Citation	Condition or Requirement

1932(a)(1)(A)

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

The State of Alabama 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
__X__ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

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

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

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

Citation	Condition or Requirement

a. Primary Care Case Management

Payments to Physicians:

Providers participating in the Primary Care Case Management program are reimbursed up to $2.60 per member per month in geographic regions of the State not operating under the Health Home authority. This rate is calculated as follows:

1. A variable rate based on the illness burden of each physician/practice's panel of patients as refleted on the Patient 1st Profiler report. Low risk patients which are those identified to have an acuity level of .9 or less are reimbursed $1.00 per member per month and high risk patients or those that are identified to have an acuity level of greater than .9 are reimbursed $1.60 per member per month.

2. For providing voice-to-voice access to medical advice and care for enrolled recipients 24 hours a day, seven days a week the provider is reimbursed $1.00 per member per month.

Providers participating in the Primary Care Case management program are reimbursed as follows in geographic regions of the State operating under the Health Home authority:

1. $.50 per member per month

2. An additional $8.00 per member per month is reimbursed for those patients identified as having a chronic health condition in accordance with approved State Plan page 3.1-H.

b. Payments for Care Management:

Providers of care management participating in the Primary Care Case Management program in geographic locations of the State not operating under the Health Home authority are reimbursed upon state-developed fee schedule rates which are the same for both governmental and private providers of case management and care coordination. Governmental providers are settled to cost annually.

Citation	Condition or Requirement

Providers of care management services for those patients identified as having a chronic health condition as per the approved State Plan page 3.1-H and who are in geographic locations that are designated as patient care networks are reimbursed $9.50 per qualified member per month.

Alabama operates a statewide PCCM managed care program for the state's Medicaid citizens. The Patient 1st Program began January 1, 1997 under the authority of a 1915(b) waiver and was operational until February 29, 2004. The State chose not to pursue renewal of the program at that time due to administrative and budgetary constraints. By February 2005, the Patient 1st Program was re-implemented statewide. The overarching goal of Patient 1st is to provide Alabama Medicaid recipients a medical home.

Within the Patient 1st Program, patients are assigned to a primary medical provider (PMP). The PMP is responsible for providing directly or through referral, necessary medical care. PMPs are paid a case management fee for each recipient and enhanced case management fees are paid for individual in certain categories. Alabama Medicaid provides feedback to providers in through a variety of reports.

Through Patient 1st, providers have access to resources that can enhance their case management. Recipients who qualify for Health Home for Individuals with Chronic Conditions can utilize care management services from the Patient Care Network, Community Mental Health Centers, Substance Abuse Providers and others.

All Patient 1st recipients can receive traditional case management for the PCCM program provided through a contract with the Alabama Department of Public Health (ADPH) or the Alabama Department of Human Resources (ADHR). ADPH and ADHR have licensed and trained case managers available throughout the State. Services provided are traditional case management services and include; assistance with understanding program requirements, help with transportation needs, assessment of the home environment and factors that may prevent the patient from being compliant with medical care protocols; mental health issues, child health issues such as understanding the need for preventive care, i.e. immunizations, etc.

Each patient that is referred into the case management system receives a risk assessment. Areas assessed include social supports, community supports, shelter/ nutrition/ communication resources, economic status, education/ language needs, physical health, mental health, parenting history and children's issues. From the risk assessment, a plan of action is developed in conjunction with the patient. Follow-up

Citation	Condition or Requirement

from the assessment and/or plan of action is provided back to the person making the referral into the system. ADPH and ADHR are paid through fee for service.

The State also has the ability to make direct referrals into the ADPH case management system for issues such as excessive emergency room use, patient dismissal, provider utilization, and patient education. In that State staff has contact with the patient, oftentimes issues are identified that may be preventing the patient from optimizing their medical home. Common reasons include lack of program understanding, transportation needs, and medical compliance.

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

   If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

   __X__ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

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

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

   __X__ iv. Incentives will not be renewed automatically.

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

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

   ____ vii. Not applicable to this 1932 state plan amendment.

CFR 438.50(b)(4)

4. Describe the public process utilized for both the design of the program and its

Citation	Condition or Requirement

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.)*

A Patient 1st Advisory Council was established during the design and implementation of the program in 1997. The Council is comprised of Medical Directors from the Patient Care Networks who are PMPs and represent the PMPs in their region. Federal Qualified Health Centers and Rural Health Clinics also have representation on the Council. The purpose of the Patient 1st Advisory Council is to address concerns presented by providers, recipients, and interested stakeholders in relation to Patient. Meetings are held regularly to go over issues and to obtain input for any changes to policy, including the components of the care management fee.

