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**State/Territory Name: MN**

**State Plan Amendment (SPA) #:11-029**

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

MAR 26 2012

David Godfrey, State Medicaid Director
Minnesota Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

Dear Mr. Godfrey:

Enclosed for your records is an approved copy of the following State Plan Amendment:

Transmittal #11-029 - Procurement process for managed care contracts
--Effective Date: January 1, 2012

During its review CMS determined that the State is using an obsolete version of Attachment 3.1-F. The State has indicated to CMS that it will update to the reauthorized 2011 version of Attachment 3.1-F, a copy of which is included with this letter.

If you have any additional questions, please have a member of your staff contact Courtenay Savage at (312) 353-3721 or by e-mail at Courtenay.Savage@cms.hhs.gov.

Sincerely,

[redacted]

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

cc: Lisa Knazan

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: 11-29

2. STATE: Minnesota

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
January 1, 2012

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 of Title XIX

7. FEDERAL BUDGET IMPACT:
a. FFY '12: ($93,681)
b. FFY '13: ($99,507)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Preprint p. 71
Att. 3.1-F, pp. 4, 9

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Same

10. SUBJECT OF AMENDMENT:
Managed care

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:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Ann Berg

14. TITLE:
Deputy Medicaid Director

15. DATE SUBMITTED:
December 27, 2011

16. RETURN TO:

Lisa Knazan
Minnesota Department of Human Services
Federal Relations Unit
P.O. Box 64983
St. Paul, MN 55164-0983

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:
12-27-11

18. DATE APPROVED:
March 26, 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2012

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Alan Freund

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

Revision: HCFA-AT-84-2 (BERC)
01-84

OMB No. 0938-0193

State MINNESOTA

Citation

4.23 Use of Contracts

42 CFR Part 434.4
48 FR 54013

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

____ Not applicable. The State has no such contracts.

42 CFR Part 438

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Risk contracts are procured through an open procurement process that is consistent with 45 CFR Part 92. The State does not use a competitive bid process, but contracts with any willing and qualified provider that meets the State's contract standards for managed care organizations, with the following exception. The state uses a competitive bid process in the Twin Cities' seven county metropolitan area for contracts affecting families and children and recipients described in Attachment 3.1-F, at D.1. The risk contract is with:

x a managed care organization that meets the definition of §1903(m) of the Act and 42 CFR §438.2

__ a prepaid inpatient health plan that meets the definition of 42 CFR §438.2

__ a prepaid ambulatory health plan that meets the definition of 42 CFR §438.2

__ not applicable.

State: MINNESOTA

| Citation | Condition or Requirement |
|---|---|
| | D. Eligible Groups |
| §1932(a)(1)(A)(i) | 1. List all eligible groups that will be enrolled on a mandatory basis.<br>i. parents, caretakers and children under §1931 and transitional assistance, and in other AFDC-related categorically needy groups<br>ii. categorically needy pregnant women and infants<br>iii. infants in the State Children's Health Insurance Program Medicaid expansion<br>iv. categorically needy children under age 21 in AFDC-related groups<br>v. adults without children described in Attachment 2.2-A, Page 9b3.<br>vi. adults without children eligible for coverage under the authority of the Minnesota Prepaid Medical Assistance Project Plus (PMAP+) section 1115 waiver, No. 11-W-0039/5. |
| | 2. Mandatory exempt groups identified in §1932(a)(2) and 42 CFR §438.50.<br><br>Use a check mark to affirm if there is voluntary enrollment for any of the following mandatory exempt groups. |
| §1932(a)(2)(B)<br>42 CFR §438.50(d)(1) | i. _x_ Recipients who are also eligible for Medicare. *Note: Applicable to individuals blind or disabled under age 65 whose basis of Medicaid eligibility is something other than a disability.*<br><br>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)<br>42 CFR §438.50(d)(2) | ii. ___ American 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 health 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)<br>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)<br>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)<br>42 CFR §438.50(d)(3)(iii) | v. ___ Children under the age of 19 years who are in state-subsidized foster care or other out-of-the-home placement. |
| §1932(a)(2)(A)(iv)<br>42 CFR §438.50(d)(3)(iv) | vi. _x_ Children under the age of 19 years who are receiving foster care or adoption assistance under Title IV-E. *Note: Applicable only to children receiving adoption assistance under Title IV-E.* |

