DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Wells	12/30/10

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-283	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR C: Ms. Forkner, Dep'S. CMS, file	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [✓] 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 Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

December 27, 2010

Ms. Emma Forkner, Director
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

RE: South Carolina Title XIX State Plan Amendment, Transmittal # 10-004

Dear Ms. Forkner:

We have reviewed South Carolina's State Plan Amendment (SPA) 10-004, submitted to the Atlanta Regional Office on July 1, 2010. This amendment enrolls Medicaid beneficiaries on a mandatory basis into managed care organizations (MCOs) and/or primary care case management (PCCM) programs in absence of a section 1115 or section 1915(b) waiver authority.

Based on the information provided, the Centers for Medicare & Medicaid Services (CMS) is approving South Carolina SPA 10-004. This amendment is effective October 1, 2010. The signed CMS-179 and the approved plan pages are enclosed.

South Carolina worked diligently to address the concerns identified during our review process including: public process, passive and default enrollment processes and provider network adequacy. You have indicated that mandatory enrollment will be implemented statewide beginning January 1, 2011, to all new recipients and to current recipients at the time they complete their annual eligibility redetermination.

Expansion of the South Carolina *Healthy Connections Choices* will require ongoing collaboration between the CMS and your department to approve MCO contract amendments, review enrollment materials and monitor readiness activities of the State's program expansion. To that end, CMS intends to closely monitor the expansion of the *Healthy Connections Choices* program. That monitoring will include the following activities over the next twelve months:

- A conference call in early January 2011 to ascertain State readiness for expansion;
- CMS review and approval of MCO contract amendments;
- CMS review and approval of beneficiary enrollment and choice communication materials;
- Bi-weekly conference calls between your department and CMS during the first few months of *Healthy Connections Choices* implementation;

- CMS attendance (via conference call) at monthly Medical Care Advisory Committee meetings throughout calendar year 2011;
- CMS attendance (via conference call) at regularly scheduled MCO/MHN Health Plans meetings throughout calendar year 2011;
- Convene a public forum with advocates and beneficiaries in mid 2011 to assess progress of program expansion;
- Regular State updates to CMS on enrollment/disenrollment, provider network issues, grievances and appeals;
- CMS review of Enrollment Broker data metrics (and appropriate State response as needed) to minimize auto-assignments to the extent possible; and

Documentation of the State's implementation and monitoring of corrective action plans recommended by the Department's External Quality Review Organization

We look forward to working collaboratively with the State during the expansion of *Healthy Connections Choices*. We appreciate the effort and cooperation provided by your staff during our review. If you have any questions or need further assistance, please contact Trina Roberts at (404) 562-7418.

Sincerely,

Trina Roberts
for

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

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 10-004

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, 2010

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:
Section 1932(a)(1)(A) of the Social Security Act (the Act) Section of 1902 of the Act of statewideness (42CFR 431.50) freedom of choice (42 CFR 431.51 or comparability (42CFR 440.230) and 42 CFR 438.50

7. FEDERAL BUDGET IMPACT:
a. FFY 10-11 $ Budget neutral
b. FFY 11-12 $ Budget neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F, Pages 1 through 13

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-F, Pages 1 through 13

10. SUBJECT OF AMENDMENT:
The State of South Carolina enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case management programs (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority.

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:
Ms. Forkner was designated by the Governor to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Emma Forkner

13. TYPED NAME:
Emma Forkner

14. TITLE:
Director

15. DATE SUBMITTED:
July1, 2010

16. RETURN TO:
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
07/01/10

18. DATE APPROVED:
12/22/10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/01/10

20. SIGNATURE OF REGIONAL OFFICIAL:
Irena Roberts for

21. TYPED NAME:
~~Jackie Glaze~~

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

23. REMARKS:

FORM HCFA-179 (07-92)

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 mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case management programs (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
____ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
√ iii. Both

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

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

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

*The State will pay the entity (the Managed Care Organization or the Primary Care Coordination Management programs) a Per Member Per Month (PMPM) fee. The payment arrangements for the MCOs or PCCMs will be specified in these respective contracts and Policy and Procedures Guides in accordance with the contract requirements outlined in section 42 CFR 438.6 and with approval of the Centers for Medicare and Medicaid.

Citation	Condition or Requirement
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)	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 MCO and PCCM programs. The State sought input from the Medical Care Advisory Committee and providers who participate in the Medicaid program. The State has on-going independent evaluation performed to monitor the quality and efficiency of the Managed Care entities. This includes financial analysis as well as traditional quality monitoring, such as CAPHS and HEDIS measures. The State has also established monthly public Managed Care Organization/Medical Homes Network Health Plan Meetings in order to gain public input. These meeting dates are posted on the agency's website on an annual basis with agendas prepared in response to public requests/agency initiatives. Beneficiaries, representatives from other state agencies,

Citation	Condition or Requirement

providers/provider groups and advocacy groups are welcomed to attend/participate. 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 six (6) times per year.

1932(a)(1)(A)

5. 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)
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.

Citation	Condition or Requirement
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.
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.

   i. Partners for Healthy Children - Children up to age 19 who meet financial criteria, disregarding Foster Care, SSI eligible, TEFRA and any other child whose eligibility is based on disability.
   ii. Low Income Families (LIF) with at least one child under 18 (or 19 if still in secondary school) who meet financial criteria.
   iii. Transitional Medicaid beneficiaries who receive Medicaid for a temporary period when they have been determined ineligible because of increased earnings.
   iv. Optional Coverage for Pregnant Women (OCWI) beneficiaries who are pregnant women and meet financial criteria.
   v. Beneficiaries over age 18 who are eligible for the Federal SSI program and are entitled to Medicaid coverage.
   vi. SSI Pass-Along beneficiaries who become ineligible for SSI cash assistance as a result of cost of living increases received after April 1977.
   vii. Beneficiaries who are disabled widows and widows who would be eligible for SSI except for the increase in disability benefits.
   viii. Beneficiaries who are disabled widows and widowers aged 60 through 64 who would be eligible for SSI except for early receipt of social security benefits.

