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 Organization, 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 group affected by the new mandatory managed care program.

Upon implementation of the program, the State will continue to utilize providers from the various medical advisor committees, recipients involved in NET advisory committees, staff liaisons to advisory groups that include both providers and recipients, and member satisfaction surveys.

Beginning in 2011, DCH conducted a very inclusive and transparent process in analyzing redesign options and designing the program specific to youth in foster care, juvenile justice and adoption assistance. DCH and its Agent facilitated public input through statewide stakeholder focus groups, two public hearings an online survey and task forces. DCH also allowed for submission of comments through a "MyOpinion" Mailbox.

Beginning in February 2012, DCH convened three external task forces (Provider, Children and Families and "ABD" task forces) and a Mental Health and Substance Abuse Workgroup to provide ongoing input into program design which will continue through and after implementation as needed. The Children and Families Task Force has served in a key role in helping to define the program design and will be very involved in implementation and transition. This task force includes parents of members, advocacy organizations and provider groups.

Additionally, DCH formed an internal 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)*

Citation	Condition or Requirement

The Joint Task Force is advisory in nature and its goal is to provide guidance regarding the transition of youth in foster care and adoption assistance into the Georgia Families program. This guidance has and will help to ensure a program that is child-centric and focused on coordination of care.

Examples of additional methods that DCH will employ to continue collecting public input during and after implementation are as follows:

- *Inclusion of stakeholders such as foster and adoptive parents, members and advocates on an as needed basis*
- *Requirement for the CMO to employ Ombudsmen staff who will be responsible for identifying and resolving issues, identifying and resolving issues pertaining to access to health care services, and communicating and educating members, providers, caregivers, foster and adoptive parents, state agencies and residential placement facilities and report findings to the Medicaid Agency*
- *Inclusion of related topics in the agenda for the Medical Care Advisory Committee on an as needed basis*

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)

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.

Citation	Condition or Requirement
42 CFR 438.50(c)(1)	
1932(a)(1)(A)(i)(I) 1905(t) 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) 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. __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*

Citation	Condition or Requirement

income limit pursuant to Section 1925.

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).

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 Medicaid on the day the child is born.*

Breast and Cervical Cancer *– Pursuant to section 1902(l)(10)(ii)(xviii) women under 65 who have been screened through Title XV CDC screening and have been diagnosed with breast or cervical cancer.*

Refugees *– Those individuals who have the required INS documentation showing they meet a status in one of these groups: refugees, asylees, Cuban parolees/Haitian entrants, Amerasians or human trafficking victims.*

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 Urban Indian program operating under a contract or grant with

Citation	Condition or Requirement
	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.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. __X__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)*

Citation	Condition or Requirement
	• *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, ____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)* The State identifies the eligibility groups through the MMIS. 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; *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*

Citation	Condition or Requirement

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 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 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

Citation	Condition or Requirement

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

1. *Children enrolled in the Georgia Pediatric Program (GA PP) who are eligible under another aid category in addition to section 1902(e)(3) will be exempted from enrollment. In the case of the inadvertent enrollment into managed care, the enrollee, provider or another state agency may request disenrollment based upon the enrollee's participation in GAPP.*

2. *Recipients enrolled under group health plans for which DCH provides payment for premiums, deductibles, coinsurance and other cost sharing, pursuant to Section 1906 of the Social Security Act.*

3. *Individuals enrolled in a Hospice category of aid.*

4. *Individuals enrolled in a Nursing Home category of aid.*

Citation | Condition or Requirement

42 CFR 438.50

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

Eligibility Group Name	Social Security Act and CFR Citations
Youth less than 26 years of age who are receiving foster care or who are less than 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 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 26 years of age who are receiving foster care or who are less than 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 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)[1] 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

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

[1] 1902(a)(10)(A)(i)(III) is RSM covers pregnant women and newborns. The assumption is that newborns would not be in juvenile justice, so this reference applies specifically to pregnant women.

Citation	Condition or Requirement

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. 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 he 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.

Youth in Foster Care and Youth in Juvenile Justice

The CMO will honor the member's guardian's PCP and dental home selection. Should a voluntary selection not be made, the CMO will auto-assign the member to a PCP and dental home using a formula that includes analysis of prior claims history if available or PCP or dentist selection of other CMO members with the same address. Members may request changes to their PCP and dental home at any point in time.