State: MINNESOTA

| Citation | Condition or Requirement |
|---|---|
| §1932(a)(4)<br>42 CFR §438.50(f) | 2. State process for enrollment by default.<br>Describe how the state's default enrollment process will preserve:<br>i. the existing provider-recipient relationship (as defined in H.1.i.).<br><br>If it is a new enrollee, the Department determines whether an associated household member has an existing provider-recipient relationship. If there is a relationship, the new enrollee is enrolled in the same MCO.<br><br>When applying, an enrollee is asked to select a MCO and a provider.<br><br>ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.1.ii).<br><br>See 2. i, above.<br>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)*<br><br>For all but certain contracts in the Twin Cities' seven county metropolitan area, ~~t~~There is default assignment enrollment on a rotating basis between MCOs, assigned by the MMIS system, when all of the following are met:<br>· eligibility is open<br>· recipient resides in a managed care county<br>· recipient is not currently enrolled in a MCO<br>· recipient is not in a §1932(a)(2) excluded group<br><br>The system determines a default MCO plan by searching to find if any associated household member is enrolled in managed care. Next, it determines whether that MCO is available for enrollment in the recipient's county of residence.<br><br>If no associated household member is enrolled in managed care, or an associated household member is active but the MCO of that household member is not available for enrollment in the county of residence, then selection of a default MCO is determined on a rotating basis using all MCOs available for enrollment in the recipient's county of residence.<br><br>For the seven county Twin Cities' metropolitan area, the state will direct the default assignment to a single MCO for each county, and will adjust the default plan as necessary to manage capacity. |
| §1932(a)(4)(A), (D) 3.<br>42 CFR §438.50(f)<br>42 CFR §438.56(c) | As part of the state's discussion on the default enrollment process, include the following information:<br><br>i. The state will x /will not ___ use a lock-in for managed care. |

State:

| Citation | Condition or Requirement |
|---|---|

1932(a)(1)(A)

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

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 ***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).

| Citation | | Condition or Requirement |
|---|---|---|
| 1905(t)<br>42 CFR 440.168<br>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.<br><br>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)).<br><br>____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.<br><br>____ii. Incentives will be based upon specific activities and targets.<br><br>____iii. Incentives will be based upon a fixed period of time.<br><br>____iv. Incentives will not be renewed automatically.<br><br>____v. Incentives will be made available to both public and private PCCMs.<br><br>____vi. Incentives will not be conditioned on intergovernmental transfer agreements.<br><br>____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): |

| Citation | Condition or Requirement |
|---|---|

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.

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.

| Citation | Condition or Requirement |
|---|---|
| 1932(a)(1)(A)<br>42 CFR 447.362<br>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. |
| | 2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.<br><br>Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups. |
| 1932(a)(2)(B)<br>42 CFR 438(d)(1) | i. ____Recipients who are also eligible for Medicare.<br><br>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)<br>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. |

| Citation | Condition or Requirement |
|---|---|
| 1932(a)(2)(A)(i)<br>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)<br>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)<br>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)<br>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)<br>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. <u>Identification of Mandatory Exempt Groups</u> |
| 1932(a)(2)<br>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)<br>42 CFR 438.50(d) | 2. Place a check mark to affirm if the state's definition of title V children is determined by:<br>____i. program participation,<br>____ii. special health care needs, or<br>____iii. both |
| 1932(a)(2)<br>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.<br>____i. yes<br>____ii. no |

| Citation | Condition or Requirement |
|---|---|
| 1932(a)(2)<br>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)*<br>i. Children under 19 years of age who are eligible for SSI under title XVI;<br>ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;<br>iii. Children under 19 years of age who are in foster care or other out-of-home placement;<br>iv. Children under 19 years of age who are receiving foster care or adoption assistance. |
| 1932(a)(2)<br>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)<br>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)*<br>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

42 CFR 438.50

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

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)<br>42 CFR 438.50 | 2. State process for enrollment by default.<br>Describe how the state's default enrollment process will preserve:<br>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.)* |
| 1932(a)(4)<br>42 CFR 438.50 | 3. As part of the state's discussion on the default enrollment process, include the following information:<br>i. The state will____/will not____ use a lock-in for managed care managed care. |

| Citation | Condition or Requirement |
|---|---|
| | ii. The time frame for recipients to choose a health plan before being auto-assigned will be_____. |
| | iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)* |
| | iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)* |
| | v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)* |
| | vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)* |

| 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 ____ 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). |
| | K. Information requirements for beneficiaries |
| | Place a check mark to affirm state compliance. |
| 1932(a)(5)<br>42 CFR 438.50<br>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)<br>1905(t) | L. List all services that are excluded for each model (MCO & PCCM) |
| 1932 (a)(1)(A)(ii) | M. Selective contracting under a 1932 state plan option |
| | To respond to items #1 and #2, place a check mark. The third item requires a brief narrative. |
| | 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. |

| Citation | Condition or Requirement |
|---|---|

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.