



MEDICAID ADVOCACY

Coalition to Assure Redesign Effectiveness
for Medicaid (CARE-M)

Design Qualifications for Request for Proposals

Medicaid Redesign

July 2, 2012

The Coalition for Redesign Effectiveness for Medicaid (CARE-M) has closely followed the efforts of the Department of Community Health and Navigant to construct a Medicaid program that will better meet the needs of the current covered lives and to consider the opportunities and challenges of extending managed care to new populations.

In light of the recent news that a “plan” may be forthcoming at the DCH Board meeting on July 12th, and a Request for Proposal to follow, the advocates in CARE-M forward the following recommendations for consideration in the RFP.

As you know, the goals of the redesign have been expressed as

- Enhance appropriate use of services by members
- Achieve long term sustainable savings in services
- Improve health care outcomes for members

And as you know, feedback from advocates has stressed that improved healthcare outcomes for members should be the primary goal. By extension, we suggest that the best reason for going forward with a Medicaid project of such scope and potential impact is to achieve improvement in the Medicaid system of services and supports, and as a result, improvement in the healthcare outcomes of the members.

CARE-M members’ recommendations to the Department are to first, revise and innovate the health care delivery system for those who are currently managed by CMOs. This should be the first priority because it is time for the Department of Community Health (DCH) to renew its care management contracts for the existing Low Income Medicaid (LIM) population, while potentially prepare for the addition of thousands more low income adults to the Medicaid roles. Evaluating the priorities for improving health outcomes for current members is important. Improving efficiencies in utilizing health care and financial resources by implementing innovations in services delivery and management for low income populations currently under the Care Management Organizations is essential and should be the focus of DCH at this time.

Second, consider phasing in care management of populations in ABD who are NOT currently managed. For example, children served under the Katie Beckett Waiver option do not currently have care coordination, but they would benefit from having that service. The children in foster care is another population that could benefit from improved coordination of their care, particularly because they move around so much and have increased pharmacy costs.

Third, DCH should delay requiring that CMOs manage the care for ABD participants in nursing homes and those Medicaid waiver participants that have care coordination services. Programs such as the Community Care Services Program (CCSP), and the Service Options Utilizing Resources in the Community Environment (SOURCE), programs that will be combined into the

Elderly and Disabled Waiver will continue to have care coordination. Aged waiver participants are often among the least expensive ABD Medicaid participants. Individuals in the NOW, COMP and ICWP waivers are also managed and have capitated rates for particular services.

Fourth, if the decision is made to include LTSS in managed care, this move contains the opportunity to move towards the desire most individuals have to live and receive the supports they need at home or in other small community settings. These opportunities include:

- Potentially improving overall service and care coordination for Georgians who receive both LTSS services and medical services for chronic medical conditions, resulting in higher quality of life outcomes as well as cost efficiencies achieved through reduced hospitalizations and emergency room use.
- Potentially shifting the focus and funding from more costly institutional care to less costly HCBS by placing responsibility for both institutional care and HCBS with one managed care entity.

In summary, first, retool the CMO arrangements for the populations currently in managed care. Second, consider phasing in the Medicaid populations that are not currently managed, but whose care is complex and could benefit from increased coordination and integration. Third, only bring LTSS into managed care if it will support enhanced coordination between health care and community support, and support rebalancing the system from more expensive institutional care to community care. Finally, bring other waived populations in last.

DCH must keep in mind that for some of the new populations that the Navigant report recommends bringing into a managed care environment, ‘healthcare outcomes’ must be more broadly interpreted. For the Aged, Blind and Disabled populations, these outcomes must include an array of community-based supports that are not provided in a traditional, medical model of managed care. Therefore, the components that we enumerate and describe here propose aspects of a managed care system that we as advocates consider essential to successful redesign for new populations.

Any new extensions of managed care into the ABD population must be founded on the principles of the ADA and Olmstead. Proposals to reform the Medicaid system must emphasize the outcomes being sought for people receiving services, such as “better quality of life, control over their services and supports, full participation in community life, protection of individual rights, employment options for working age adults.” (NCD, pg.5)

Bottom line, a full scale redesign is not worth doing if it’s not done better.

We list below the primary concerns about the redesign plan. We describe the elements we feel are critical to any proposed plan that are common to all Medicaid populations, and then detail some components that are more specific to particular populations. As the process moves forward, we will supply additional details relating to these components.

A. Cross-Cutting Issues for All Medicaid Members in Managed Care

Concern 1: State Oversight and Accountability: Regardless of the details of redesign, DCH must build and maintain adequate staff capacity and expertise at the state level to implement the plan, oversee operations, and diligently enforce contract requirements.

Concern 2: Medicaid Redesign Vehicle: Advocates have not been told if the state is seeking a Section 1115 waiver, or whether they are considering a 1915 (b) and 1915 (c) combination. An 1115 application could mean that all populations are in, including individuals on the waiting lists. The 1115 waiver application requirements recently renewed in April 2012 carry specific transparency obligations which the state must meet.

Concern 3: Stakeholder Participation: Each population included in managed care must be fully engaged in designing, implementing, and monitoring the outcomes and effectiveness of the managed care program and be empowered to bring issues occurring in care delivery forward to the attention of the managed care entities and the Department of Community Health. Stakeholders must be confident that these efforts will result in better outcomes for people. This involvement should not end with the awarding of contracts, but should continue with providing feedback on system performance and recommendations for plan improvement. In order to perform this role effectively, stakeholders need access to performance data and progress on established benchmarks. DCH has indicated their intent to keep the Task Forces together to review the planning process through implementation. However much feedback we have offered the agency though, we have little sense of how that feedback has been received, processed or considered in the development of the redesign itself.

After integration has been implemented, consumer involvement should extend into ongoing monitoring through representation in standing advisory groups at both a state and local plan level.

Every MCO must convene meetings with a representative group of its members at least quarterly to document fully all grievances raised by individuals at the meetings, to keep comprehensive minutes of all member meetings that are made available to all individuals, and to provide written responses to all articulated grievances prior to the convening of the next member meeting. The MCO's should notify all members at least 15 days prior to each meeting regarding the date and location of the meeting, and offer to assist with transportation to the meeting if the member cannot travel independently. Telephone access or other provisions should be made for participation by people who cannot travel.

Concern 4: Definition of Medical Necessity: Definitions of medical necessity will determine which services are approved for individuals and must be adjusted or amended to include those home and community-based services that are necessary to support individuals in a stable way in their homes, but which are not necessarily of a medical nature. Medical necessity drives the questions, "What benefits are covered? (E.g., are they limited to diagnosis and treatment, or do they also include preventive care? Are experimental or investigational services excluded, and how are determinations made?) Does the definition recognize and mandate the complete EPSDT benefit package for children under 21? And who determines whether the care is medically necessary? [See Appendix A].

