

STANDARDS AND METHODS FOR ASSURING HIGH QUALITY CARE

The ultimate goal of this State Plan is the establishment of a comprehensive program which will assure that the provision of high quality medical and remedial care and services will be available to every resident of the State who, because of lack of financial resources, might otherwise be deprived thereof. To achieve this end, the following will obtain:

1. Efforts to assure receipt of high quality care and services by eligible individuals will include, but not necessarily be limited to:
 - a. Seeking and applying more efficacious ways and means of maintaining meaningful surveillance over service availability and utilization which will ascertain that the right service is provided to the right individual and at, and for, the right time, or that corrective action is in order;
 - b. Consultation with present and potential providers of medical and remedial care and services to assist in improving the quality and quantitative balance of services available;
 - c. Utilization of specialized professional consultation in developing and assessing pertinent elements of the program, such as drugs and pharmaceuticals;
 - d. Integration into the program of existing State Agency standards relative to Crippled Children's and Maternal and Child Health programs which it administers, and development of improved standards relating to the delivery of medical and remedial care and services;
 - e. Exploration of changes in existing methodologies used in delivering services in order to better utilize available resources;
 - f. Establishment and operation of a registry and referral service to facilitate accessibility of services;
 - g. Consultation with the State medical care advisory committee in planning and promoting ways and means of reaching the goal of comprehensive medical care; and
 - h. Further development of active cooperation and coordination among all health and welfare interests in the State.

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2. In order to assure that the quality of medical and remedial care and services delivered under this plan is capable of maintaining a satisfactory level, providers of such care and services will be required to:

a. Comply with applicable portions of

- (1) Standards established as conditions of participation under Title XVIII of the Social Security Act,
- (2) Requirements of Supplement D-5000,
- (3) Regulations cited in Section D.3 of this Chapter IV and,
- (4) The "Conditions of Participation" established by the State Agency as cited in Section C of this Chapter.
- (5) Exception to the above may be made under Section F of this Chapter.

b. Meet applicable licensure requirements of the jurisdiction in which the care or service is provided.

c. Meet the following additional qualifications, as applicable:

(1) Physician (Includes osteopathic physician)

(a) General Requirement

A graduate of a recognized school of medicine and/or school of osteopathy and licensed to practice medicine, surgery and/or osteopathic medicine and surgery within the jurisdiction in which the service is provided.

(b) General Practice Physician

A licensed physician who devotes his professional activities to the general practice of medicine and surgery.

(c) Specialist Physician

A licensed physician who engages in the practice of a medical or surgical specialty and is certified by the appropriate medical specialty board; qualified for admission to the examinations of such board; or holds an active staff appointment in a hospital approved for training in the appropriate specialty with privileges in that specialty.

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(2) Dentist(a) General Requirement

A graduate of a recognized school of dentistry and licensed to practice dentistry within the jurisdiction in which the service is provided.

(b) Dentist - General Practice

A licensed dentist who is engaged in the practice of general dentistry.

(c) Dentist - Specialist

Certified or eligible for certification by the board of certification for his particular specialty. Such board of certification must be approved by the American Dental Association.

(3) Nursing Personnel(a) Registered Graduate Nurse

Licensed to practice as such within the jurisdiction in which the service is provided, and qualified by education, training, experience and demonstrated ability for the position occupied.

(b) Public Health Nurse

Licensed to practice as a graduate registered nurse within the jurisdiction in which the service is provided, and especially trained or experienced in the practice of public health nursing.

(c) Practical Nurse

Licensed to practice as such within the jurisdiction in which the service is provided.

(d) Nurses' Aides and Other Auxiliary Nursing Personnel

Qualified by education, training, experience and demonstrated ability for the position occupied, and work under supervision of a registered professional nurse. (For Nurse Aide Training and Competency Evaluation Programs - See Attachment 4.11A).

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(4) Dietician and Nutritionist

Formal education, training and experience in dietetics or nutrition, or in both; and preferably, meeting the requirements for certification of the American Dietetic Association.

