DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

JAN 3 1 2011

Susan Dreyfus, Secretary
Department of Social and Health Services
Post Office Box 45010
Olympia, Washington 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number 09-011

Dear Ms. Dreyfus:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional office has completed its review of Washington State Plan Amendment (SPA) Transmittal Number 09-011. This amendment offers a chronic care management program to eligible Medicaid clients residing in King County.

The SPA is approved effective January 3, 2011. CMS could not approve the SPA retroactive to January 1, 2009, as originally requested. The State was non-compliant with Benchmark Plan regulations, until it modified the SPA document on January 3, 2011. In accordance with 42 CFR 440.320, the revised SPA eliminates the auto-enrollment process.

If you have any additional questions or require any further assistance, please contact me, or have your staff contact Gilson DaSilva, at (206) 615-2065 or gilson.dasilva@cms.hhs.gov.

Sincerely,

Barbara K. Richards
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc:
Douglas Porter, Administrator, State Medicaid Director
Ann Myers, State Plan Coordinator

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: **09-011**

2. STATE: Washington

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
~~Jan. 1, 2009~~ January 3, 2011 (P+I)

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:

7. FEDERAL BUDGET IMPACT:
a. FFY ~~2009 $0~~ 2011 $255,000 (P+I)
b. FFY ~~2010 $0~~ 2012 $340,000 (P+I)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-C, pages 2 through ~~14~~ 15 (P+I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-C, pages 2 through 10

10. SUBJECT OF AMENDMENT:
Chronic Care Management

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: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Stan Marshburn

14. TITLE:
Interim Secretary

15. DATE SUBMITTED:

16. RETURN TO:
Ann Myers
Department of Social and Health Services
Health and Recovery Services Administration
626 8th Ave SE MS: 45504
Olympia, WA 98504-5504

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: MAR 2 6 2009

18. DATE APPROVED: JAN 3 1 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 0 3 2011

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Barbara K. Richards

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

23. REMARKS:

Pen and ink changes authorized by the State on 11/10/2010.
Pen and ink changes authorized by the State on 1/27/2011.
Pen and ink changes authorized by the State on 2/3/11.

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

ALTERNATIVE BENEFITS

BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE

3.1 Amount, Duration, and Scope of Services

Medicaid is provided in accordance with the requirements of sections 1902(a), 1902(e), 1902(z), 1903(i), 1905(a), 1905(p), 1905(r), 1905(s), 1906, 1915, 1916, 1920, 1925, 1929, and 1933 of the Act; section 245(h) of the Immigration and Nationality Act; and 42 CFR Parts 431, 440, 441, 442, and 483

C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State elects to provide alternative benefits:

X Provided

__ Not Provided

X Title of Alternative Benefit Plan A- *King County Care Partners Chronic Care Management and Medical Home Program*
_ Title of Alternative Benefit Plan B

1. Populations and geographic area covered

The State will provide the benefit package to the following populations:

a) __ Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, that may be required to enroll in an alternative benefit plan to obtain medical assistance.
(Note: Populations listed in section 1b. may not be required to enroll in a benchmark plan, even if they are part of an eligibility group included in 1a.)

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the state will require to enroll in the alternative benefit plan;
- Each eligibility group the state will allow to voluntarily enroll in the alternative benefit plan;
- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
		Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance		
		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
		Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group: •		
		Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)		
		Medicaid expansion/optional targeted low-income children eligible under 1902(a)(10)(A)(ii)(XIV)		
		Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: •		

b). X

The following populations will be given the option to voluntarily enroll in an alternative benefit plan.

Please indicate in the chart below:

- Each eligibility group the state will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included group (e.g., income standard).
- Specify the geographic area in which each group will be covered.

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State WASHINGTON

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	Mandatory categorically needy low-income parents eligible under 1931 of the Act		
	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):		
X	Individuals qualifying for Medicaid on the basis of blindness	*Categorically Needy - Aged, Blind and Disabled adults aged 21 and over, who reside in King County Washington and who have had an encounter in a clinic within the Contractor's FQHC network within the previous 15 months, and who have been determined at high risk of future high healthcare costs within the next 12 months.* *Eligible clients receive services via the fee-for-service system. These are high risk clients with complex medical needs and are diagnosed with one of the following chronic medical conditions, in addition to a mental health and/or chemical dependency issue:* *Diabetes, Heart failure, coronary artery disease, cerebrovascular disease, renal failure, chronic pain associated with musculoskeletal conditions and other chronic illness including migraine, cancer, chronic respiratory conditions including asthma and/or COPD, hematological conditions such as hemophilia, and including persons with comorbid mental health and/or chemical dependency conditions.*	*King County, Washington*