Concern 5: Appeals and Independent Problem Resolution - Stakeholders must be certain that any managed care system implemented in Georgia includes an easily navigable appeal system that ensures full Medicaid rights. A managed care appeals system must provide members the right to file grievances about the service and treatment provided by the MCO, its contractors and its providers. The appeals system must ensure existing Medicaid due process rights under federal and state law and regulations, including:

Appeals:

- Timely, adequate notice of adverse decisions in the principal language of the individual, including what action the MCO is taking; an easy-to-understand explanation of the basis for the decision; the criteria supporting the MCO's decision; an explanation of how the MCO appeals process works; and the right to representation.
- The notice must state how much time the member has to appeal and the method by which they must appeal, and the notice must be issued at least ten days prior to the adverse action taking place.
- Other rights include the right to timely access to the individual's file with the MCO and all documents related to the decision
- The right to a fair hearing, including:
 - the right to bring witnesses
 - the opportunity to confront and cross-examine adverse witnesses
 - the right to receive a written decision that summarizes the facts and criteria supporting the decision
- Benefits paid pending final resolution of terminations or denials may not be limited to the current authorization period and must be provided until the matter is resolved.

Hearing officers must be impartial and independent, receive training regarding the delivery of Medicare and Medicaid benefits, including Long-Term Services and Supports and Behavioral Health services to seniors and persons with disabilities, and take non-medical goals into account e.g., independence and choice. The state must publicly share data on denial, termination, and reversal rates (including partial denials), the numbers of appeals and grievances filed, and the number of appeals that result in a reversal of an initial decision. [See Appendix B on Grievances and Appeals, Appendix C on Prior Authorization periods, and Appendix D on Grievance System Reports)

Independent Problem Resolution:

The managed care system must include an independent ombudsman who has expertise in the delivery of Medicare and Medicaid benefits to seniors and persons with disabilities, including Long-Term Services and Supports and Behavioral Health services, will assist beneficiaries with appeals, and will identify systemic problems in the MCO and be able to bring those concerns to the agency authority. Wisconsin has a very effective Ombudsman Program which is able to address concerns and grievances before they need to rise to the formal appeals process, which is more responsive to consumers and cost-saving for the state. See Wisconsin's contract for an effective example, found at <http://www.dhs.wisconsin.gov/LTCare/Memberinfo/disombuds.htm>

DCH should establish a Medical Loss Ratio (MLR) for CMOs, and should publish the MLRs for each CMO as well as the underlying components of the MLR.

B. Focus on Issues for ABD

Concern 1: Carve-Out: If all of ABD is considered for inclusion in the managed care model then the nursing facility population must be included in the redesign. The potential for realizing cost savings through rebalancing institutional care and home and community based care is

significantly curtailed if this population is carved out. A carve-out would make it impossible for the state to lower costs by substituting equally or more effective community-based care for institutional care. In addition, surveys indicate that several thousand individuals in nursing facilities have expressed the desire to move out into the community, we have more individuals with developmental disabilities living in the nursing facilities than we had in the state hospitals at the start of the DOJ settlement agreement, and we also have children in nursing homes. There must be financial consequences for a managed care organization if an individual selects a nursing facility as their service option. If nursing homes are not at risk under managed care financing, high need individuals in the community whose needs cannot be easily met are too likely to end up in institutional placement. If Georgia wishes to manage its resources effectively and flexibly, to ensure that individuals are served in the most integrated setting, and desires to extend services to individuals on the waiting lists, then ALL Medicaid resources must be managed under the same program umbrella.

Concern 2: Phase-Ins: If the state determines to keep the nursing facility resources off the table in the plan to be released, then the ABD population must be phased in gradually, over years, including the nursing home population. The entry of each ABD population should be preceded by a readiness assessment that unearths existing methods of financing and rate structures, specialized services necessary, modifications that may be needed in facilities, programs, services, administrative policies and practices in order to smoothly transition to a managed care delivery system. Piloting the care delivery for new populations, assessing its effectiveness, addressing the gaps and deficiencies and developing plans to ramp up should precede any full roll out. Enrollment for persons with disability must be voluntary with strong opt-out mechanisms, and the appropriate appeals processes must be in place.

Concern 3: Measurement: Enrollment of ABD populations utilizing home and community-based systems will require a different set of measurement tools and indicators. The tools most commonly used for assessing quality in Medicaid services (External Quality Review Organizations EQROs, the HEDIS measures, the Consumer Assessment of Healthcare Providers and Systems (CAHPS), Accreditation and Pay for Performance tools) are mostly focused on acute care, and are not relevant to assessing the quality of long term and home and community-based supports and services for people with disabilities. As you may know, the Division of Developmental Disabilities has been using the Core Indicators, a series of measures that does assess the quality of home and community-based supports. This instrument has comparability with at least 26 other states, includes consumer satisfaction measures, and has historical data in Georgia as well. This instrument set should be considered as having potential to assess the LTSS provided in the new managed care contracts if the responsibility extends to the ABD populations.

Other assessment tools should be considered as well. In addition to the standard national “health” outcomes, there should be other measures such as avoidable hospitalizations, avoidable facility care, depression screenings and cholesterol measures after coronary events. There should also be process measures such as access to specialists, access to equipment, non-emergency transportation, timely access to plan representatives and timely and fair resolution of complaints.

The assessment tool currently used for evaluating the quality of dental services in Medicaid and PeachCare are the HEDIS measures. The use of HEDIS measures for dental care is not an accurate indicator of whether children in Georgia are receiving comprehensive dental care as it counts any dental encounter which takes into account screenings, etc., not dental treatments. In

the September 2011 *Annual Report on the Quality of Care of Children in Medicaid and CHIP*, CMS acknowledged that quality measurement tools are better in medicine, more established and more widespread than in dentistry. In fact, the Secretary's report keys in on the use of the EPSDT CMS-416 reporting and its use of the additional breakdown in data collection into categories as a good measurement tool. While there are still limitations to the use of CMS-416, specifically that it does not account for length of enrollment, it still provides a better picture of dental utilization in Georgia and should be considered as an alternate or additional measurement tool.

Neither the 1115 waiver programs nor the Medicaid – Medicare dual eligibles programs mandate standard reporting requirements or relevant performance outcomes measures. This does not mean Georgia should go forward without consideration of measures that will help the system learn if it is achieving the outcome goals it espouses.

Concern 4: DOJ Settlement: If individuals with behavioral health issues or developmental disabilities are brought into managed care the HMO contracts must include the deliverables in the Department of Justice Settlement Agreement. The DOJ settlement is building an infrastructure for all people in the mental health population and not just the 9000 person target population of the settlement. The robust infrastructure must continue to be developed for all people and not just the target population. We strongly recommend that the Department of Behavioral Health and Developmental Disabilities maintain responsibility for monitoring the progress of the settlement deliverables, and that the monitoring and reporting responsibility of the Independent Reviewer, Elizabeth Jones, is retained.

