care provider office and wait times for scheduled appointments.

For assignment to a specific nurse case manager within a disease management entity, the process will be developed by the disease management entity.

v. 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.)*

The information packet described above includes member rights, including disenrollment rights. Enrollees have the opportunity to change their PCP within the first 90 days of enrollment or reenrollment and every six months thereafter. Enrollees may change PCP at any time with cause. Enrollees have access to a toll-free number for Member Services to assist with PCP selection, PCP changes and access issues that may occur. Periodic surveys are done to assess enrollee satisfaction including travel time to the primary care provider office and wait times for scheduled appointments.

Enrollees assigned to a nurse case manager in the enhanced PCCM disease management program may disenroll at any time.

vi. Describe the default assignment algorithm used for auto-assignment.

Citation	Condition or Requirement

(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)

Enrollees are auto-assigned to the provider using an algorithm that ensures historical usage, family history, sex, age and geographic proximity. If the claims history shows the enrollee has prior history with a PCP, the enrollee is assigned to that provider. If no history with a PCP exists, a search is done for a family member's history with a PCP for assignment. Lacking any historical or family history, enrollees are assigned to PCPs using an algorithm based on age, sex, geographic proximity, and in a manner that equitably distributes enrollees among qualified PCCMs available.

vii. 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)*

The State monitors changes in the rate of PCP default assignment through reports generated from the MMIS.

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).

   For the enhanced PCCM disease management program the State will contract with one entity per region. Enrollment in the enhanced PCCM disease management program is voluntary, and enrollees will have a choice of nurse case managers.

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

Citation	Condition or Requirement

___ 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.

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

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

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will _x_/will not___ use lock-in for PCP enrollment.

2. The lock-in will apply for_12 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).

GBHC enrollees are permitted to disenroll with a PCP at any time with cause. (Cause may be, but is not limited to: enrollees who need covered Medicaid services that are not provided by the PCP on moral or religious grounds, poor quality care, lack of access to covered services, lack of access to experienced providers, the enrollee moves out of the PCPs service area.) Enrollees will be allowed to request a change in PCP during the first 90 days of enrollment and at least every six months thereafter without cause.

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)

_x_ The state assures that its state plan program is in compliance with 42 CFR

Citation		Condition or Requirement
42 CFR 438.50 42 CFR 438.10		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.*
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 nses to limit the nnmber of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)* *The State will limit the number Enhanced PCCM vendors to one per Region; however, there will be no limited contracting of qualified Primary Care Providers. Additionally, the Enhanced PCCM vendor will have multiple nurse case managers for members to freely choose from.* 4. ____ The selective contracting provision in not applicable to this state plan.