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State WASHINGTON

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
		The eligible population will exclude Clients: • *Under age 21;* • *Eligible for enrollment in the Department's Healthy Options managed care program;* • *Receiving hospice services;* • *Receiving case management services for HIV/AIDS;* • *Who have End Stage Renal Disease;* • *Who are Pregnant;* • *With Third Party Coverage that provides a comparable service;* • *Who become eligible for Medicare coverage; or* • *Clients enrolled in one of the following:* • *The Washington Medicaid Integration Partnership (WMIP); or* • *The Program of All Inclusive Care for the Elderly (PACE) program.*	
X	Individuals qualifying for Medicaid on the basis of disability	*Categorically Needy - Aged, Blind and Disabled adults aged 21 and over, who reside in King County Washington and who have had an encounter in a clinic within the Contractor's FQHC network within the previous 15 months, and who have been determined at high risk of future high healthcare costs within the next 12 months.* *Eligible clients receive services via the fee-for-service system. These are high risk clients with complex medical needs and are diagnosed with one of the following chronic medical conditions, in addition to a mental health and/or chemical dependency issue:*	*King County, Washington*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
		Diabetes, Heart failure, coronary artery disease, cerebrovascular disease, renal failure, chronic pain associated with musculoskeletal conditions and other chronic illness including migraine, cancer, chronic respiratory conditions including asthma and/or COPD, hematological conditions such as hemophilia, and including persons with comorbid mental health and/or chemical dependency conditions. *The eligible population will exclude clients:* • *Under age 21;* • *Eligible for enrollment in the Department's Healthy Options managed care program;* • *Receiving hospice services;* • *Receiving case management services for HIV/AIDS;* • *Who participated in the Contractor's previous chronic care management program;* • *Who have End Stage Renal Disease;* • *Who are pregnant;* • *With Third Party Coverage that provides a comparable service;* • *Who become eligible for Medicare coverage, or* • *Clients enrolled in one of the following:* • *The Washington Medicaid Integration Partnership (WMIP); or* • *The Program of All Inclusive Care for the Elderly (PACE) program.*	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(vii)		
	Institutionalized individuals assessed a patient contribution towards the cost of care		
	Individuals dually eligible for Medicare and Medicaid		
	Disabled children eligible under the TEFRA option - section 1902(e)(3)		
X	Medically frail and individuals with special medical needs	*Categorically Needy - Aged, Blind and Disabled adults aged 21 and over, who reside in King County Washington and have had an encounter in a clinic within the Contractor's FQHC network within the previous 15 months, and who have been determined at high risk of future high healthcare costs within the next 12 months.* *Eligible clients receive services via the fee-for-service system. These are high risk clients with complex medical needs and are diagnosed with one of the following chronic medical conditions, in addition to a mental health and/or chemical dependency issue:* *Diabetes, Heart failure, coronary artery disease, cerebrovascular disease, renal failure, chronic pain associated with musculoskeletal conditions and other chronic illness including migraine, cancer, chronic respiratory conditions including asthma and/or COPD, hematological conditions such as hemophilia, and including persons with comorbid mental health and/or chemical dependency conditions.*	*Reside in King County Washington*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
		The eligible population will exclude clients: • *Under age 21;* • *Eligible for enrollment in the Department's Healthy Options managed care program;* • *Receiving hospice services;* • *Receiving case management services for HIV/AIDS;* • *Who participated in the Contractor's previous chronic care management program;* • *Who have End Stage Renal Disease;* • *Who are pregnant;* • *With Third Party Coverage that provides a comparable service;* • *Who become eligible for Medicare coverage, or* • *Clients enrolled in one of the following:* • *The Washington Medicaid Integration Partnership (WMIP); or* • *The Program of All Inclusive Care for the Elderly (PACE) program.*	
	Children receiving foster care or adoption assistance under title IV-E of the Act		
	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)		
	Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)		
	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)		

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State WASHINGTON

Limited Services Individuals

	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

c) For optional populations/individuals (checked above in 1a. & 1b.), describe in the text box below the manner in which the State will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State plan.