Citation	Condition or Requirement

ix. Aged or disabled beneficiaries (ABD) who have countable monthly income at or below 100% of the Federal Poverty level and resources below a defined limit.

x. Working Disabled beneficiaries who meet the Social Security definition of disabled and are working who also meet financial criteria.

xi. Beneficiaries who are uninsured women diagnosed and found to need treatment for breast and/or cervical cancer or pre-cancerous lesions.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. √ Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*

1932(a)(2)(C)
42 CFR 438(d)(2)

ii. √ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

Tribal members are identified by Indian Health Service providers and associated claims are paid under the fee-for-service system.

1932(a)(2)(A)(i)
42 CFR 438.50(d)(3)(i)

iii. √ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.

1932(a)(2)(A)(iii)
42 CFR 438.50(d)(3)(ii)

iv. √ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.

Citation	Condition or Requirement
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--
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)* i. Children under 19 years of age who are eligible for SSI under title XVI; eligibility database ii. Children under 19 years of age who are eligible under section 1902 (e) (3) of the Act;

Citation	Condition or Requirement
	eligibility database
	iii. Children under 19 years of age who are in foster care or other out-of-home placement;
	eligibility database and self-identification
	iv. Children under 19 years of age who are receiving foster care or adoption assistance.
	eligibility database and self-identification
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)*
	All eligible children under 19 years of age who meet special needs criteria as defined in the State Plan may request disenrollment at any time by contacting the enrollment broker. Disenrollment will be processed at the earliest disenrollment period.
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.
	Medicare eligible beneficiaries are identified in the MMIS system by their Medicare plan types and are excluded from mandatory enrollment into managed care.
	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.

Citation	Condition or Requirement
	Tribal members are identified by Indian Health Service providers and associated claims are paid under the fee-for-service system.

Citation	Condition or Requirement

42 CFR 438.50

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

The following eligible groups will be excluded from enrolling in managed care:

1. Beneficiaries in a nursing home or institutional long-term care facility.
2. Beneficiaries hospitalized for an extended period longer than thirty (30) days.
3. Beneficiaries receiving family planning services only.
4. Beneficiaries that are considered refugees.

42 CFR 438.50

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

Other eligible groups that will be excluded from mandatory enrollment into managed care but may enroll on a voluntary basis include the following categories of beneficiaries:

1. Beneficiaries in home and community waiver programs.
2. Beneficiaries under one (1) year of age where SCDHHS cannot determine the mother's enrollment in a health plan.
3. Beneficiaries who reside in a residential care facility or a community long-term care facility.

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

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

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

Citation	Condition or Requirement

i. the existing provider-recipient relationship (as defined in H.1.i).

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 utilizes an Enrollment Broker to provide enrollment assistance in an unbiased, informative manner. The Enrollment Broker assists the beneficiary's plan selection by matching the Plan's providers, services and locations with the beneficiary's needs and preferences by discussing participating providers and special services offered by the various plans. The Enrollment Package that is issued to each eligible beneficiary provides directions that enable them to make an informed choice regarding their managed care plan and provider; preserving the beneficiary's current provider relationship if desired,. The Enrollment Broker also offers each beneficiary, including non-English speaking beneficiaries, 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 Enrollment Broker also provides training opportunities to the provider community that emphasizes the opportunities managed care offers to their patients. Educational campaigns emphasizing the benefits of a medical home are also directed to the beneficiaries. When qualified beneficiaries fail to select a managed care health plan, the Enrollment Broker will assign them to a plan. The assignment of beneficiaries to a health plan incorporates algorithms that ensure an equitable distribution of beneficiaries to each plan eligible to receive new members. The assignment process includes logic that assures the beneficiary of a secondary choice, should the assigned plan not meet their needs.

1932(a)(4)
42 CFR 438.50

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

i. The state will √ /will not____ use a lock-in for managed care.

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

Citation	Condition or Requirement

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

The State will use Enrollment Broker generated correspondence that has been approved by SCDHHS to notify Medicaid beneficiaries 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 Enrollment Broker generated correspondence that has been approved by SCDHHS to notify the Medicaid beneficiaries 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 default assignment of beneficiaries to managed care health plans is performed by the Enrollment Broker on a monthly basis utilizing a customized assignment algorithm for the State. The process links beneficiaries with available health plans in their geographical area and ensures that there is a choice of health plans where appropriate, should the beneficiary request a transfer. The assignment process also ensures that beneficiaries are assigned to an MCO or PCCM in their geographic region that is accepting new members. The distribution of these beneficiaries to the health plans occurs through the use of a leveling procedure designed to equitably assign beneficiaries across all of the available plans in the geographic area. The procedure maintains family relationships whenever possible to minimize confusion.

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, addressing Enrollment/Disenrollment Trends by Plan.

Citation	Condition or Requirement

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.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will √/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.

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).

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 excluded services: None
MCO excluded services:

Institutional Long Term Care Facilities/Nursing (after the first thirty (30) continuous days post- admission)
Mental Health, Alcohol and Other Drug Abuse Treatment Services
Non-Ambulance Transportation
Glasses, contacts and fitting fees
Dental Services
Targeted Case Management Services
Pregnancy Prevention Services – Targeted Populations
MAPPS Family Planning Services
Organ Transplantation
School Based Services

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.

Citation	Condition or Requirement

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