Concern 5: Provider Network – Choice, Capacity, Accessibility: There must be an adequate array of providers to meet the needs of any subgroup of the ABD population that the state determines to include in a managed care program. The network needs to include those who furnish health care, behavioral health, and home and community-based long term supports. Community based supports and services are necessary for individuals with mental illness and substance use in recovery models, and for individuals with DD/ID who need side by side support for activities of daily living. There should be sufficient numbers of qualified providers in each specialty area to allow participants to choose among alternatives (NCD, p.6). In Georgia, special attention needs to be paid to rural areas, and to cultural and linguistic diversity. Individuals should be enabled to go out of network if they need a particular type of provider that is not available in their HMO network. The Dental Provider panels should be re-opened to allow any willing dental provider who is properly credentialed by the department to be allowed into the managed care networks to provide dental services to all members.

In addition, all health care services and supports must be provided in ADA compliant settings. Facilities must be physically accessible, transportation services must meet ADA standards, and communications, information and technology must accommodate physical, sensory and cognitive impairments so that individuals with disabilities can understand and participate in their health care.

The managed care organizations need to preserve the existing service array as much as possible, allowing individuals to keep their existing practitioners with whom they may have had long relationships. Companies need to adapt and create new services to changing needs and opportunities. Particularly important to people with physical disabilities is the provision of prosthetics, durable medical equipment and assistive technology that enables people to function

as independently as possible in their own homes, and to maintain employment. The DME providers must be brought into the provider network.

Current providers in the DD/ID sub-population tend to be smaller in scope (only a few individuals served) and may be niche providers (only respite, or only supported employment). Managed care networks must retain and support these small providers and continue to develop others. Providers should not be excluded for lack of administrative and/or billing capacity. Many resources – public and private – have been invested to develop long-term services and supports in Georgia. Continued public-private partnerships, that develop these local providers and networks, does more than just meet the needs of Medicaid participants. Local networks mean jobs in local communities not just for health care providers, but for the entire community. Requiring CMOs to include in their networks local providers of long-term services and supports, both in the community and in facilities, keeps the decisions for care local, the providers of care local, and the dollars for care local.

The rate structure needs to be adequate to maintain the participation of providers in the network. A percentage of any savings achieved through coordination or administrative efficiencies should be returned to the system of care to enhance or extend programs or services.

Finally, the investment that the state has made in self-directed, family directed or consumer-directed models must be preserved, and individuals allowed to continue self-direction.

Concern 6: Dental Services: In addition to the recommendations above, some of which reference dental services, the redesign plan should include the following provisions as they relate specifically to the delivery of dental care to members in Medicaid and PeachCare.

A carve out of dental services to one CMO would eliminate the confusions and administrative hassles for both the patients and providers as currently exists under the 3 CMOs and their 2 dental subcontractors (which will be increasing to 3 subcontractors in November). If a single CMO provider for dental services is not a viable option, a provision should be in place that each CMO entity that is awarded a contract is required to join together and contract with one single dental subcontractor vendor with one set of administrative rules, one set of reimbursement fees, and a single source credentialing for all CMOs.

Uniform, standardized, quarterly dental utilization reporting requirements for the CMOs in reporting to DCH. At a minimum, reports should include the number of unique dental encounters by age group and type of service performed (utilizing CDT codes as reported on dental claims).

Revised annual dental utilization reporting measures, other than HEDIS as mentioned previously under Concern 3: Measurement. For dental specifically, HEDIS is more of a measure of access points, not true utilization, and other measures should be considered.

C. Focus on Issues for Children

Concern 1: Design Priorities: Coverage, access, and quality for children, including those with special needs, are key policy priorities that must be addressed in the program redesign. These

policy priorities are fundamental to creating a sustainable and responsive health care system that: 1) meets the needs of enrollees today and 2) establishes high standards of health care service delivery that can serve as a foundation for expanded models in the future. DCH should not consider any program design options that have not demonstrated evidence of:

- Improved health care outcomes
- Ensured and improved access to necessary health care services, including dental services
- Appropriately controlled utilization of health care resources, including dental resources
- Prioritized administrative cost savings

Concern 2: Relationship to Eligibility and Enrollment: Although eligibility, enrollment, and renewal are not functions performed by care management organizations (CMOs), all three are connected to program design. Eligibility, enrollment, and renewal concern the front-end, and program design concerns the back-end. Thus, the redesign should have coverage goals that further simplify processes to ensure coverage for all children that includes:

- Eliminating length of time required for a child to be uninsured prior to enrollment in PeachCare or reduce to 30 days similar to the waiting period for commercial plans
- Increasing administrative efficiencies by simplifying enrollment policies and creating electronic interfaces with multiple public program data sources for Express Lane Eligibility determination at application and renewal
- Extending user-specific online access for Medicaid enrolled children
- Adopting 12-month continuous eligibility
- Adopting an administrative renewal process
- Adopting self-declaration of income for application and renewal
- Email and text messaging notifications and renewal determinations and premium payment due dates for Medicaid and PeachCare

Elements that should be included or reflected in the RFP include:

Concern 3: Access:

- Improve access to pediatric specialists
- Higher reimbursement for some pediatric specialist provider types (e.g., pediatric orthopedists)
- Monitor to ensure CMOs are complying with policies for establishing timely and appropriate out-of-network provider arrangements for children needing care
- Explore technological approaches such as telemedicine
- Require transparency as it relates to CMO reimbursement rates to providers
- Require CMOs to offer provider networks that supply a comprehensive packages of acute and chronic care benefits for children
- Require reporting on pediatric and pediatric subspecialists provider participation, including pediatric dental providers
- Establish provider network standards, particularly for primary care pediatricians, behavioral health providers, dentists, hospitals, home health agencies, and ancillary therapists. These standards could:
 - Specify the types of providers with pediatric expertise who must be participating in the network or available through other arrangements

- Require that these providers be available in community-based settings
- Stipulate that the numbers and locations of providers be sufficient to assure that care be delivered in a timely manner
- Establishment of medical and dental homes to improve care coordination
- Require plans to demonstrate satisfactory arrangements for ensuring access to specialty centers (both in and out of state) for the diagnosis and treatment of rare disorders
- Monitor compliance for access standards for primary care as well as specialty services including:
 - Appointment waiting times
 - Travel times to appointments
 - Telephone call back waiting times
 - Prior authorization response times
 - After hours handling of emergencies

Concern 4. Quality:

- Increase EPSDT screening ratios to a minimum of 90 percent for children three and under
- Increase EPSDT screening ratios by a minimum of 10 percentage points above the national average for children ages 10 and above
- Continue public reporting of quality outcomes through the annual HEDIS findings and CMO-specific Performance Improvement Programs
- Increase performance standards for childhood immunizations and lead screenings to the 75th percentile
- Report separately on the use of services by children with chronic and disabling conditions
 - Encounter data for ambulatory care must be disaggregated to isolate information on discrete services such as outpatient behavioral health, ancillary therapy, home health, and case management
 - Require reporting on the children with special needs who received more than a specified number of visits in each of these service areas
- Add more well-child visit measures for older age groups beyond the first 15 months of life to the performance standards
- Modernize program design features in medical home models to establish value-driven, high quality care for children
 - Establish a statewide EHR for Medicaid and PeachCare enrollees
 - Developed patient-centered, care coordination in partnership with primary care providers that integrates all aspects of care (both physical and behavioral)
- Standardize formularies across CMOs
- Modify performance measures to capture the following:
 - Percent of kids whose doctor recorded and reported their BMI
 - Number of child enrollees receiving preventive dental services (fluoride and treatment)
- Percent of child enrollees receiving one or more dental sealants (data reporting to include the location in which the sealant was placed, i.e. a dental office, school based program, or other setting)