Eligible clients are encouraged to participate in the program through mailings from the state and the Chronic Care Management (CCM) contractor, coordinated outreach by the CCM contractor and their community partners (including mental health agencies, agencies providing services to the homeless, chemical dependency programs and the Community Health Centers who participate in the project), and telephonic outreach by the CCM contractor. Clients who choose to participate in the program maintain eligibility for the regular Medicaid benefits at all times. The opt-in program provides chronic care management services to clients determined to be in the high-risk group described above.

Clients are told at the time they are contacted (and via correspondence if that is the method of contact) that they are not required to participate in the program to maintain Medicaid benefits, and that they may end their enrollment at any time. Clients are also told they may re-enroll at a later time, if they determine they would like to participate in the program.

The state monitors this requirement via review of letters and documents, as well as client records kept by the RN care managers.

2. Description of the Benefits

X The State will provide the following alternative benefit package (check the one that applies).

a) X Benchmark Benefits

_ **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

_ **State Employee Coverage** – A health benefits coverage plan that is offered and generally available to State employees within the State involved.

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In the text box below please provide either a World Wide Web URL (Uniform Resource Locator) link to the State's Employee Benefit Package or insert a copy of the entire State's Employee Benefit Package.

_ **Coverage Offered Through a Commercial Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State involved.

In the text box below please provide either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

X **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State plan or to services in any of the three Benchmark plans above.

In addition to all regular Medicaid program benefits, the alternative benefit package provides a chronic care management program for clients at high risk of poor outcomes and high healthcare costs. The state provides the Contractor with a monthly list of eligible clients, who are then contacted by the Contractor for possible enrollment. Clients may choose to enroll in the Chronic Care Management Program, but have the ability to decline participation in the program, or to disenroll from the program at any time. Eligible clients also have the ability to re-enroll in the program if they decide at a later date to participate in program services.

The Contracted entity: The City of Seattle, Aging and Disability Services division, provides chronic care management services. The Contractor utilizes a team-based approach to care management, assisting enrollees to gain access to clinical, psychiatric, chemical dependency, social services and pharmacy resources.

The Contractor provides chronic care management services to enrollees determined to be at high risk of poor health outcomes and high healthcare costs and are described below. All medical services are provided by nurse care managers who are employees of the Contractor. Outreach activities and coordination between healthcare systems such as mental health, chemical dependency and services such as housing, transportation and other services, may provided by Social Workers who are also employees of the Contractor and who work under the direction of the nurse care manager. The program also includes a care coordinator at the primary care clinics that participate in the program, to ensure a smooth transition from the more intensive chronic care management activities to a less intensive setting with a primary care provider.

Chronic care management services are provided to clients who are determined to be in the group at highest risk of poor health outcomes and include: nursing assessment, health education regarding specific conditions, medication education, education on appropriate use of health care resources, early recognition of changes in health condition, "translation" of primary care provider (PCP) treatment plan and linkage to the PCP office. Additionally, the program provides assistance to enrollees in locating a primary care provider and gaining access to mental health and/or chemical dependency services as described below:

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1. *Eligible clients are referred to the chronic care management program by the State, by case managers or providers in other settings (such as medical and mental health clinics, or care managers and social workers for other programs).*

2. *When an eligible client is referred to the chronic care management program, the contractor's outreach staff contacts the client to describe the program, obtain the client's consent to participate in the program and conduct the nonmedical portion of the initial assessment. These activities are conducted by Social Workers and/or Chemical Dependency Counselors, under the direction of the nurse care manager.*

3. *After the client is enrolled in the program, the nurse care manager completes the medical portion of the assessment to determine risk factors, health status, enrollee's self management skills, adherence to treatment plan, and knowledge of and adherence to prescribed medications.*

4. *Based on the assessment, the nurse care manager develops a care plan in coordination with the enrollee and if available, the enrollee's caregivers, family, and primary care provider. The plan is based on the client's specific needs in managing their health conditions, including language barriers, mental health and chemical dependency needs, multiple medications, housing status, and others. If necessary, the nurse assists the enrollee to connect with and learn to properly utilize primary care services.*

5. *The care plan is designed to help the enrollee develop the skills to:*
    a. *Self-manage his/her condition;*
    b. *Understand the appropriate use of resources needed to care for his/her condition(s);*
    c. *Identify "triggers" that negatively affect his/her health condition with the goal of seeking appropriate attention before he or she reaches crisis level;*
    d. *Utilize the healthcare system appropriately, making and keeping scheduled appointments with primary care or other providers;*
    e. *Develop the ability to address barriers to using the health care system;*
    f. *Manage multiple medications, adhere to the medication schedule, refilling and renewing prescriptions and*
    g. *Reach agreement with his or her medical provider on a treatment plan and adhere to that plan.*

