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 __x__ i. MCO (Care Management Organizations – CMOs) ____ ii. PCCM (including capitated PCCMs that qualify as PAHPs) ____ iii. Both
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)		2. The payment method to the contracting entity will be: ____ i. fee for service; __x__ ii. capitation; ____ iii. a case management fee; __x__ iv. a bonus/incentive payment; ____ v. a supplemental payment, or ____ vi. Other (Please provide a description below).
1905(t) 42 CFR 440.168 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.)*

In February 2003, the State issued a request for information seeking comprehensive proposals to redesign the Medicaid program to improve quality and provider accountability while achieving budget predictability and cost containment. Over 42 responses were received. For the next several months, meetings were held with providers, consumer groups, insurance representatives and other stakeholders to design a new program.

In October 2003, a diverse team of stakeholders, including senior executives from healthcare provider organizations and advocacy groups, assembled for several days to discuss state strategies to promote quality healthcare, enhanced access, shared member and provider responsibility, improved efficiency, and better cost management.

In August 2004, the State announced that it would implement a mandatory managed care program using Care Management Organizations. From

Citation	Condition or Requirement
	September 2004 through October 2004, the State held stakeholder sessions with physician and hospital providers, senior associations, children and family coalitions, and others to ensure participation and input from all groups affected by the new mandatory managed care program.
	Upon implementation of the program, the State will continue to utilize providers from the various medical advisory committees, recipients involved in NET advisory committees, staff liaisons to advocacy groups that include both providers and recipients, and member satisfaction survey.
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): 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. x 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) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. N/A The state assures that all the applicable requirements of section 1905(t) 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

Citation	Condition or Requirement
	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. _x_ 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) for 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 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.

- ***Low Income Families*** *– Section 1931 adults and children who meet the standards of the old AFDC (Aid to Families with Dependent Children) program.*
- ***Transitional Medicaid*** *–Former Low-Income Medicaid (LIM) families who are no longer eligible for LIM because their earned income exceeds the income limit, pursuant to section 1925.*
- ***Pregnant Women (Presumptive)*** *- Pregnant women with family income at or below 200 percent of the federal poverty level who receive temporary Medicaid under the Presumptive Medicaid Eligibility Program, pursuant to section 1920(a).*
- ***Pregnant Women (Right from the Start Medicaid - RSM)*** *- Pregnant women with family income at or below 200 percent of the federal poverty level who receive Medicaid through the RSM program. Pursuant to section 1902(a)(10)(A)(i)(iv) and 1902(l)(1)(A) and 1902(e)(5).*

Citation	Condition or Requirement
	• ***Children (Right from the Start Medicaid - RSM)*** - *Children under age nineteen (19) whose family income is at or below the appropriate percentage of the federal poverty level for their age and family, pursuant to section 1902(l)(1)(B) and 1902 (l)(1)(C) and 1902 (l)(1)(D).* • ***Children (newborn)*** – *Pursuant to section 1902(e)(4), a child born to a woman who is eligible for Medicaid on the day the child is born.* • ***Breast and Cervical Cancer*** – *Pursuant to section 1902(1)(10)(ii)(xviii), women under 65 who have been screened through Title XV CDC screening and have been diagnosed with breast or cervical cancer.*
	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.)* *N/A – there is no voluntary enrollment*
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. ____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.

Citation	Condition or Requirement
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. Medical eligibility includes, but is not limited to:

- *burns*
- *cardiac conditions*
- *cystic fibrosis*
- *hearing disorders*
- *spina bifida*
- *cerebral palsy*
- *diabetes mellitus*
- *vision disorders*
- *craniofacial anomalies (including cleft lip/palate)*
- *gastrointestinal disorders*
- *neurological and neurosurgical conditions including epilepsy and hydrocephalus*
- *orthopedic and/or neuromuscular disorders (scoliosis)*
- *congenital or traumatic amputations of limbs*

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

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

____i. program participation,

Citation	Condition or Requirement
	____ 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;

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 managed care, 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;

iii.

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 managed care, 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 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 managed care, notification by the

Citation	Condition or Requirement

enrollee, provider or other state agency of the exempt status will be processed by the State and the child will be disenrolled.

v. 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 managed care, 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.