Additionally, the CMO has three avenues through which it must coordinate to try to obtain information about a member's existing provider relationships for use in auto-assigning members when necessary to a PCP and dental home and in providing care management services:

1. *Coordinate with Division of Family and Children Services or Division of Juvenile Justice case workers who are charged with determining the current relationships*

Citation | Condition or Requirement

2. *Contact the member's prior insurer to request the information*

3. *For members who were enrolled in Medicaid prior to enrollment with the CMO, review claims data to identify providers to whom the member has had regular visits*

Youth in Adoption Assistance

The CMO will honor the member's guardian's PCP and dental home selection. Should a voluntary selection not be made, the CMO will auto-assign the member to a PCP and dental home using a formula that includes analysis of prior claims history if available or PCP or dentist selection of other CMO members with the same address. Members may request changes to their PCP and dental home at any point in time.

Additionally, the CMO has three avenues through which it must coordinate to try to obtain information about a member's existing provider relationships for use in auto-assigning members when necessary to a PCP and dental home and in providing care management services:

1. *Coordinate with Division of Family and Children Services or Division of Juvenile Justice case workers who are charged with determining the current relationships*

2. *Contact the member's prior insurer to request the information*

3. *For members who were enrolled in Medicaid prior to enrollment with the CMO, review claims data to identify providers to whom the member has had regular visits*

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

Citation	Condition or Requirement

traditional Medicaid providers.

Youth in Foster Care and Youth in Juvenile Justice

CMO provider networks for Medicaid members are limited to Medicaid-participating providers. Additionally, the CMO is required to contract with significant traditional Medicaid, Division of Family and Child Services and Department of Juvenile Justice providers.

Youth in Adoption Assistance

CMO provider networks for Medicaid members are limited to Medicaid-participating 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 highest Auto Assignment score in the service region. See Section 3.v below which describes how the Auto Assignment process promotes equitable distribution among qualified CMOs.

Youth in Foster Care and Youth in Juvenile Justice

DCH is contracting with one CMO to provide services to eligible members in foster care and juvenile justice. The contract with the CMO outlines requirements for allowing members or their guardians to request disenrollment for cause in accordance with 42 CFR 438.56. The contract also requires the CMO to assist members with the disenrollment process by providing required forms to members and referring members to DCH or its Agent who will make disenrollment determinations.

Youth in Adoption Assistance

DCH is contracting with one CMO to provide services to eligible members in adoption assistance who do not opt out of the CMO.

Citation	Condition or Requirement

Members who opt out of the single statewide CMO will be served through the fee-for-service delivery system. The contract with the CMO outlines requirements for allowing members or their guardians to request disenrollment for cause in accordance with 42 CFR 438.56. The contract also requires the CMO to assist members with the disenrollment process by providing required forms to members and referring members to DCH or its Agent who will make disenrollment determinations.

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.

Youth in adoption assistance may elect to opt out of the CMO without cause within the first 90 calendar days following the date of the member's initial enrollment with the CMO or the date DCH sends the member notice of the enrollment, whichever is later (Open Enrollment Period). Members who opt out will return to the Medicaid fee-for-service delivery system. Members in adoption assistance who do not opt out within the first 90 calendar days of enrollment in the CMO will remain with the CMO until the member's next enrollment period, subject to eligibility. These members may request to opt out of the CMO without cause every 12 months thereafter. The members may request to opt out of the CMO for cause at any time.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be __30 days___.

Youth in Foster Care and Youth in Juvenile Justice

All youth in foster care and youth in juvenile justice will be assigned to one CMO; therefore, an auto-assignment process will not be used.

Youth in Adoption Assistance

All youth in adoption assistance will be assigned to one CMO; therefore, an auto-assignment process will not be used.

Citation	Condition or Requirement

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 enrollee's service region*

Youth in Foster Care and Youth in Juvenile Justice

While an auto-assignment process is not required, DCH has a process in place to mail notification of the member's enrollment with the CMO.

Youth in Adoption Assistance

While an auto-assignment process is not required, DCH has a process in place to mail notification of the member's enrollment with the CMO. The packet will also include explanation about disenrollment procedures for members in adoption assistance who want to opt out of the CMO.

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

Citation | Condition or Requirement

accordance with 42 CFR 438.56(d)(2) and as determined by the State until the annual anniversary date of the enrollee's enrollment.

