Table of Contents

State/Territory Name: IL

State Plan Amendment (SPA) #: 11-007

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

FEB 14 2012

Julie Hamos, Director
Illinois Department of Healthcare and Family Services
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

ATTN: James Parker and Michelle Maher

Dear Ms. Hamos:

Enclosed for your records is an approved copy of the following State Plan Amendment (SPA).

Transmittal #11-007 - Approves Illinois' 1932(a) State plan amendment to implement mandatory managed care for the adult aged, blind and disabled population in Cook County and the surrounding boarder counties.

--Effective Date: May 1, 2011

If you have any questions, please have a member of your staff contact Michelle Baldi at (312) 353-0909 or by email at Michelle.Baldi@cms.hhs.gov

Sincerely,

[redacted]

Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTER FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **11-07**

2. STATE: **ILLINOIS**

3. PROGRAM IDENTIFICATION: **Title XIX of the Social Security Act (Medicaid)**

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **May 1, 2011**

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

[ ] NEW STATE PLAN [ ] AMENDMENT TO BE CONSIDERED AS NEW PLAN [X] AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1932(a) *Social Security Act*

7. FEDERAL BUDGET IMPACT
a. FFY **2011— ($1.4) million**
b. FFY **2012— ($9.2) million**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F pages ~~1-15~~ 16-29 per State request

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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

10. SUBJECT OF AMENDMENT:
Integrated Care Program - Mandatory Managed Care for the AABD Population.

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
[X] OTHER, AS SPECIFIED: Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: **Julie Hamos**

14. TITLE: **Director of Healthcare and Family Services**

15. DATE SUBMITTED: 6-30-11

16. RETURN TO:
Department of Healthcare and Family Services
Bureau of Program and Reimbursement Analysis
Attn: Greg Wilson, Chief
201 South Grand Avenue East
Springfield, IL 62763-0001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JUN 30 2011

18. DATE APPROVED: FEB 10 2012

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
MAY - 1 2011

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME
Verlon Johnson

22. TITLE:
Associate Regional Administrator

23. REMARKS:

FORM CMS-179 (07/92)

Instructions on Back

Citation	Condition or Requirement

1932(a)(1)(A)

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

The State of Illinois enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) through the Integrated Care program, which, unlike the PPCM program, is a full-risk capitated program, 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

_X__ 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;
_X__ii. capitation;
____iii. a case management fee;
_X__iv. a bonus/incentive payment;
____v. a supplemental payment, or
____vi. other. (Please provide a description below).

Contractors may earn payments based on performance for specified quality metrics. To fund the incentive pool, each month the Department shall withhold a portion of the contractual Capitation rate. The withheld amount will be one percent (1%) in the first measurement year, one and a half percent (1.5%) in the second measurement year and two percent (2%) in the third measurement year.

Citation	Condition or Requirement

Subsequent withheld amounts will be negotiated. The withheld amount will be combined with an additional bonus amount funded by the Department so that total funding of the incentive pool shall be equal to five percent (5%) of the Capitation rate. An equal portion of the incentive pool will be allocated to each P4P Metric. If Contractor reaches the target goal on a P4P Metric, Contractor will earn the percentage of the incentive pool assigned to that P4P Metric. Withholds of Contractor's Capitation payment will begin with the January 15, 2012. For purposes of measuring P4P Metrics, calendar year 2010 will be considered the initial baseline year and calendar year 2012 will be considered the initial measurement year. All measurement years will be calendar years. In subsequent measurement years, the previous year's performance will be the baseline for that measurement year unless the previous year's performance was below the initial baseline, in which case the initial baseline remains the baseline. The P4P metrics for the first three years are specified in the contracts with the MCOs. They include metrics such as preventive visits, behavioral health supports, dental utilization, disease specific therapies, ambulatory care follow-up, medication management, and community retention. P4P metrics, baselines and goals for future years will be negotiated.

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.