Concern 5: Covered Services: Specify pediatric benefits

- Include extensive language in the managed care contract explaining the many pediatric services covered under Medicaid
- In developing contract language for plans serving children with chronic or disabling conditions, list and describe pediatric benefits as distinct from those for adults
- Include a glossary as CMOs may interpret many terms and concepts differently than DCH. Some benefits for children that may need defining include:
 - Rehabilitations services
 - Outpatient behavioral health services
 - Therapeutic services
 - Medical equipment, supplies, and corrective appliances

Concern 6. Medical necessity standard for children:

- Provide in their contracts pediatric medical necessity criteria that are consistent with EPSDT and distinct from criteria used for adults [See definitions related to medical necessity in Appendix A]
- Base medical necessity decisions for children on peer-reviewed publications, expert pediatric and psychiatric medial opinion, and medical community acceptance

Concern 7: Continued Stakeholder Input:

- Establish an advisory council and collaborate with child advocates on monitoring performance

Concern 8: Special Needs of Children in Foster Care

D. Focus on Issues for Behavioral Health

The Behavioral Health and Substance Use Disorder Workgroup has done substantial work on recommendations for the RFP. That work will not be included in its entirety here, but was submitted to the Department separately.

E. Focus on Long Term Services and Supports – Aging

Concern 1: Enrollment: The enrollment process is extremely important, especially during the transition to Medicaid Managed Care (MMC) from traditional fee-for-service. The enrollee needs to understand how the change will impact them and how to choose a plan. There must be a process for individuals to receive individualized counseling about the options they have in choosing a plan. During a counseling session, a counselor can ensure that an enrollee not only makes an educated and informed choice about a plan, but also that the enrollee understands the implications of the choice and the change to MMC. People need continuity of providers especially when they have providers they trust.

Although states often require a MMC plan to doing some limited screening at the time of enrollment, some states require that a plan perform an assessment shortly after initial

enrollment. Arizona requires its plans to do a screening within seven (7) days, an on-site contact within twelve (12) days and require that appropriate services are being delivered within thirty (30) days. Pennsylvania has its enrollment broker ask specific health status questions, as does Texas and Maryland. New Jersey sends the last 2 years of an enrollee's fee for service claims to the new MMC plan. All of these are good efforts to make sure that enrollees' needs are known to new health plans and providers.

Concern 2: State and Federal Oversight and Monitoring: Structures must be in place to ensure that MCOs are performing contracted duties and delivering high quality services. Oversight and monitoring should be a coordinated and complementary effort by CMS, state agencies, an independent advocate for enrollees, and stakeholder committees. Where the MCO is also providing Medicare benefits, Medicare must also be involved.

States must have an oversight and monitoring plan that clarifies what role each of the relevant agencies will play. In Georgia, numerous agencies have been involved in the delivery of long term services supports. Expertise from each of these agencies should be leveraged in a managed LTSS program, but roles need to be delineated and a clear lead agency ultimately responsible for the program should be identified.

States must restructure and rehire as necessary to ensure that staff have expertise in overseeing, monitoring and contracting with MCOs.

Specific activities for overseeing and monitoring delivery of LTSS must be developed. For example:

- A dashboard that monitors the delivery of HCBS. Beneficiaries would have the ability to call into the state-run dashboard if a personal care attendant did not report to work and the state would have the ability to send a replacement worker immediately. The dashboard would track over time the MCOs ability to provide timely access to HCBS.
- Secret shopper surveys that test the adequacy of LTSS networks.
- Audits of MCO operations related to LTSS delivery.
- Review and analysis of LTSS encounter data submitted by MCOs.

Concern 3: Alignment with Balancing Incentives Payment Program: In order to meet the goals of the Medicaid redesign, the plan must be fully aligned with DCH's CMS approved application for the Balancing Incentives Payment Program (BIPP). The goal of the BIPP program is to provide a greater number of non-institutional long-term care options. Georgia's approved proposal has to fully implement the three core components of a more balanced system as identified by the BIPP: (1) a no-wrong door entry point system, (2) conflict free case management and (3) standardized instruments to determine eligibility and appropriate services. It is our strong recommendation that any changes to Georgia's Medicaid system build on the more balanced program created through the BIPP effort, incorporating all three of these components into the Medicaid redesign.

- **Permanently adopt the no-wrong door system outlined in GA's BIPP application.**

The no wrong door system ensures that all Georgia residents will have access to and be screened for all appropriate programs. It not only streamlines the system for consumers who are often in crisis but it connects individuals to the program that best meets their needs reducing both the undercare and overcare that can increase costs to the Medicaid system. GA's CMS approved No Wrong Door system appoints the state's network of twelve Aging and Disability Resource Centers as a primary point of entry for home and community services. This system is built on a comprehensive statewide database with over 24,000 updated resources that allows all residents of GA to receive quality counseling and information, eligibility screening and appropriate referrals.

- **Adopt conflict-free screening, enrollment and case management across the entire long term care system and employ a standardized assessment tool.**

Conflict-free case management ensures that the entity reviewing the consumer's current financial and health status and reviewing their care options is not in any way connected to the entity that will provide and therefore benefit financially from the service delivery. The ADRC's are well positioned to support and provide this conflict free case management for the state. Current intake and screening processes with options counselors using standardized screening tools (DON-R) and the large aging and disabilities resource database (with 24,000 listings) will ensure that individuals access their preferred choice of home and community based options to remain in their homes. But the only way to provide the needed cost efficiencies to the Medicaid system is if the No Wrong Door serves as the central intake point for all long term care services including nursing facility admissions. This will achieve one mandatory intake procedure for the entire Medicaid nursing facility and waiver populations.

- **Divert and transition individuals from high cost institutional care to lower cost home and community based services.**

In addition to the conflict free and persons centered options counseling provided to all applicants seeking long-term care services, Medicaid funded ADRC options counseling to nursing facility residents and the Money Follows the Person program must continue to successfully transition individuals from an institutional setting to their preferred community options. Seventy six percent (76%) of the Medicaid expenditures for the Aged population pays for nursing facility services. It is imperative to contain these costs, if the entire Medicaid system is going to realize savings. Nursing facilities are a critical part of the long term care system, but they are also one of the most expensive long term care services. Wherever possible and wherever appropriate, residents must be provided community based options The 2011 CCSP Annual Report shows the cost savings of home and community based services. In this report the 2011 costs were \$25,873 for nursing facility care versus \$9,006 for CCSP home and community based care.