Youth in Adoption Assistance

Youth in adoption assistance may elect to opt out of the assigned CMO without cause within the first 90 calendar days following the date of the member's initial enrollment with the CMO or the date DCH sends the member notice of the enrollment, whichever is later (Open Enrollment Period). Members who opt out will return to the Medicaid fee-for-service delivery system. Members in adoption assistance who do not opt out within the first 90 calendar days of enrollment in the CMO will remain with the CMO until the member's next enrollment period, subject to eligibility. These members may request to opt out of the CMO without cause every 12 months thereafter. Members who opt out are permitted to re-enter the CMO.

The Member Handbook will detail information about enrollment and disenrollment processes, including information about disenrollment options within the first 90 days of enrollment. The Member Handbook is included in the information packet that the CMO must provide to new members.

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.)*

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 he 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 he 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*

Citation	Condition or Requirement

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 highest Auto Assignment score in the region; the Auto Assignment score will be a composite score comprised of a Quality component weighted at 70% as well as a Cost component weighted at 30%. The State will review the overall scores periodically and may prospectively change the weighting of the Quality and cost scores.*

Youth in Foster Care and Youth in Juvenile Justice

Not applicable as all members will be assigned to one CMO.

Youth in Adoption Assistance

Not applicable as all members will be assigned to one CMO.

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.

Youth in Foster Care and Youth in Juvenile Justice

Not applicable as all members will be assigned to one CMO.

Youth in Adoption Assistance

Not applicable as all members will be assigned to one CMO.

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.

Citation | Condition or Requirement

Youth in Foster Care and Youth in Juvenile Justice

Not applicable as all members will be assigned to one CMO.

Youth in Adoption Assistance

Not applicable as all members will be assigned to one CMO.

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. __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. Additionally, DCH has elected to contract with a single CMO that has targeted expertise to effectively handle the unique and complex health care needs of youth in foster care and youth in juvenile justice. 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.

Youth in Foster Care and Youth in Juvenile Justice

Youth in foster care and eligible youth in juvenile justice will be assigned to the one CMO contracted to provide services to this population.

Youth in Adoption Assistance

Youth in adoption assistance will be assigned to one CMO, but may elect to opt out to receive services through the fee-for-service delivery system.

___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

Citation	Condition or Requirement

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.

The State will apply this provision to enrollees who have a temporary loss of Medicaid which the State has defined as 2 months (62 days 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.

Members in adoption assistance may opt out of the CMO for cause at any time and return to the Medicaid fee-for-service delivery system. The following constitutes cause for disenrollment by these members:

- *The CMO does not, because of moral or religious objections, provide the covered service the member seeks.*
- *The member needs related services to be performed at the same time and not all related services are available within the network. The member's provider or another provider have determined that receiving service separately would subject the member to unnecessary risk.*

Citation	Condition or Requirement

- *Other reasons, per 42 CFR 438.56(d)(2), include, but are not limited to, poor quality of care, lack of access to services covered under the contract, or lack of providers experienced in dealing with the member's health care needs. (DCH or its Agent shall make determination of these reasons.)*

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 the duration of 30 days is excluded. All care in an ICF/MR is excluded.*

- *Experimental, Investigational, or Cosmetic procedures are excluded. Reconstructive procedures may be covered when there is documentation that the procedure is both medically necessary and primarily to restore or improve function or to correct deformity resulting from congenital or developmental anomaly, disease, trauma, or previous therapeutic or surgical process.*

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.

Citation	Condition or Requirement

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

Additionally, DCH has elected to contract with a single CMO that has targeted expertise to effectively handle the unique and complex health care needs of youth in foster care and youth in juvenile justice. 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 (approximately 27,000 members including youth in adoption assistance) over multiple plans would create a barrier to the development of the necessary infrastructure and processes that are needed to properly serve the child. Additionally, there is significant overlap in the Medicaid providers contracted with each CMO; therefore, contracting with only one CMO will not impede provider choice. The single CMO, in fact, is required to contract with significant traditional Medicaid, Division of Family and Child Services and Department of Juvenile Justice providers.

Additionally, DCH believes the CMO's expertise will also effectively handle the unique and complex health care needs of youth in adoption assistance. Therefore, DCH will contract with the CMO to also serve this population. However, youth in adoption assistance may elect to opt out of the assigned CMO and be served through the fee-for-service delivery system.

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

Citation	Condition or Requirement

CMS-10120 (exp. 3/31/2014)