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State:			
– Citation		Conditi	on or Requirement
- 1932(a)(1)(A)	A.	The State ofinto managed case managers authority. Thi Security Act (to plan to require care entities where the entities wher	enrolls Medicaid beneficiaries on a mandatory basis care entities (managed care organization (MCOs) and/or primary care (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority is granted under section 1932(a)(1)(A) of the Social the Act). Under this authority, a state can amend its Medicaid state certain categories of Medicaid beneficiaries to enroll in managed ithout being out of compliance with provisions of section 1902 of the deness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or (42 CFR 440.230). This authority may <i>not</i> be used to mandate Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health), nor can it be used to mandate the enrollment of Medicaid
	В.	enrolled in cer "special needs	who are Medicare eligible, who are Indians (unless they would be tain plans—see D.2.ii. below), or who meet certain categories of "beneficiaries (see D.2.iii vii. below)
	Б.		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)	PAHPs)	i.	MCO _ii. PCCM (including capitated PCCMs that qualify as
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)			ment method to the contracting entity will be: _i. fee for service; capitation; a case management fee; a bonus/incentive payment; a supplemental payment, or other. (Please provide a description below).
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State:		
– Citation		Condition or Requirement
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1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv	3.	For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.
		If applicable to this state plan, place a check mark to affirm the state has met all of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).
		i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.
		ii. Incentives will be based upon specific activities and targets.
		iii. Incentives will be based upon a fixed period of time.
		iv. Incentives will not be renewed automatically.
		v. Incentives will be made available to both public and private PCCMs.
		vi. Incentives will not be conditioned on intergovernmental transfer agreements.
		vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4) program and its	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.)
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State:		OMB No.:0938-0933
– Citation		Condition or Requirement
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1932(a)(1)(A)		 The state plan program will/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)		1The state assures that all of the applicable requirements
1903(m)		of section 1903(m) of the Act, for MCOs and MCO contracts will
42 CFR 438.50(c)(1)		be met.
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Citation		Condition or Requirement
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1932(a)(1)(A)(i)(I)		2The state assures that all the applicable requirements of section
1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)		1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3.	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.	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)	5.	The state assures that all applicable managed care
require 42 CFR 438 42 CFR 438.50(c)(4 1903(m)	ements 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.	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) CFR 447.362 for 42 CFI 42 CFR 438.50(c)(6)	7. R 447.362	The state assures that all applicable requirements of 42 payments under any nonrisk contracts will be met.
45 CFR 74.40	8. CFR	The state assures that all applicable requirements of 45 92.36 for procurement of contracts will be met.
	D. <u>Elig</u>	ible groups
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State:		_
– Citation	Cor	dition or Requirement
- 1932(a)(1)(A)(i)	1. List	all eligible groups that will be enrolled on a mandatory basis.
	CFR 438.	ndatory exempt groups identified in 1932(a)(1)(A)(i) and 42 50. a check mark to affirm if there is voluntary enrollment any
		he 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) when 42 CFR 438(d)(2) Ind	ii. dian	Indians who are members of Federally recognized Tribes except the MCO or PCCM is operated by the Indian Health Service or an 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
1932(a)(2)(A)(i) Supplemental	iii.	Indian Health Care Improvement Act. Children under the age of 19 years, who are eligible for
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Citation	Con	dition or Requirement
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42 CFR 438.50(d)(3)(i)		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) out-of-	v.	Children under the age of 19 years who are in foster care or other
42 CFR 438.50(3)(iii)		the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi.	Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii)		viiChildren under the age of 19 years who are receiving services
42 CFR 438.50(3)(v)	ough 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 o	f Mandatory Exempt Groups
1932(a)(2)	1. Des that are	cribe how the state defines children who receive services funded
42 CFR 438.50(d)		under section 501(a)(1)(D) of title V. (Examples: children eiving services specific clinic or enrolled in a particular program.)