- **Leverage other public and private resources.**

Comprehensive intake, screening and counseling allows an individual to consider all their options. Counselors in the ADRC are able to consider not only what Medicaid services are appropriate but help individuals maximize their own personal resources and use existing the state and local service system to augment the services under the Medicaid Waiver program. In many cases these non-Medicaid resources divert those applying for Medicaid Waiver

services to other, more appropriate programs, keeping individuals out of the Medicaid system. In FY 2011, Medicaid Waiver programs received 20,600 requests for services. By using the ADRC options counseling process, only 2,525 were recommended for CCSP; the remaining individuals were directed to other alternative options, including private pay. The Medicaid redesign should not fragment the coordinated supportive services delivery system, but bolster the ability to bring other resources to bear.

APPENDIX A

Note to CARE-M: We have been trying to work on this definition and are not satisfied with it yet. It is an effort to expand from the state's old definition.

COVERED BENEFITS AND SERVICES

4.5.1 Included Services

4.5.1.1 The Contractor shall at a minimum provide Medically Necessary services and Benefits pursuant to the Georgia State Medicaid Plan, and the Georgia Medicaid Policies and Procedures Manuals. Such Medically Necessary services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under Fee-for-Service Medicaid. The Contractor may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or Condition.

4.5.2 Individuals with Disabilities Education Act (IDEA) Services

4.5.2.1 For Members up to and including age two (2), the Contractor shall be responsible for Medically Necessary IDEA Part C services provided pursuant to an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP).

4.5.2.2 For Members age 3-21, the Contractor shall not be responsible for Medically Necessary IDEA Part B services provided pursuant to an IEP or IFSP. Such services shall remain in FFS Medicaid.

4.5.2.2.1 The Contractor shall be responsible for all other Medically Necessary covered services.

4.5.3 Enhanced Services

4.5.3.1 In addition to the Covered Services provided above, the Contractor shall do the following:

- Place strong emphasis on programs to enhance the general health and well-being of Members;
- Make health promotion materials available to Members;
- Participate in community-sponsored health fairs; and
- Provide education to Members, families and other Health Care Providers about early intervention and management strategies for various illnesses.

4.5.3.2 The Contractor shall not charge a Member for participating in health education services that are defined as either enhanced or Covered Services.

4.5.4 Medical Necessity

4.5.4.1 Based upon generally accepted medical practices in light of Conditions at the time of treatment, Medically Necessary services are those that are:

- Required for the diagnosis, prevention and/or treatment of illness, disability, infirmity or impairment and which are necessary to improve, restore or maintain health, well-being and independent functioning;
- Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the eligible Member's medical Condition, interfere with a Member's capacity for normal activity, or threaten some significant disability;
- Compatible with the standards of acceptable medical practice in the community;
- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms or condition;

4.5.4.2 There must be no other equally effective and substantially less costly treatment, service and setting available.

4.5.4.3 Clinical policies, medical policies, clinical criteria or other generally accepted clinical practice guidelines used to assist in evaluating the medical necessity of a requested health service shall be used only as guidelines and shall not be the basis for a final determination of medical necessity.

4.5.4.4 For children under 21, the Contractor is required to provide medically necessary services to correct or ameliorate physical and behavioral health disorders, a defect, or a condition identified in an EPSDT (Health Check) screening, regardless whether those services are included in the State Plan, but are otherwise allowed pursuant to 1905 (a) of the Social Security Act. See Diagnostic and Treatment, Section 4.7.5.2. 71. "Correct or ameliorate" means to improve or maintain a child's health in the best condition possible, compensate for a health problem, prevent it from worsening, prevent the development of additional health problems, or improve or maintain a child's overall health, even if treatment or services will not cure the recipient's overall health. O.C.G.A. §49-4-169.1.

4.5.5 Experimental, Investigational or Cosmetic Procedures, Drugs, Services, or Devices

4.5.5.1 Pursuant to the Georgia State Medicaid Plan and the Georgia Medicaid Policies and Procedures Manuals, in no instance shall the Contractor cover experimental, investigational or cosmetic procedures, drugs, services or devices that are not recognized by the Federal Drug Administration, the United States Public Health Service, peer-reviewed medical literature, Medicare, Medicaid and/or the Department's contracted peer review organization as more likely than standard treatment to benefit the Member's medical Condition.

4.5.6 Moral or Religious Objections

4.5.6.1 The Contractor is required to provide and reimburse for all Covered Services. If, during the course of the Contract period, pursuant to 42 CFR 438.102, the Contractor elects not to provide, reimburse for, or provide coverage of a counseling or Referral service because of an objection on moral or religious grounds, the Contractor shall notify:

- DCH within one hundred and twenty (120) Calendar Days prior to adopting the policy with respect to any service;
- Members within ninety (90) Calendar Days after adopting the policy with respect to any service; and
- Members and Potential Members before and during Enrollment.

4.5.6.2. The Contractor acknowledges that such objection will be grounds for recalculation of rates paid to the Contractor.

APPENDIX B

4.14 INTERNAL GRIEVANCE/APEALS SYSTEM

4.14.1 General Requirements

4.14.1.1 The Contractor's Grievance System shall include a process to address Grievances. The Contractor's Appeals Process shall include an Administrative Review process and access to the State's Administrative Law Hearing (State Fair Hearing) system. The Contractor's Appeals Process shall include an internal process that must be exhausted by the Member or P4HB Participant prior to accessing an Administrative Law Hearing.

4.14.1.2 The Contractor shall develop written Grievance System and Appeals Process Policies and Procedures that detail the operation of the Grievance System and the Appeals Process. The Contractor's policies and procedures shall be available in the Member's and P4HB Participants primary language. The Grievance System and Appeals Process Policies and Procedures shall be submitted to DCH for review and approval as updated.

4.14.1.3 The Contractor shall process each Grievance and Administrative Review using applicable State and federal statutory, regulatory, and GF Contractual provisions, and the Contractor's written policies and procedures. Pertinent facts from all parties must be collected during the investigation.

4.14.1.4 The Contractor shall give Members and P4HB Participants any reasonable assistance in completing forms and taking other procedural steps for both Grievances and Administrative Reviews. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTD and interpreter capability.

4.14.1.5 The Contractor shall acknowledge receipt of each filed Grievance and Administrative Review in writing within ten (10) Business Days of receipt. The Contractor shall have procedures in place to notify all Members and P4HB Participant in their primary language of Grievance and Appeal resolutions.

4.14.1.6 The Contractor shall ensure that the individuals who make decisions on Grievances and Administrative Reviews were not involved in any previous level of review or decision-making; and are Health Care Professionals who have the appropriate clinical expertise, as determined by DCH, in treating the Member's and P4HB Participants Condition or disease if deciding any of the following:

- An Appeal of a denial that is based on lack of Medical Necessity;
- A Grievance regarding denial of expedited resolutions of an Administrative Review; and
- Any Grievance or Administrative Review that involves clinical issues.

4.14.1.7 Member Medical Review Process for PeachCare for Kids®

DCH also allows a state review on behalf of PeachCare for Kids® members. If the member or parent believes that a denied service should be covered, the parent must send a written request for review to the Care Management Organization (CMO) in which the affected child is enrolled. The CMO will conduct its review process in accordance with Section 4.14 of the contract.