(5) Optometrist

Licensed to practice optometry in the jurisdiction in which the service is provided.

(6) Podiatrist

Licensed to practice podiatry in the jurisdiction in which the service is provided.

(7) Physical Therapist

Graduate of a program of physical therapy approved by the Council on Education of the American Medical Association in collaboration with the American Physical Therapy Association, or its equivalent.

(8) Occupational Therapist

Registered by the American Occupational Therapy Association or a graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association and engaged in the required supplemental clinical experience prerequisite to registration by the American Occupational Therapy Association.

(9) Speech Therapist

Graduate of a course in speech therapy and certified or eligible for certification by the American Speech and Hearing Association or its equivalent.

(10) Psychologist

Graduate from a recognized psychology training program and certified by the American Board of Examinations for Professional Psychology or by the District of Columbia Board of Examinations of the Psychological Association or its equivalent.

(11) Social Worker

(a) Master's Degree from an approved school of social work and certified or eligible for certification by the National Association of Social Workers.

(b) Assistant

Qualified by education, training, experience and demonstrated ability for the position to which appointed and works under the supervision of a social worker.

(12) Clinical Laboratory Technologist

(a) Graduate of an approved training program in clinical laboratory technology and registered or eligible for registration by the American Society of Clinical Pathology or its equivalent.

(b) Laboratory Technician

Qualified by education, training, experience and demonstrated ability for the position occupied and works under supervision of a clinical laboratory technologist.

(13) Radiology Technician

Graduate of an approved course in radiology technology and certified or eligible for certification by the American Registry of Radiologic Technicians or by the Registry of Medical Technicians (ASCP) as a nuclear medical technician.

(14) Pharmacist

Graduate of a recognized school of pharmacy and licensed to practice pharmacy in the jurisdiction in which the service is provided; and those pharmacists already licensed to practice in the District of Columbia.

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(15) Personal Care Providers

- (a) Provider Agencies offering Personal Care Aide services shall have and adhere to a current Provider Agreement with the Department of Human Services, Commission on Health Care Financing.
- (b) The Provider shall perform the following:
- (i) Verify the recipient's eligibility for Personal Care Aide services.
 - (ii) Assure completion of documentation required for certification and authorization of PCA services.
 - (iii) Develop an appropriate plan of care, which is to be completed and reviewed by a Registered Nurse at least every 60 days.
 - (iv) Provide quality services according to the plan of care, including proper assignment and supervision of personal care aides.
 - (v) Provide supervisory visits within 48 hours of initiation of services and every 60 days, to the recipient's home by a Registered Nurse to monitor the quality of Personal Care Aide services and gather information for the recipient's continued plan of care. When a recipient's situation warrants, such as a new PCA, or change in health status, a supervisory visit should also be made.
 - (vi) Maintain documentation of services for a minimum of five (5) years. Documentation shall include:
 - 1) Medical information pertinent to developing a plan of care, in addition to initial and subsequent care plans.
 - 2) General information including recipient's name, identification number, address, telephone number, age, sex, name and telephone number of emergency contact person, physician's name, name and telephone number of personal care provider or provider agency.

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3) Dates of service and description of services provided, including progress notes of personal care aide and Registered Nurse supervisor.

- (vii) Coordinate services between levels of care to avoid duplication and gaps in care.
 - (viii) Discontinue Personal Care services when such services are no longer required or adequate to meet the recipient's needs.
 - (ix) Notify the State Medicaid Agency and the recipient when services are no longer required, including indication for discontinued services (e.g. improvement in level of independent function, hospital admission, nursing home admission, death).
 - (x) Recertify PCA services according to I (C) (1) of this section.
 - (xi) Assure that PCAs employed by the provider meet the qualifications required by the Medicaid agency.
 - (xii) Provide and document at least 12 hours of continuing education for Personal Care Aides each year.
- (c) Personal Care Aides must meet the following qualifications:
- (i) Be at least 18 years of age.
 - (ii) Be a U.S. Citizen or alien who is lawfully authorized to work in the U.S.
 - (iii) Be mentally, physically and emotionally competent to provide services as certified by a physician.
 - (iv) Be able to accept instruction from a registered nurse.
 - (v) Successfully complete a 75-hour training course approved by the State Medicaid Agency and hold Home Health Aide Certification consistent with Medicare/Medicaid guidelines.
 - (vi) Complete 3 hours of continuing education at quarterly intervals, in addition to annual CPR recertification.
 - (vii) Be able to read and write the English language.
 - (viii) Be acceptable to the recipient.
 - (ix) Pass a police clearance every 6 months.