1932(a)(2) V children	2.	Place a check mark to affirm if the state's definition of title
42 CFR 438.50(d)		is determined by:
		i. program participation, ii. special health care needs, or
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– Citation	Condit	ion or Requirement
-	iii.	both
1932(a)(2) 42 CFR 438.50(d)		check mark to affirm if the scope of these title V services yed through a family-centered, community-based, coordinated stem.
	i. ii.	yes no
1932(a)(2) children who are ex (Examples: eligibili	xempt 42 CFR 438	
	i.	Children under 19 years of age who are eligible for SSI under title XVI;
	ii.	Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;
	iii.	Children under 19 years of age who are in foster care or other out- of-home placement;
	iv.	Children under 19 years of age who are receiving foster care or adoption assistance.
1932(a)(2)	5. Descri an exempt	be the state's process for allowing children to request ion from
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State:		
– Citation	Conditi	on or Requirement
– 42 CFR 438.50(d)	as defi	andatory enrollment based on the special needs criteria ned in the state plan if they are not initially identified as t. (Example: self-identification)
1932(a)(2) are 42 CFR 438.50(d)	exempt from ma	escribe how the state identifies the following groups who andatory enrollment into managed care: (Examples: of aid codes in the eligibility system, self- identification) Recipients who are also eligible for Medicare.
	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.
42 CFR 438.50	F. <u>List othe</u> mandatory en	er eligible groups (not previously mentioned) who will be exempt from rollment
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State:			-
- Citation		Cond	ition or Requirement
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42 CFR 438.50	G. <u>Li</u>	st all othe	er eligible groups who will be permitted to enroll on a voluntary basis
	Н. <u>Ег</u>	nrollment	process.
1932(a)(4)	1.	Defini	tions
42 CFR 438.50		i.	An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.
		ii.	A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4)	2.	State _I	process for enrollment by default.
42 CFR 438.50		Descri	be how the state's default enrollment process will preserve:
		i.	the existing provider-recipient relationship (as defined in H.1.i)
		ii.	the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).
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		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.)
1932(a)(4) 42 CFR 438.50	include	3. i. ii.	As part of the state's discussion on the default enrollment process, the following information: The state will/will not use a lock-in for managed care managed care. The time frame for recipients to choose a health plan before being auto-assigned will be
		iii.	Describe the state's process for notifying Medicaid recipients of their auto-assignment. (Example: state generated correspondence.)
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	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.)	
	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.)	
	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)	
1932(a)(4) 42 CFR 438.50	I. <u>State assura</u>	nces on the enrollment process	
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	Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.
	1The 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.
	2The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).
	3 The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.
	This provision is not applicable to this 1932 State Plan Amendment.
	4The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a) (3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)
	This provision is not applicable to this 1932 State Plan Amendment.
	5 The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.
	This provision is not applicable to this 1932 State Plan Amendment.
1932(a)(4) 42 CFR 438.50	J. <u>Disenrollment</u>
	1. The state will/will not use lock-in for managed care.
	2. The lock-in will apply for months (up to 12 months).
	3. Place a check mark to affirm state compliance.
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State:		
- Citation		Condition or Requirement
		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).
	K.	Information requirements for beneficiaries Place a check mark to affirm state compliance.
1932(a)(5) 42 CFR 438.50 42 CFR 438.10		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)
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.
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_		/will not intentionally limit the numbe contracts under a 1932 state plan option.
	contracting e	tate assures that if it limits the number on ntities, this limitation will not substantially impaintees to services.
	entities it cor	criteria the state uses to limit the number of tracts under a 1932 state plan option. (Example aber of providers and/or enrollees.)
	4 The selection state plan.	ctive contracting provision in not applicable to thi
information unless it	displays a valid OMB control	195, no persons are required to respond to a collection of number. The valid OMB control number for this information ete this information collection is estimated to average 10 hour
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complete and review estimate(s) or sugges	the information collection. If	s, search existing data resources, gather the data needed, and you have comments concerning the accuracy of the timplease write to: CMS, 7500 Security Boulevard, Attn: PRA-1850.	
CMS-10120 (exp.	01/31/2008)		
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