4.14.1.7.1 If the decision of the CMO review maintains the denial of service, a letter will be sent to the parent detailing the reason for denial. If the parent elects to dispute the decision, the parent will have the option of having the decision reviewed by the Formal Appeals Committee. The request should be sent to:

Department of Community Health
PeachCare for Kids®
Administrative Review Request
2 Peachtree Street, NW, 37th floor
Atlanta, GA 30303-3159

4.14.1.7.2 The decision of the Formal Grievance Committee will be the final recourse available to the member. In reference to the Formal Grievance level, the State assures:

- Enrollees receive timely written notice of any documentation that includes the reasons for the determination, an explanation of applicable rights to review, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue, pending review.
- Enrollees have the opportunity for an independent, external review of a delay, denial, reduction, suspension, termination of health services, failure to approve, or provide payment for health services in a timely manner. The independent review is available at the Formal Grievance level.
- Decisions are written when reviewed by DCH and the Formal Grievance Committee.
- Enrollees have the opportunity to represent themselves or have representatives in the process at the Formal Grievance level.
- Enrollees have the opportunity to timely review their files and other applicable information relevant to the review of the decision. While this is assured at each level of review, members will be notified of the timeframes for the appeals process once an appeal is filed with the Formal Grievance Committee.
- Enrollees have the opportunity to fully participate in the review process, whether the review is conducted in person or in writing.
- Reviews that are not expedited due to an enrollee's medical condition will be completed within 90 calendar days of the date of a request is made.

- Reviews that are expedited due to an enrollee's medical condition shall be completed within 72 hours of the receipt of the request.

4.14.2 Grievance Process

4.14.2.1 A Member, Member's Authorized Representative, or P4HB Member may file a Grievance to the Contractor either orally or in writing. A Grievance may be filed about any matter other than a Proposed Action. A Provider cannot file a Grievance on behalf of a Member or P4HB Member.

4.14.2.2 The Contractor shall ensure that the individuals who make decisions on Grievances that involve clinical issues are Health Care Professionals who have the appropriate clinical expertise, as determined by DCH, in treating the Member or P4HB Member's Condition or disease and who were not involved in any previous level of review or decision-making.

4.14.2.3 The Contractor shall provide written notice of the disposition of the Grievance as expeditiously as the Member or P4HB Member's health Condition requires but must be completed within ninety (90) days but shall not exceed ninety (90) Calendar Days of the filing date.

4.14.3 Proposed Action

4.14.3.1 All Proposed Actions shall be made by a physician, or other peer review consultant, who has appropriate clinical expertise and is appropriately licensed to treat the Member or P4HB Member's Condition or disease.

4.14.3.2 In the event of a Proposed Action, the Contractor shall notify the Member or P4HB Member in writing. The Contractor shall also provide written notice of a Proposed Action to the Provider. The Contractor shall provide the notice to the Member or P4HB at the same time it provides notice to the provider. This notice must meet the language and format requirements in accordance with Section 4.3.2 of this Contract and be sent in accordance with the timeframes described in Section 4.14.3.4.

4.14.3.3 The notice of Proposed Action must contain the following:

- The Action the Contractor has taken or intends to take, including the service or procedure that is subject to the Action.
- Additional information, if any, that could alter the decision.
- The reasons for the Action must have a factual basis and legal/policy basis. The notice shall include the specific facts pertinent to the Member or P4HB Member's condition and a statement of and a citation to the specific law, rule or policy basis for the Action. The notice shall also state which company and what employee within that company made the initial decision.

- A telephone number, fax number and address where the Member or P4HB Member may request and promptly obtain a copy of his or her file and the law, rule or policy that is the basis for the Action, and the credentials of the Health Care Professional who made the decision.
- Information that the Member or P4HB Member's may receive a copy of their case file, including Medical Records, and any other documents and records considered during the Proposed Action within fifteen (15) calendar days of making an oral or written request and information on how to request such a file from the Contractor, including an address, telephone number and fax number. The notice shall state that if the Member, the Member's Authorized Representative, P4HB Member or the Provider requests a copy of the Member's case file either orally or in writing, such case file shall be provided to the requesting party by U.S. Mail, electronic mail or facsimile within fifteen (15) calendar days. The Contractor shall pay the costs of providing a copy of the case file to the requesting party.
- The Member or P4HB Member's right to file an Administrative Review through the Contractor's internal Grievance System as described in Section 4.14.
- The Provider's right to file a Provider Complaint as described in Section 4.9.7;
- The requirement that a Member or P4HB Member exhaust the contractor's internal Administrative Review Process;
- The circumstances under which expedited review is available and how to request it; and
- The Member or P4HB Member's right to have Benefits continue pending resolution of the Administrative Review with the Contractor, Member or P4HB Member instructions on how to request that Benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.
- The Member or P4HB Member's right to be represented by a person of his or her choice and the telephone number of the Georgia Legal Services or Atlanta Legal Aid Program in the area.

4.14.3.4 The Contractor shall mail the Notice of Proposed Action within the following timeframes:

4.14.3.4.1 For termination, suspension, or reduction of previously authorized Covered Services at least ten (10) Calendar Days before the date of Proposed Action or not later than the date of Proposed Action in the event of one of the following exceptions:

- The Contractor has factual information confirming the death of a Member or P4HB Member.
- The Contractor receives a clear written statement signed by the Member or P4HB Member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information.

- The post office returns Contractor mail directed to the Member or P4HB Member indicating no forwarding address and the Member's whereabouts are unknown and (refer to 42 CFR 431.231(d) for procedures if the Member or P4HB Member's whereabouts become known).
- The Member or P4HB Member's Provider prescribes an immediate change in the level of medical care.

4.14.3.4.2 The date of action will occur in less than ten (days), in accordance with 42 C.F.R. §483.12(a) (5) (ii), which provides exceptions to the 30 days' notice requirements of 42 C.F.R. § 483.12(a) (5) (i).

4.14.3.4.3 The Contractor may shorten the period of advance notice to five (5) Calendar Days before date of action if the Contractor has facts indicating that action should be taken because of probable Member or P4HB Member Fraud and the facts have been verified, if possible, through secondary sources.

4.14.3.4.5 For denial of payment, at the time of any Proposed Action affecting the Claim.

4.14.3.4.6 For standard Service Authorization decisions that deny or limit services, within the timeframes required in Section 4.11.2.5.1.

4.14.3.4.7 If the Contractor extends the timeframe for the decision and issuance of notice of Proposed Action according to Section 4.11.2.5, the Contractor shall give the Member or P4HB Member written notice of the reasons for the decision to extend the timeframe and inform the enrollee of the right to file a Grievance if he or she disagrees with that decision. The Contractor shall issue and carry out its determination as expeditiously as the Member or P4HB Member's health requires and no later than the date the extension expires.