Recipients are also able to submit a concern about the program through a written complaint process.

AMA meets regularly with PCNA representatives including Medical Directors, Pharmacist, and Executive Directors. These staff represents the providers in their geographic regions and serves as a conduit between the agency and providers. These meetings will serve as the Patient 1st Advisory Council meetings.

AMA will meet annually with recipients and Medicaid eligibility staff to get feedback on the program operations.

AMA also meets regularly with provider organizations and Physician Task Force to seek input surrounding program changes.

The Alabama Medical Care Advisory Committee reviews all major program changes for the Medicaid program. Recipient advocates serve on this Committee.

1932(a)(1)(A)

5. The state plan program will _X_ /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. __X__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. __X__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. __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)

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

42 CFR 438.50(c)(6)

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.

Section 1931 Children and Related Populations
Blind/Disabled Adults and Related Populations
Blind/Disabled Children and Related Populations
Aged and Related Populations

There may be individuals, decided on a case-by-case basis, which would not benefit from the program. For Patient 1st, these individuals typically have complex medical conditions that are being coordinated by a specialty care provider. Currently there are approximately 413exemptions approved for medical reasons. Additionally, there may be foster children or eligibles living in an institutional setting that might be exempted. Before any individual is exempted from participation, the provider serving that individual is given the opportunity to participate as a PMP for that patient.

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. __X__ Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment.

Citation	Condition or Requirement
	(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.) Dual Eligible recipients may voluntarily enroll in Patient 1st. Recipients who voluntarily enroll may dis-enroll at any point. Voluntary enrollment is completed through a recommendation of a provider or through direct application of the recipient.
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. __X__ 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. __X__ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) CFR 438.50(3)(iii)	v. __X__ Children under the age of 19 years who are in foster care or other out-42 of- the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. __X__ 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. __X__ 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. The State assures that these recipients will be permitted to disenroll from the PCCM program on a month to month basis.

Citation	Condition or Requirement

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.)*

The Children's Rehabilitation Service (CRS), a division of the Alabama Department of Rehabilitative Service, is a statewide organization of skilled professionals providing quality medical, rehabilitative, coordination, and support services for children with special health care needs and their families. Each of Alabama's 67 counties is served through a network of 15 community-based offices. Any child or adolescent younger than 21 years of age who is a resident of Alabama and has a special health care need is eligible for CRS. In Alabama, the Title V Maternal and Child Health Program is administer by the Alabama Department of Public health. This agency contracts with CRS to administer services to children and youth with special health care needs, making CRS Alabama's Title V Children with Special Health Care Needs Program. There is no automated way to identify these clients. There is a procedure for representatives for these individuals to notify the Patient 1st Program of the need for exemption. It is recognized that these individuals typically have complex medical conditions that are being coordinated by a specialty care provider.

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
__X__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

Citation	Condition or Requirement
	____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; Self identification is used to exempt these clients. ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; Self identification is used to exempt these clients. iii. Children under 19 years of age who are in foster care or other out-of-home placement; Eligibility database and coordination with Alabama Department of Human Resources iv. Children under 19 years of age who are receiving foster care or adoption assistance. Eligibility database and coordination with Alabama Department of Human Resources
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)* The Patient 1st Program is based on the premise that patient care is best served by a medical home where a Primary Medical Provider (PMP) may coordinate care. If

Citation	Condition or Requirement

in the physician's opinion, the patient does not benefit from the Patient 1st Program, an exemption can be requested.

Either the PMP or the attending physician can submit this request on behalf of the patient. These are classified as medical on the number of exemptions.

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.

Aid Codes in eligibility system

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.

The State coordinates with the Poarch Creek Indian Health Department to be sure any tribal members who are assigned to other Patient 1st providers are aware they can elect to receive services from the tribal clinic or be exempted. An opportunity is offered for recommendations, comments, and assistance whenever possible to meet specialized individual and community needs.

42 CFR 438.50

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

NA

Citation	Condition or Requirement

42 CFR 438.50

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

NA

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).

