DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Wells	1-3-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000430	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Bowling ✓	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

December 18, 2006

Log - Wells
"Rec. Action"
cc: Bowling

RECEIVED
DEC 27 2006
Department of Health & Human Services
OFFICE OF THE DIRECTOR

Mr. Robert M. Kerr, Director
Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Re: South Carolina Title XIX State Plan Amendment, Transmittal #06-010

Dear Mr. Kerr:

We have reviewed South Carolina's State Plan Amendment (SPA) 06-010 which was submitted to the Atlanta Regional Office on September 27, 2006. This State Plan Amendment proposes to restructure the program and payment system that will consolidate the responsibility for the Network services into one contract.

Based on the information provided, we are pleased to inform you that South Carolina SPA 06-010 is approved. The effective date is October 1, 2006.

Copies of the signed CMS-179 form and approved plan page are enclosed. If you have any questions regarding this amendment, please contact Elaine Elmore at (404) 562-7408.

Sincerely,

Hugh L. Webster

for Renard L. Murray, D.M.
Associate Regional Administrator
Division of Medicaid & Children's Health

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SC 06-010

2. STATE: South Carolina

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2006

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
In accordance with federal regulations (42 CFR 433.36)

7. FEDERAL BUDGET IMPACT:
a. FFY 2007 $-0-
b. FFY 2008 $-0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A, Limitation Supplement, Pages 8z.1, 8z.2, 8z.3 and 8z.4
SUPPLEMENT 1 TO ATTACHMENT 3.1-A, Page 1(m)
Attachment 4.19-B, Page 6e

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 3.1-A, Limitation Supplement, Pages 8z.1, 8z.2, 8z.3and 8z.4
SUPPLEMENT 1 TO ATTACHMENT 3.1-A, Page 1(m)
Attachment 4.19-B, Page 6e

10. SUBJECT OF AMENDMENT:
To restructure the South Carolina Medicaid primary Care Case Management Program (PCCM) program and payment system that will consolidate the responsibility for the Network services into one contract. This contract will be with the Network rather than its many parts. The designated agent for the Network will be the Care Coordination Services Organization.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Mr. Kerr was designated by the Governor to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Robert M. Kerr

13. TYPED NAME:
Robert M. Kerr

14. TITLE:
Director

15. DATE SUBMITTED:
September 26, 2006

16. RETURN TO:

SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 27, 2006

18. DATE APPROVED:
December 18, 2006

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2006

20. SIGNATURE OF REGIONAL OFFICIAL:
Mark L. Wolters for Renard Murray

21. TYPED NAME:
Renard L. Murray, D.M.

22. TITLE:
Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS: Approved with the following changes as authorized by the State Agency on e-mail dated 12/19/06: Item 8: Change "Attachment 3.1-A, Limitation Supplement, Pages 8z.1, 8z.2, 8z.3, and 8z.4" to "Attachment 3.1-A, Limitation Supplement, Page 8z.1"; Delete "Supplement 1 to Attachment 3.1-A, Page 1(m)"; Add "Attachment 3.1-F, Pages 1 thru 13". Item 9: Add "New" which relates to Attachment 3.1-F, Pages 1 thru 13.

Required credentials for a Case Manager Assistant will include no less than a high school diploma or GED, and skills/competencies sufficient to perform assigned tasks or the capacity to acquire those skills/competencies.

F. Free Choice of Providers

All adults eligible for Medicaid and the subject of an abuse or neglect report referred to the South Carolina Department of Social Services will be eligible to receive these case management services. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of case managers and the freedom to switch case managers if and when they desire.

2. Eligible recipients will have free choice of providers of other medical care under the state plan. Case managers will assure that freedom of choice of physicians and other medical care providers is maintained at all times.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Services for clients who are insured by a third party payor which covers the cost of case management will be reimbursed by the third party payor. Title XIX funds will be used when a client has no third party coverage and is eligible for Medicaid. The few remaining clients will have their case management services funded by Social Services Block Grant or state funds.

As of June 30, 2006, services will no longer be covered and reimbursed.