4.14.3.4.8 For authorization decisions not reached within the timeframes required in Section 4.11.2.5 for either standard or expedited Service Authorizations, Notice of Proposed Action shall be mailed on the date the timeframe expires, as this constitutes a denial and is thus a Proposed Action.

4.14.4 Administrative Review Process

4.14.4.1 An Administrative Review is the request for review of a "Proposed Action". The Member, the Member's Authorized Representative, the P4HB Member or the Provider acting on behalf of the Member with the Member's written consent, may file an Administrative Review either orally or in writing. Unless the Member, P4HB Member or Provider requests expedited review, the Member, the Member's Authorized Representative, P4HB Member or the Provider acting on behalf of the Member with the Member's written consent, must follow an oral filing with a written, signed, request for Administrative Review.

4.14.4.2 The Member, the Member's Authorized Representative, P4HB Member or the Provider acting on behalf of the Member with the Member's written consent, may file an Administrative Review with the Contractor within thirty (30) Calendar Days from the date of the notice of Proposed Action.

4.14.4.3 Administrative Reviews shall be filed directly with the Contractor, or its delegated representatives. The Contractor may delegate this authority to an Administrative Review committee, but the delegation must be in writing.

4.14.4.4 The Contractor shall ensure that the individuals who make decisions on Administrative Reviews are individuals who were not involved in any previous level of review or decision-making; and who are Health Care Professionals who have the appropriate clinical expertise in treating the Member or P4HB Member's Condition or disease if deciding any of the following:

- An Administrative Review of a denial that is based on lack of Medical Necessity.
- An Administrative Review that involves clinical issues.

4.14.4.5 The Administrative Review process shall provide the Member, the Member's Authorized Representative, P4HB Member or the Provider acting on behalf of the Member with the Member's written consent, a reasonable opportunity to present evidence and allegations of fact or law, in person, as well as in writing. The Contractor shall inform the Member or P4HB Member of the limited time available to provide this in case of expedited review.

4.14.4.6 The Administrative Review process must provide the Member, the Member's Authorized Representative, P4HB Member or the Provider acting on behalf of the Member with the Member's written consent, opportunity, before and during the Proposed Action and Administrative Review process, to examine the Member or P4HB Member's case file, including Medical Records, and any other documents and records considered during the Administrative Review process. If the Member, the Member's Authorized Representative, P4HB Member or the Provider requests a copy of the Member's case file either orally or in writing, such case file shall be provided to the requesting party by U.S. Mail, electronic mail or facsimile within fifteen (15) calendar days. The Contractor shall pay the costs of providing a copy of the case file to the requesting party.

4.14.4.7 The Administrative Review process must include as parties to the Administrative Review the Member, the Member's Authorized Representative, the Provider acting on behalf of the Member with the Member's written consent, P4HB Member or the legal representative of a deceased Member's estate.

4.14.4.8 The Contractor shall resolve each Administrative Review and provide written notice of the resolution to each party and to the provider whether or not the provider is representing the Member, as expeditiously as the Member or P4HB Member's health Condition requires but shall not exceed forty-five (45) Calendar Days from the date the Contractor receives the Administrative Review. For expedited reviews and notice to affected parties, the Contractor has no longer than three (3) working days or as expeditiously as the Member or P4HB Member's physical or mental health condition requires, whichever is sooner. If the Contractor denies a Member or P4HB Member's request for expedited review, it must transfer the Administrative Review to the timeframe for standard resolution specified herein and must make reasonable efforts to give the Member or P4HB Member prompt oral notice of the denial, and follow up within two (2) Calendar

Days with a written notice. The Contractor shall also make reasonable efforts to provide oral notice for resolution of an expedited review of an Administrative Review.

4.14.4.9 The Contractor may extend the timeframe for standard or expedited resolution of the Administrative Review by up to fourteen (14) Calendar Days if the Member, Member's Authorized Representative, P4HB Member or the Provider acting on behalf of the Member with the Member's written consent, requests the extension or the Contractor demonstrates (to the satisfaction of DCH, upon its request) that there is need for additional information and how the delay is in the Member or P4HB Member's interest. If the Contractor extends the timeframe, it must, for any extension not requested by the Member or P4HB Member, give the Member or P4HB Member written notice of the reason for the delay.

4.14.5 Notice of Adverse Action

4.14.5.1 If the Contractor upholds the Proposed Action in response to an Administrative Review filed by the Member or P4HB Member, the Contractor shall issue a Notice of Adverse Action within the timeframes described in Section 4.14.4.8 and 4.14.4.9. The Notice of Adverse Action shall be mailed to the Member, P4HB Member, the Member's Authorized Representative, and the Provider.

4.14.5.2 The Notice of Adverse Action shall meet the language and format requirements as specified in 4.3 and include the following:

- The results and date of the Adverse Action including the service or procedure that is subject to the Action.
- Additional information, if any, that could alter the decision.
- The specific reason used as the basis of the Adverse Action, including findings on the specific facts pertinent to the Member or P4HB Member's condition and a statement of and citation to the specific law, rule or policy basis for the Adverse Action.

• Information that the Member or P4HB Member's may receive a copy of their case file, including Medical Records, and any other documents and records considered during the Proposed or Adverse Action within fifteen (15) calendar days of making an oral or written request and information on how to request such a file from the Contractor, including an address, telephone number and fax number. The notice shall state that if the Member, the Member's Authorized Representative, P4HB Member or the Provider requests a copy of the Member's case file either orally or in writing, such case file shall be provided to the requesting party by U.S. Mail, electronic mail or facsimile within fifteen (15) calendar days. The Contractor shall pay the costs of providing a copy of the case file to the requesting party.

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- The right to request a State Administrative Law Hearing within thirty (30) Calendar Days of the mailing of the Notice of Adverse Action, either orally or in writing, and the telephone number, fax number and address to contact to request a State Administrative Law Hearing;
- The right to continue to receive Benefits pending a State Administrative Law Hearing;

- How to request the continuation of Benefits;
- Information explaining that the Member or P4HB Member may be liable for the cost of any continued Benefits if the Contractor's action is upheld in a State Administrative Law Hearing.
- Circumstances under which expedited resolution is available and how to request it.
- The Member or P4HB Member's right to be represented by a person of his or her choice and the telephone number of the Georgia Legal Services or Atlanta Legal Aid Program in the area.

4.14.6 Administrative Law Hearing

4.14.6.1 The State will maintain an independent Administrative Law Hearing process as defined in O.C.G.A. §49-4-153 and as required by federal law, 42 CFR 431.200. The Administrative Law Hearing process shall provide Members or P4HB Members an opportunity for a hearing before an impartial Administrative Law Judge. The Contractor shall comply with decisions reached as a result of the Administrative Law Hearing process.

4.14.6.2 The Contractor is responsible for providing counsel to represent its interests. DCH shall be a party to the case.