Prior to automatic assignments, recipients are encouraged and provided the opportunity to select a PMP. If no PMP is selected the Agency automatically assigns enrollees to PMPs based on proximity and the following algorithm: newborn, sibling, past PMP, historical claims and random. Recipients who are added to the Medicaid eligibility file are notified of their Patient 1st assignment approximately within 5 days of assignment.. The assignment begins the first day of the month following the assignment. During the first month of the initial Patient 1st assignment recipients are encouraged to utilize the PMP for any needed care. During this month the recipient can utilize any other provider without a referral in order to allow the recipient ample time to

Citation	Condition or Requirement

change the PMP selection. PMP change request allow recipients to utilize the new PMP beginning on the day the change is requested. Beginning the PMP assignments the first day of the month following assignment allows the recipient to begin the relationship with the health home sooner while allowing care without referrals during the first month of the initial assignment allows the recipient time to change the PMP assignment. A listing of all providers serving that patient's county is included in the enrollment packet and is maintained on the Agency's website. Providers are also notified on a monthly basis of all patients on their panel including information on those who have been disenrolled. The assignment process takes into account the group practices and/or clinic affiliation.

The State regularly reviews assignments to ensure that the assignment process is working correctly. The assignment reason is compared to the information on file to ensure that the most appropriate assignment algorithm was applied.

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

Providers with a history of serving Patient 1st recipients can request an increase of 25% above these limits. Any expansion above 125% of these limits must be approved by the AMA Medical Director after a review of panel management, recipient outcomes, and area need.

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
	Each PCCM FTE (defined as 32 hours per week on-site) is allowed 1200 patients. Up to 2 physician extenders (e.g. nurse practitioner) can be used to extend the caseload by 400 each. Clinic provider caseloads are determined by the total number of FTE physicians and physician extenders. Providers who have historically seen a higher caseload of Medicaid patients may be authorized a caseload greater than allowed by this formula.
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 managed care.
	ii. The time frame for recipients to choose a health plan before being auto-assigned will be 30 days.
	iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)* The Agency automatically assigns enrollees to PMPs based on proximity and the following algorithm: newborn, sibling, past PMP, historical claims and random. Recipients who are added to the Medicaid eligibility file are notified of their Patient 1st assignment by written 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.)* The State assures that recipients will be permitted to disenroll from a managed care provider on a month to month basis. Enrollees are educated about the Patient 1st Program at the time of Medicaid eligibility determination as well as through the enrollment packet.

Citation	Condition or Requirement
	Recipients can disenroll without cause at any time up to three times during a calendar year. If a recipient disenrolls from a PMP more than three times in a given calendar year the recipient may be reviewed for possible lock in to a single provider without the ability to disenroll without cause for 12 months. Recipients can notifiy the Agency by phone, letter or through the use of a web site. Additionally, recipients often select a new PMP and have that provider notify the agency of the change. These changes are effective the month following notification if received prior to the 15th of the month and the new provider can begin care of the recipient immediately following submission of the PMP Change Form.
	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 Agency automatically assigns enrollees to PMPs based on proximity and the following algorithm: newborn, sibling, past PMP, historical claims and random.
	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 regularly reviews assignments to ensure that the assignment process is working correctly. The assignment reason is compared to the information on file to ensure that the most appropriate assignment algorithm was applied and is working properly. The State also tracks the reasons for PMP changes on a monthly basis through the MMIS to identify problems with assignments.
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. __X__ 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.)

   __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 up to 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

Recipients may be considered for lock-in to a specific PMP without the ability to disenroll without cause for the following reasons:

More than three request for PMP changes within a calendar year
Behavior indicating drug seeking behavior

Recipients who are locked-in to a provider will be notified in writing and will be reviewed on a quarterly basis. Lock-in status will not apply for greater than 12 months.

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 following PCCM exempt services do not require PCP authorization:

- Independent Labs & Hospital Labs
- Mental Health Services
- Physicians: Anesthesiologists, Oral Surgeons, Pathologists, Radiologists/Diagnostic, Nuclear Medicine
- Pregnancy-Related Services
- Independent Radiologists & Hospital Radiologists
- Targeted Case Management
- Ambulance
- Certified Emergency
- Dental
- Dialysis
- EEG/EKG Related Services
- End Stage Renal Disease
- EPSDT Development Diagnostic Assessment
- Routine Eye Exams
- Eyeglass & Other Lens Fittings
- Family Planning

Citation	Condition or Requirement

- Diabetic Supplies
- Gynecology/Obstetrics Services
- Hearing Aids
- Hospice
- Immunizations
- Physician Inpatient Consults/Visits
- Inpatient Hospital Services (per diem)
- Cancer treatments including Chemotherapy and Radiation

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 __X__ intentionally limit the number of entities it contracts under a 1932 state plan option.

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

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

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

CMS-10120 (exp. 3/31/2014)