Citation	Condition or Requirement

_____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 researched various integrated care models through literature and reaching out to other state Medicaid programs. The state held many meetings with clients, client advocates and providers to assist with the development of the program, development of the RFP to solicit the contractors, and to guide the implementation of the program. Invitees and attendees included representatives from:

- other state agencies, such as the Division of Mental Health, Division of Developmental Disabilities and the Department on Aging;
- provider associations, such as the Illinois Hospital Association, Illinois Association of Rehabilitation Facilities, IL Occupational Therapy Association, Illinois Homecare Council, Illinois Primary Health Care Association;
- individual providers;
- client advocates, such as Centers for Independent Living, IARF, Area Agencies on Aging, IL Council on Developmental Disabilities, AIDS Foundation of Chicago, The ARC of Illinois, The Hope Institute for Children and Families, Equip for Equality, Campaign for Real Choice in Illinois, Center for Developmental Disabilities Advocacy and Community Supports, National Alliance on Mental Illness-IL, AARP;
- local health departments;
- private companies, such as pharmaceutical companies;
- American Indian Health Services of Chicago and
- members of the Illinois General Assembly.
- The State will continue to have meetings with representatives from the above listed entities throughout implementation and on an on-going basis. These meetings will be through ad-hoc requests and regularly scheduled stakeholders meetings.

Citation	Condition or Requirement

- The State's tribal consultation process included contacting the American Indian Health Services of Chicago (AIHSC) on April 6, 2011, to notify them of the State's intention to submit this SPA. A copy of the State's administrative rule was provided, and a meeting was set up on April 7, 2011, to discuss the consultation process, including this proposed amendment. On May 13, 2011, a draft copy of this SPA was provided to the AIHSC for review and comment.

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__X__/ voluntary_____ enrollment will be implemented in the following county/area(s):

   i. county/counties (mandatory) Du Page, Kane, Kankakee, Lake, Will and Suburban Cook (with the exception of the city of Chicago as defined as areas with zip codes that begin with "606") effective May 1, 2011.

   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. _X_ 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. _N/A_ 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)

3. _X_ The state assures that all the applicable requirements of section 1932

Citation	Condition or Requirement
42 CFR 438.50(c)(3)	(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. **X** 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. **X** 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. **X** 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) for 42 CFR 447.362 42 CFR 438.50(c)(6)	7. **N/A** The state assures that all applicable requirements of 42 CFR 447.362 payments under any nonrisk contracts will be met.
45 CFR 74.40	8. **X** 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. The following individuals residing in the counties listed in subsection B.5.i.: - Persons age 19 and older who are aged, blind or disabled and meet more restrictive eligibility criteria than those under SSI and as described in 42 CFR sections 435.121, 435.122, 435.130, 435.133, 435.134. - Certain institutionalized individuals who were eligible in December 1973 as described in 42 CFR 435.131. - Persons age 19 or older who would be eligible if institutionalized except they receive home and community based services under a waiver as described in 42 CFR 435.217. - Qualified Severely Impaired Blind and Disabled Individuals older than age 19 and under age 65 as described in 1902(a)(10)(A)(i)(II) and 1905(q) of the Social Security Act. - Disabled widows and widowers as described in section 1634 of the Act.

Citation	Condition or Requirement

- Persons age 19 and older who qualify for the AABD expansion as described in 42 CFR sections 435.320, 435.322 and 435.324.
- Persons age 19 and older who qualify for Health Benefits for Workers with Disabilities under the Ticket to Work-Work Improvement Act (TWWIIA) as described in 1902(a)(10)(A)(II).

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. __X__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)
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)

vii. ____Children under the age of 19 years who are receiving services through a

Citation	Condition or Requirement
42 CFR 438.50(3)(v)	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.)*
Children identified as either receiving services from, or participating in, a particular program will be identified through the use of paid claims data.

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:

_X_ 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.

_X_ 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;
Recipient database and self-identification.

ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;
Recipient database and self-identification.

iii. Children under 19 years of age who are in foster care or other out-of-home placement;
Recipient database and self-identification.

iv. Children under 19 years of age who are receiving foster care or adoption assistance.

Citation	Condition or Requirement
	Recipient 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)* Not applicable
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. Recipient database and self-identification. 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. Recipient database and self-identification.
42 CFR 438.50	F. <u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u> - Children under 19 years of age; - Individuals eligible for Medicare Part A or enrolled in Medicare Part B; and - Participants with spend-down; and - Participants who are presumptively eligible; and - Participants in the Illinois Breast and Cervical Cancer program; and - Participants with comprehensive third party insurance; - Participants eligible through Illinois Healthy Women; and - Participants eligible through Asylees and Torture Victims.
42 CFR 438.50	G. <u>List all other eligible groups who will be permitted to enroll on a voluntary basis</u> 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

Citation	Condition or Requirement

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.

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:

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

Existing provider-recipient relationships will be considered based on historical claims data and requests by the recipient.