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Attachment 3 – Services: General Provisions

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

The State provides benchmark benefits:

- Provided
- Not Provided

States can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying “Plan A” was checked then the remainder of the pre-print that would appear would be specific only to “Plan A”. If “Plan B” was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State and would correlate to “Plan B” only.)

Title of Alternative Benefit Plan A	D.C. Healthy Families II
Title of Alternative Benefit Plan B	
Title of Alternative Benefit Plan C	

1. Populations and geographic area covered

a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10)(A)(i)(VIII) and 1902(k)(2)

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

- (i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in an alternative benefit plan to obtain medical assistance.

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State plan under section 1902(a)(10)(A)(i) of the Act.

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- An individual who qualifies for medical assistance under the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.
- An individual entitled to benefits under any part of Medicare.
- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.
- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.
- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State's definition of individuals who are medically frail or otherwise have special medical needs should include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.
- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.
- An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.
- A parent or caretaker relative whom the State is required to cover under section 1931 of the Act.
- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.
- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.
- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.
- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

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.

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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)		
Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
		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: • • • •		

(ii) The following populations will be given the option to voluntarily enroll in an alternative benefit plan. Please indicate in the chart below:

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

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); Individuals qualifying for Medicaid on the basis of blindness Individuals qualifying for Medicaid on the basis of disability 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 (42 CFR §440.315) Disabled children eligible under the TEFRA option - section 1902(e)(3) Medically frail and individuals with special medical needs 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)		
pt-In Enrollment	Included Eligibility Group and Federal Citation 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)	Targeting Criteria	Geographic Area

Limited Services Individuals

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	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)		

(iii) For optional populations/individuals (checked above in 1a. & 1b.), describe in the text box

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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.

b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, States may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

- (i) The State has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Specify whether the benchmark will cover these individuals statewide or otherwise.

The benchmark will cover individuals statewide.

- (2) For optional populations/individuals [checked above in b(i)], 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.

2. Description of the Benefits

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

- a) Benchmark Benefits

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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.

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 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.

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.

All benefits and applicable limitations are provided, as outlined by the District of Columbia State Plan under Title XIX of the Social Security Act, Medical Assistance Program in Section 3 – Services: General Provisions

b) **Benchmark-Equivalent Benefits.**

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

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[Empty rectangular box]

(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;
- ' Coverage of prescription drugs
- ' Mental health 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;
- ' Emergency services
- ' Family planning services and supplies

(ii) Additional services

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

[Empty rectangular box]

(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

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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 two 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:

- 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.

3. Service Delivery System
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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. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)
- ' 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). (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)
- ' 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.
- ' The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).
- The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

The alternative benefit plan will be provided through a combination of fee-for-service reimbursement and managed care, as outlined in Attachment 3.1F. The District has a mandatory managed care program. Upon enrollment, beneficiaries will have 90 days to select a health plan or a plan will be assigned. Until a plan is selected or assigned, the beneficiary is enrolled in fee-for-service.

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).

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' Through Benchmark only

' As an Additional benefit under section 1937 of the Act

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

Emergency and non-emergency transportation services are provided through a transportation broker or managed care plan. Services are provided according to Section 3.1(c)(1) and Attachment 3.1D.

- The State assures that effective January 1, 2014 any benchmark benefit plan provides at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- The State assures that family planning services and supplies are covered for individuals of child-bearing age.

6. Economy and Efficiency of Plans

- 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.

7. Compliance with the Law

- 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

- The State will implement this State Plan amendment on May 1, 2010 (date).

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