6. *After the care plan has been developed and agreed to by the enrollee, the nurse care manager monitors the enrollee to ensure the enrollee understands the plan and is adhering to it and to provide instructions for care.*

7. *If the enrollee needs help in accessing services through the mental health, chemical dependency or social service systems, the Contractor's Social Worker provides assistance in coordinating with providers in the other system and ensuring that the enrollee understands the service. The Social Worker may also help the enrollee get transportation to the appointment through the Department's contracted transportation brokerage or through other means if the appointment is not for a Medicaid-covered service.*

8. *The frequency of contact between the nurse care manager and enrollees is determined by the enrollee's level of need. The contractors are required to meet with enrollees on a face-to-face basis if it is not possible to reach enrollees by telephone, or if the enrollee is unable to participate by telephone.*

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9. *When the enrollee and the nurse care manager determine that the enrollee is ready to transition from chronic care management services to less intensive setting with a primary care provider, the nurse care manager works with the enrollee, care coordination staff in the primary care clinic, and the enrollee's primary care provider to ensure a smooth transition.*

Freedom of Choice:

1. *The Chronic Care Management program provides assistance to enrollees in connecting with Primary Care services through one of the Federally Qualified Health Centers or participating primary care clinics if the enrollee does not already have a PCP. Enrollees may select the clinic where they will receive services, and providers who they see for primary care services. If an enrollee already has an established relationship with a primary care provider, he or she may maintain the relationship with the existing provider unless he or she wishes to change providers. If the enrollee requests a new provider, care management staff will assist the enrollee to change providers.*

2. *New enrollees are assigned a nurse care manager; however, if the enrollee wishes to change to another nurse care manager, the Contractor will work with the enrollee to make the change.*

Prepaid Ambulatory Health Plan:

For the purposes of this program, the Contractor is considered a Prepaid Ambulatory Health Plan and complies with all the required provisions of the Federal Regulation.

b) __ Benchmark-Equivalent Benefits.

Specify which benchmark plan or plans this benefit package is equivalent to:

(i) Inclusion of Required Services – The State assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

__ Inpatient and outpatient hospital services;

__ Physicians' surgical and medical services;

__ Laboratory and x-ray services;

__ Well-baby and well-child care services as defined by the State, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;

__ Other appropriate preventive services including emergency services and family planning services included under this section.

(ii) __ Additional services

Insert a full description of the benefits in the plan including any limitations.

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(iii) __ The State assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;
- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

Insert a copy of the report.

iv __ The State assures that if the benchmark plan used by the State for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following four categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State:

- Prescription drugs;
- Mental health services;
- Vision services, and/or
- Hearings services,

In the text box below provide a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c) ___ Additional Benefits

___ Insert a full description of the additional benefits including any limitations.

___ Other Additional Benefits (If checked, please describe)

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3. Service Delivery System

Check all that apply.

__ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider.

__ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t).

__ The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR 438, 1903(m), and 1932).

__ The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR 438.

X The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

Alternative benefit services for will be offered through Prepaid Ambulatory Health Plan Contracts (PAHPs) between disease management providers and the state. All other Medicaid State Plan services will be provided via the state's fee-for-service system and Regional Support Network for Mental Health services.

__ The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished.

4. Employer Sponsored Insurance

__ The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

__ The State assures EPSDT services will be provided to individuals under 21 years old who are covered under the State Plan under section 1902(a)(10)(A).

__ Through Benchmark only

__ As an Additional benefit under section 1937 of the Act

X The State assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

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X The State assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

Transportation is provided by the State through the transportation services program derived from and authorized under the State Plan Attachment 3.1-A page 62 Sec. 24 Transportation. Transportation is provided through statewide brokered services contracts.

6. Economy and Efficiency of Plans

X The State assures that alternative benefit coverage is provided in accordance with Federal upper payment limits, procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Rates information, including certification of actuarial soundness, will be submitted with the rates and contract package.

7. Compliance with the Law

X The State will continue to comply with all other provisions of the Social Security Act in the administration of the State plan under this title.

8. Implementation Date

X The State will implement this State Plan amendment on 1/3/2011.