

State:

Citation	Condition or Requirement
1932(a)(1)(A)	<p>A. <u>Section 1932(a)(1)(A) of the Social Security Act.</u></p> <p>The State of _____ enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may <i>not</i> 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)</p>
	<p>B. <u>General Description of the Program and Public Process.</u></p> <p>For B.1 and B.2, place a check mark on any or all that apply.</p>
1932(a)(1)(B)(i) 1932(a)(1)(B)(ii) 42 CFR 438.50(b)(1)	<p>1. The State will contract with an</p> <p>___ i. MCO ___ ii. PCCM (including capitated PCCMs that qualify as PAHPs) ___ iii. Both</p>
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	<p>2. The payment method to the contracting entity will be:</p> <p>___ 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).</p>
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	<p>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.</p>

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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.*)

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) _____

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	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. |
| 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. |

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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. <u>Eligible groups</u>
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis.
	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. <i>(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)</i>
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.
1932(a)(2)(A)(iii)	iv. ____Children under the age of 19 years who are eligible under

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42 CFR 438.50(d)(3)(ii)	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

- 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*)

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	<ul style="list-style-type: none">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. <i>(Example: self-identification)</i>
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: <i>(Examples: usage of aid codes in the eligibility system, self-identification)</i> <ul style="list-style-type: none">i. 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

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42 CFR 438.50	F. <u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u>
42 CFR 438.50	G. <u>List all other eligible groups who will be permitted to enroll on a voluntary basis</u>
1932(a)(4) 42 CFR 438.50	H. <u>Enrollment process.</u> 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)	2. State process for enrollment by default.

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42 CFR 438.50	<p>Describe how the state's default enrollment process will preserve:</p> <ol style="list-style-type: none"><li data-bbox="587 558 1365 585">i. the existing provider-recipient relationship (as defined in H.1.i). <li data-bbox="587 800 1328 863">ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii). <li data-bbox="587 1077 1443 1255">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). <i>(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)</i>
1932(a)(4) 42 CFR 438.50	<ol style="list-style-type: none"><li data-bbox="532 1472 1443 1711">3. As part of the state's discussion on the default enrollment process, include the following information:<ol style="list-style-type: none"><li data-bbox="587 1566 1443 1623">i. The state will____/will not____ use a lock-in for managed care managed care.<li data-bbox="587 1654 1443 1711">ii. The time frame for recipients to choose a health plan before being auto-assigned will be_____.

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	<p>iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. <i>(Example: state generated correspondence.)</i></p>
	<p>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. <i>(Examples: state generated correspondence, HMO enrollment packets etc.)</i></p>
	<p>v. Describe the default assignment algorithm used for auto-assignment. <i>(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)</i></p>
	<p>vi. Describe how the state will monitor any changes in the rate of default assignment. <i>(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)</i></p>

1932(a)(4)
42 CFR 438.50

I. State assurances 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.

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 ___ 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).

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1932(a)(5) 42 CFR 438.50 42 CFR 438.10	4. Describe any additional circumstances of "cause" for disenrollment (if any). K. <u>Information requirements for beneficiaries</u> Place a check mark to affirm state compliance. ____ 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. <u>List all services that are excluded for each model (MCO & PCCM)</u>
1932 (a)(1)(A)(ii)	M. <u>Selective contracting under a 1932 state plan option</u> 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. (<i>Example: a limited number of providers and/or enrollees.</i>)

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

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