State: South Carolina

Citation	Condition or Requirement

1932(a)(1)(A)

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

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

B. General Description of the Program and Public Process.

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

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

1. The State will contract with an

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

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

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

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

*The State will pay the Entity (the Medical Homes Network or MHN) a prospective Per Member Per Month (PMPM) case management/care coordination fee. The care management services performed by the MHN represent new incremental tasks that are not currently being performed by DHHS. The scope of these new services are intended to reflect the DHHS strategy that the PCCM product represents an addition to the continuum of managed care, falling between fee-for-service and MCOs. From this PMPM the MHN will be responsible for the provision

Citation	Condition or Requirement

of the contractually required services including care coordination and disease management and for dispersing any PMPM to the primary care physicians within its network.
** Reimbursement to the Medical Homes Network (the advisory Board and the Care Coordination Services Organization [CSO]) will be based on a shared savings model. The Network will be paid a prospective care coordination fee per member per month. In order to determine the cost savings achieved by a Medical Homes Network, the cost of enrolled Network members will be accumulated on a quarterly basis and will be compared to the cost of covering those same members in a fully insured Medicaid Managed Care Organization (MCO).

Using eligibility and enrollment data, each Network enrollee's member months will be calculated and placed into an age and sex cell developed for Medicaid MCO payment purposes. Member months will be accumulated by age and sex cells and then be applied against the applicable MCO risk adjusted rates to develop the "Medicaid Upper Payment Limit". The "Medicaid Upper Payment Limit" will also include "kicker" payments made for deliveries and births. The risk adjusted "Medicaid Upper Payment Limit" will then be compared against the Medicaid claim expenditures of Network enrollees (including any prospective care coordination fee payments paid to the CSO) to determine whether the Network achieved savings. Claim expenditures incurred by Network enrollees will include only those expenditures that are covered under the Medicaid MCO service package (including an adjustment for claims incurred but not reported).

If the Network realizes savings, then the South Carolina Department of Health and Human Services (SCDHHS) will provide an incentive and will reimburse the Network 50% of the savings realized. However, this payment cannot exceed five percent (5%) of the fee for service payments incurred by the network enrollees. The Network's CSO will be responsible for dividing the Network's share of the savings between the participating practices and the CSO, based on the agreement established between the CSO, the Advisory Board, and the participating practices. If the Network does not achieve savings, SCDHHS will impose a penalty on the Network and a portion, if not all, of the prospective care coordination fee payments must be refunded to the SCDHHS. Only the prospective care coordination fee payments are at risk since the SCDHHS will continue to directly reimburse the providers on a fee for service basis.

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)).

   _X_ i. Incentive payments to the PCCM will not exceed 5% of the total

Citation	Condition or Requirement

FFS payments for those services provided or authorized by the PCCM for the period covered.

__X__ ii. Incentives will be based upon specific activities and targets.

__X__ iii. Incentives will be based upon a fixed period of time.

__X__ iv. Incentives will not be renewed automatically.

__X__ v. Incentives will be made available to both public and private PCCMs.

__X__ vi. Incentives will not be conditioned on intergovernmental transfer agreements.

____ 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.)*

The State held a number of meetings during the design phase of the PCCM program. The State sought input from the Medical Care Advisory Committee and physicians who currently participate in the Medicaid program. The State utilized the results of consumer focus groups that had been conducted the year before. Staff visited another state's PCCM program and also interviewed other state Medicaid staff with experience in PCCMs. During the initial implementation, staff met frequently with the physicians and office staff who were participating in the pilot program. As the State began evaluating the program, staff participated in "Town Hall meetings" with consumers and made presentations to a variety of provider and advocate groups. The State will continue to utilize every opportunity to talk with the various stakeholders: consumers, providers, advocates, etc. At a minimum, the State will meet with stakeholders at least two (2) times per year.

1932(a)(1)(A)

5. The state plan program will___/will not X implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary X enrollment will be implemented in the following county/area(s):

i. county/counties (mandatory) _____

ii. county/counties (voluntary) All 46 counties of the State

Citation	Condition or Requirement

iii. area/areas (mandatory)_____

iv. area/areas (voluntary)_____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. ____The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. _√_ 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. ____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)
42 CFR 438
42 CFR 438.50(c)(4)
1903(m)

5. _√_ 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. ____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)
42 CFR 447.362
42 CFR 438.50(c)(6)

7. ____The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.