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

The Integrated Care Program contractors have targeted all Medicaid enrolled providers to join their plans, with specific emphasis on enrollment of primary care providers enrolled in the Department's Primary Care Case Management program, in which most of the beneficiaries are participating.

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.)*

Citation	Condition or Requirement

A Potential Enrollee who does not select an MCO will be auto-assigned to an MCO by the ICEB. During the first twelve (12) month period of the contract, the auto-assignment will equalize enrollment in the participating MCOs so that each MCO has approximately the same number of enrollees. The ICEB will equalize the auto-assignment by distributing the enrollment of those that do not make an active choice between the two plans, taking into considerations existing provider patient relationships, provider capacity and geographical access. During the second year, auto-assignment will occur systematically and randomly by algorithm with the same considerations, but each MCO will receive approximately fifty percent (50%) of all auto-assignments, as capacity allows. During the second year there will not be an effort to equalize enrollment between the plans. The Department will re-evaluate and modify, as necessary, the auto-assignment algorithm and may provide that auto-assignment will also be based on Contractor's performance on quality measures. The Department shall provide written notice of any modification of the auto-assignment algorithm at least sixty (60) days before the implementation of the modification.

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 **X** / 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 60 days.

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

During the enrollment process, potential enrollees will be sent an initial enrollment packet, reminder letters and a second enrollment letter. The second enrollment letter will specify the provider to whom the potential enrollee will be assigned if no choice is made. If no choice is made and a client is enrolled through auto-assignment, within five days after enrollment the MCO will send a welcome packet to the enrollee that includes all basic information, including a summary of important topics, such as how to get needed care, a benefits summary, and information about the complaint, grievance and appeal processes

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the

Citation	Condition or Requirement

first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

During the enrollment process, potential enrollees will receive an information guide from the Illinois Client Enrollment Broker. This information guide will provide information regarding disenrollment rights, including without cause during the first 90 days of enrollment.

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 algorithm will take into consideration:

- Current assignment to a PCP in the Primary Care Case Management Program
- Existing provider-client relationship based on claims data.
- The geographic location of the client and PCP.
- Special needs of the client, if known.
- Capacity limits set by HFS or the provider.
- Provider panel status.

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)*

On a weekly basis, the Illinois Client Enrollment Broker will report to the Department Potential Enrollees who have voluntarily chosen a health care delivery system and PCP, Potential Enrollees who are enrolled by auto-assignment, and Enrollees who request to change from one HMO to another HMO during enrollment change periods. Summary reports of such information will be provided by the Illinois Client Enrollment Broker to the Department on a monthly basis, and the Department will produce ad-hoc reports as necessary.

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.

Citation	Condition or Requirement

1. _X_ 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. _X_ 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. _N/A_ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   _X_ This provision is not applicable to this 1932 State Plan Amendment.

4. _N/A_ 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.)

   _X_ This provision is not applicable to this 1932 State Plan Amendment.

5. _X_ 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 _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.

   _X_ 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).

Citation	Condition or Requirement
	An Enrollee may request, orally or in writing, to disenroll from Contractor at any time for any of the following reasons: (i) the Enrollee moves out of the Contracting Area; (ii) Contractor, due to its exercise of Right of Conscience, does not provide the Covered Service that the Enrollee seeks; (iii) the Enrollee needs related Covered Services to be performed at the same time, not all of the related services are available through Contractor, and the Enrollee's PCP or other Provider determines that receiving the services separately would subject the Enrollee to unnecessary risk; or (iv) other reasons, including, but not limited to, poor quality of care, lack of access to Covered Services, lack of access to Providers experienced in dealing with the Enrollee's health care needs, or, if automatically re-enrolled and such loss of coverage causes the Enrollee to miss the Open Enrollment period.
	K. Information requirements for beneficiaries Place a check mark to affirm state compliance.
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	X 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) The covered services in the Integrated Care Program are being phased in through three service packages. Service package I will include all non-long term care services, including pharmacy, alcohol and substance abuse services and all medical services for nursing facility residents and all HCBS waiver participants. Service package II will include all nursing facility services and HCBS waiver services except those designed for individuals with developmental disabilities. Service package III will include the HCBS waiver services for individuals with developmental disabilities and ICF/DD services. The only excluded services in all three service packages are services provided in a State operated psychiatric hospital as a result of a forensic commitment and services provided through local education agencies.
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.

Citation	Condition or Requirement

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

2. __X__ 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.)*

   Through its research the State determined that the correct number of MCOs to make the program sustainable with the limited number of potential enrollees was two.

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