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 managed care, 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 managed care, 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

Citation	Condition or Requirement
	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 managed care. 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 managed care, the enrollee, provider or another state agency may request disenrollment based upon the enrollee's participation in GAPP.*
42 CFR 438.50	G. List all other eligible groups who will be permitted to enroll on a voluntary basis N/A
	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:

Citation	Condition or Requirement

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. At the time of plan selection, enrollees will also choose a primary care provider (PCP). In the event of auto-assignment of an enrollee to a CMO, the CMO will assign a primary care provider (PCP). Assignment will be made to a PCP based on prior enrollee and family history. If no enrollee or family history with a PCP exists, enrollees will be assigned to a PCP using an algorithm based on age, sex, and geographic proximity.

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

All CMOs will be contractually required to include significant traditional providers in their provider networks. Significant traditional providers are defined as those providers that provided the top 80 percent of Medicaid beneficiary encounters for the enrolled population in the base year of 2004. CMOs will also be required to contract with all FQHCs, RHCs and critical access hospitals in their service region. These contract requirements ensure that the default enrollment to any of the CMOs will maintain relationships with traditional Medicaid providers

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

If there is no historical usage by the enrollee or family, then the enrollee is assigned to the plan with the lowest capitated rates in the service region up to a predetermined capacity of lives in the region, thereafter assignment will be equitably distributed among the plans.

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 _x_/will not____ use a lock-in for managed care managed care.

Citation	Condition or Requirement

ii. The time frame for recipients to choose a health plan before being auto-assigned will be 15 days .

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

All enrollees will have 30 days from the date of eligibility notification to choose a CMO. After 30 days, enrollees are notified in writing of the auto-assignment. The auto-assignment notice will contain:

- *the name of the enrollee automatically assigned;*
- *the name of the CMO to which the enrollee was assigned;*
- *an explanation of why the auto-assignment was performed i.e. failure to select a CMO within the required time;*
- *the CMO member services telephone number;*
- *the effective date of enrollment in the CMO; and*
- *the process and timeframe for changing the CMO selection, including a description of the 90 day choice period, lock-in policy and a list of providers in the enrollees' service region.*

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.)*

Enrollees will be notified in writing of their right to disenroll without cause within the first 90 day period of the CMO plan enrollment or the date the notice of enrollment is sent, whichever is later. After the 90 day period, the enrollee may change CMO plans only for cause in accordance with 42 CFR 438.56(d)(2) and as determined by the State until the annual anniversary date of the enrollee's enrollment.

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.)*

Citation | Condition or Requirement

If a CMO selection is not made, the enrollee is auto assigned to the CMO as follows:

- *If a family member of the enrollee is already enrolled in one CMO, the enrollee shall be assigned to that CMO, (Note: the use of family enrollment as a first step was chosen because often the enrollee history consists of only one encounter, and it is a goal of the State to keep families together in the same CMO whenever possible);*
- *If there are no family members already enrolled and the enrollee has a prior or existing provider relationship then the enrollee will be assigned to the CMO of which that provider is a member;*
- *If there is no prior or existing provider relationship the enrollee will be assigned to the CMO that previously enrolled other family members;*
- *If the enrollee does not have a traditional provider in either plan, or the provider is in both plans, the Member shall be auto assigned to the CMO which has the lowest capitated rates in the region; and*
- *In the event the CMO's enrollment reaches a predetermined capacity of the total lives in the region, the CMO will not be assigned members through the auto-enrollment process.*

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)*

The State will obtain monthly reports from MMIS data.

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,

Citation	Condition or Requirement

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

   This provision will be applicable only if the State is not successful in procuring more than one CMO plan in rural areas. Enrollees will be given a choice between at least two (2) PCPs within the CMO. Any limitation imposed on the freedom to change PCPs will be no more restrictive than the limitations on disenrollment from a CMO. ***In addition, beneficiaries will have the ability to choose between two physicians or case managers.***

   ___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 managed care.

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).

   - *Enrollee requests to be assigned to the same CMO as other family members.*

Citation	Condition or Requirement
	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).
	Enrollee requests to be assigned to the same CMO as other family members.
	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)
	The CMO is only responsible for providing primary and acute care; all long term care services are excluded. Institutional care beyond a duration of 30 days is excluded. All care in an ICF/MR is excluded.
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.
	The State will limit the number of entities to four (4) plans in the Atlanta region and two (2) entities in other regions.
	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.)*
	The State will competitively procure CMO plans for participation in the program. Each plan will be evaluated and scored according to a well-defined set of

Citation	Condition or Requirement

financial and technical criteria. In the Atlanta the four plans receiving the highest acceptable scores will be selected to participate. In the other less urban regions the two plans receiving the highest acceptable scores will be selected to participate.

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