Citation	Condition or Requirement
45 CFR 74.40	8. √ 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.

None—See Section G

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. **NA**

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 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.

Citation	Condition or Requirement
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. ____Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. ____Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. ____Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. ____Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups--NA

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.)*

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
____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.

____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)*

Citation	Condition or Requirement
	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) 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)*
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.

Citation	Condition or Requirement

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. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

NA

42 CFR 438.50

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

All eligibility groups will be permitted to enroll on a voluntary basis except for nursing home residents, and any groups with Limited Medicaid Benefits (e.g., Beneficiaries eligible for Specified Low Income Medicare Beneficiaries, Payment categories 48 and 52; Beneficiaries eligible for Family Planning, Payment category 55; Individuals incarcerated in a jail or prison; Non-qualified, undocumented and illegal aliens).

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

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

Citation	Condition or Requirement

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).

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

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.)*

The State is in the process of procuring an Enrollment Broker through the competitive bid process. The successful Contractor shall provide enrollment assistance in an unbiased, informative manner. The Contractor shall assist the Member's plan selection by matching the Plan's providers, services and locations with the Member's needs and preferences by discussing participating providers and special services offered by the various plans. The Contractor shall develop an Enrollment Package that will be issued to each eligible beneficiary. SCDHHS will approve this package. The Contractor shall offer each Member, including non-English speaking Members, an opportunity to personally visit with an Enrollment Counselor within regions, or by appointment in each county to complete the Enrollment process or provide other assistance. The Contractor will be responsible for conducting an educational campaign to promote community awareness of SC Medicaid and to inform potential members about the benefits available, including preventive care and EPSDT services. The Contractor shall regularly collaborate with other State agencies and community-based advocacy and service groups that are involved in programs and activities targeted at the SC Medicaid eligible population.

1932(a)(4)
42 CFR 438.50

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

Citation	Condition or Requirement

i. The state will √ /will not ____ use a lock-in for managed care managed care.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be 30 days.

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

The State will use Contractor (Enrollment Broker) generated correspondence that has been approved by SCDHHS to notify Medicaid recipients of their auto-assignment.

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.)*

The State will use Contractor (Enrollment Broker) generated correspondence that has been approved by SCDHHS to notify the Medicaid recipients of their disenrollment rights.

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.)*

The State currently operates an auto-assignment process in only two (2) counties. The default assignment algorithm being used is very simplistic and is random. The PCPs within the Network are listed sequentially, by provider number—lowest to highest. With the first round of assignments, the first PCP in the list receives the assignment; the second PCP receives the assignment in the second round, etc.

When the State contracts with the Enrollment Broker, the Contractor will develop a much more sophisticated default assignment algorithm that will incorporate meaningful factors such as existing relationships between beneficiaries and providers, proximity of potential providers to beneficiaries, current enrollment of others in the household, etc.

Citation	Condition or Requirement

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 monitor changes in the rate of default assignment through reports generated by the enrollment broker. On a monthly basis the Contractor shall submit a report describing the Method of Plan Enrollment. On a quarterly basis the Contractor shall submit a report addressing Enrollment/Disenrollment Trends by Plan.

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. √ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. √ 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. ____ 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.

4. ____ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

   √ 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.

Citation	Condition or Requirement

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.

√ 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).

The State does not use any additional circumstances of "cause" for disenrollment other than those detailed in 42 CFR 438.56(c).

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)

PCCM - None

Citation	Condition or Requirement

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_____/will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. _____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

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

associated with allowable case management service delivery. The rate will be prospectively determined by using an average monthly caseload and the average cost of the case manager including support costs. Payment to public providers will not exceed the actual allowable cost of rendering the service. The requirements of 42 CFR 447.321 or 42 CFR 447.325 will not be exceeded.

Case management services provided by private providers will be reimbursed on a fee-for-service methodology based on the delivery of units of service. The unit of service will be a month. Payment to private providers will not exceed the established statewide average cost for the service.

As of June 30, 2006, services will no longer be covered and reimbursed.