4.14.6.3 A Member, Member's Authorized Representative or P4HB Member may request orally or in writing an Administrative Law Hearing within thirty (30) Calendar Days of the date the Notice of Adverse Action is mailed by the Contractor. If the the appeal is filed orally, the Contractor may require that it be followed up in writing, but may not require that the written follow-up request be received within the thirty (30) Calendar Day timeframe. The parties to the Administrative Law Hearing shall include the Contractor as well as the Member, Member's Authorized Representative, P4HB Member or representative of a deceased Member's estate. A Provider cannot request an Administrative Law Hearing on behalf of a Member or P4HB Member. DCH reserves the right to intervene on behalf of the interest of either party.

4.14.6.4 The hearing request and a copy of the adverse action letter must be received by the Contractor within 30 days or less from the date that the notice of action was mailed.

4.14.6.5 A Member or P4HB Member may request a Continuation of Benefits as described in Section 4.14.7 while an Administrative Law Hearing is pending.

4.14.6.6 The Contractor shall make available any records and any witnesses at its own expense in conjunction with a request pursuant to an Administrative Law Hearing.

4.14.7 Continuation of Benefits while the Contractor Appeal and Administrative Law Hearing are Pending

4.14.7.1 As used in this Section, "timely" filing means filing on or before the later of the following:

- Within ten (10) Calendar Days of the Contractor mailing the Notice of Adverse Action.
- The intended effective date of the Contractor's Proposed Action.

4.14.7.2 The Contractor shall continue the Member or P4HB Member's Benefits if the Member, the Member's Authorized Representative or P4HB Member files the Appeal timely; the Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized Provider; the original period covered by the original authorization has not expired; and the Member or P4HB Member requests extension of the Benefits.

4.14.7.3 If, at the Member or P4HB Member's request, the Contractor continues or reinstates the Member or P4HB Member's benefit while the Appeal or Administrative Law Hearing is pending, the Benefits must be continued until one of the following occurs:

- The Member or P4HB Member withdraws the Appeal or request for the Administrative Law Hearing.
- Ten (10) Calendar Day pass after the Contractor mails the Notice of Adverse Action, unless the Member or P4HB Member, within the ten (10) Calendar Day timeframe, has requested an Administrative Law Hearing either in writing or orally with continuation of Benefits until an Administrative Law Hearing decision is reached. If the appeal is filed orally, the Contractor may require that it be followed up in writing, but may not require that the written follow-up request be received within the ten (10) Calendar Day timeframe.
- An Administrative Law Judge issues a hearing decision adverse to the Member.
- The time period or service limits of a previously authorized service has been met.

4.14.7.4 If the final resolution of Appeal is adverse to the Member or P4HB Member, that is, upholds the Contractor action, the Contractor may recover from the Member or P4HB Member the cost of the services furnished to the Member or P4HB Member while the Appeal is pending, to the extent that they were furnished solely because of the requirements of this Section.

4.14.7.5 If the Contractor or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the Contractor shall authorize or provide these disputed services promptly, and as expeditiously as the Member or P4HB Member's health condition requires.

4.14.7.6 If the Contractor or the Administrative Law Judge reverses a decision to deny authorization of services, and the Member received the disputed services while the Appeal was pending, the Contractor shall pay for those services.

4.14.8 Reporting Requirements

4.14.8.1 The Contractor shall log and track all Grievances, Proposed Actions, Appeals and Administrative Law Hearing requests, as described in Section 4.18.4.5.

4.14.8.2 The Contractor shall maintain records of Grievances, whether received verbally or in writing, that include a short, dated summary of the problems, name of the grievant, date of the Grievance, date of the decision, and the disposition.

4.14.8.3 The Contractor shall maintain records of Appeals, whether received verbally or in writing, that include a short, date summary of the issues, name of the appellant, date of Appeal, date of decision, and the resolution.

4.14.8.4 DCH may publicly disclose summary information regarding the nature of Grievances and Appeals and related dispositions or resolutions in consumer information materials.

4.14.8.5 The Contractor shall submit quarterly Grievance System Reports to DCH as described in Section 4.18.4.5.

APPENDIX C

4.11.2 Prior Authorization and Pre-Certification

4.11.2.1 The Contractor shall not require Prior Authorization or Pre-Certification for Emergency Services, Post-Stabilization Services, or Urgent Care services, as described in Section 4.6.1, 4.6.2, and 4.6.3.

4.11.2.2 The Contractor shall require Prior Authorization and/or Pre-Certification for all non-emergent and non-urgent inpatient admissions except for normal newborn deliveries.

4.11.2.3 The Contractor may require Prior Authorization and/or Pre-Certification for all non-emergent, Out-of-Network services.

4.11.2.4 Authorization periods must be reasonable in light of the Member's or P4HB Member's diagnosis and condition, their expected duration, and the nature and purpose of the treatment. Authorization periods must facilitate provision of services that are sufficient in amount, duration and scope to reasonably achieve their purpose. An authorization period may not be used to prevent a Member or P4HB Member from receiving continued services pending an appeal of the proposed termination of previously authorized services.

4.11.2.5 Prior Authorization and Pre-Certification shall be conducted by a currently licensed, registered or certified Health Care Professional who is appropriately trained in the principles, procedures and standards of Utilization Review.

4.11.2.6 The Contractor shall notify the Provider of Prior Authorization determinations in accordance with the following timeframes:

4.11.2.6.1 *Standard Service Authorizations.* Prior Authorization decisions for non-urgent services shall be made within fourteen (14) Calendar Days of receipt of the request for services. An extension may be granted for an additional fourteen (14) Calendar Days if the Member, P4HB Participant or the Provider requests an extension, or if the Contractor justifies to DCH a need for additional information and the extension is in the Member's or P4HB Participant's interest.

4.11.2.6.2 *Expedited Service Authorizations.* In the event a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's or P4HB Participant's life or health the Contractor shall make an expedited authorization determination and provide notice within twenty-four (24) hours. The Contractor may extend the twenty-four (24) hour period for up to five (5) Business Days if the Member, P4HB Participant or the Provider requests an extension, or if the Contractor justifies to DCH a need for additional information and the extension is in the Member's or P4HB Participant's interest.

4.11.2.6.3 Authorization for services that have been delivered. Determinations for authorization involving health care services that have been delivered shall be made within thirty (30) Calendar Days of receipt of the necessary information.

4.11.2.7 The Contractor's policies and procedures for authorization shall include consulting with the requesting Provider when appropriate.

APPENDIX D

4.18.4.5 Grievance System Report

Pursuant to Section 4.14.8.1 the Contractor shall submit a log of Grievance, Appeals and Administrative Law Hearing requests to include at least the following:

Member identification number

Medicaid eligibility (or PeachCare) category of the Member or P4HB Member

Whether an adult or person under age 21

Type of complaint (grievance, administrative review or State Administrative Law Hearing)

Specific type of service at issue

Date notice of proposed action, notice of administrative decision mailed to Member

Date Member requested administrative review or state administrative appeal

Administrative disposition of the case:

Result

Service was approved

Service approved in part

Service denied

Service terminated

Resolution occurred by:

Settlement with Member

Administrative decision

State administrative hearing

DCH decision

Date notice of disposition mailed to provider.