



State Guide to CMS Criteria for Children’s Health Insurance Program (CHIP) Managed Care Contract Review and Approval

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This guide covers the standards that are used by the Centers for Medicare & Medicaid Services (CMS) Division of Managed Care Operations (DMCO) staff to review and approve state contracts with managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), non-emergency medical transportation prepaid ambulatory health plans (NEMT PAHP), and primary care case manager entities (PCCM entity) for the provision of Children’s Health Insurance Program (CHIP) benefits. Although the guide addresses the regulatory provisions applicable to state contracts with Primary Care Case Managers (PCCMs), CMS does not require that states submit these contracts for CMS review and approval. The intention of this guide is to provide transparency on the criteria for contract approvals and to help states verify that CHIP contracts with managed care entities meet all CMS requirements.¹ This guide is an update to the 2018 State Guide to CMS Criteria for CHIP Managed Care Contract Review and Approval, and applies to contract actions with an effective start date on or after December 14, 2020.

This guide is organized into four sections. **Section I** outlines the contract requirements based on existing federal requirements Title XXI of the Social Security Act (referred to as “the Act”), 42 CFR part 457, and 42 CFR part 438, including requirements incorporated into the Medicaid and Children’s Health Insurance Program Managed Care Final Rule (referred to as “the 2020 Final Rule”) published November 13, 2020 and effective on December 14, 2020.² A requirement is classified as an “existing standard” if it was in effect prior to the release of the 2020 Final Rule (i.e., in effect in 42 CFR part 457 and 42 CFR part 438, edition revised as of May 6, 2016) and did not materially change within the 2020 Final Rule. This section is organized by topic and describes existing standards as well as standards that are new or modified with an effective date that falls on or after December 14, 2020. The new or modified standards included in this Guide update are as follows:

¹ This guide is not intended as a substitute to legal advice or review of the applicable law; it does not grant rights or impose obligations. It is a tool to aid states in their contract development practices. Federal requirements outlined in statute and regulation control over this guide.

² The 2020 Final Rule (CMS-2408-F, 85 FR 72754) is available at:
<https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicare-and-childrens-health-insurance-program-chip-managed-care>.

Enforcement Date	Guide Section	Item Number(s)
Existing standard, but the federal regulatory citation changed effective 12/14/2020	I.E.4. Anti-Gag	I.E.4.05
	I.E.6. Provider Notification of Grievance and Appeals Rights	I.E.6.01 – I.E.6.05
	I.H.1. Grievance and Appeals System	I.H.1.01 – I.H.1.10
	I.H.2. Notice of Adverse Benefit Determination Requirements	I.H.2.01 – I.H.2.06
	I.H.3. Notice of Adverse Benefit Determination Timing	I.H.3.05 – I.H.3.11
	I.H.4. Who May File Appeals and Grievances	I.H.4.01, I.H.4.03
	I.H.5. Timeframes for Filing Appeals	I.H.5.01 – I.H.5.03
	I.H.6. Process for Filing an Appeal or Expedited Appeal Request	I.H.6.01 – I.H.6.10
	I.H.7. Timeframes for Resolving Appeals and Expedited Appeals	I.H.7.01 – I.H.7.12
	I.H.8. Notice of Resolution for Appeals	I.H.8.01 – I.H.8.05
	I.H.10. Grievances	I.H.10.01 – I.H.10.09
	I.H.11. Grievances and Appeal Recordkeeping Requirements	I.H.11.01 – I.H.11.08
	I.J.4. Sanctions	I.J.4.01 – I.J.4.19
Contract actions with an effective start date on or after 12/14/2020	I.C.1. Beneficiary Notification Language and Format	I.C.1.04 – I.C.1.07
	I.C.4. Network Provider Directory	I.C.4.01 – I.C.4.10
	I.C.6. Provider Termination and Incentives	I.C.6.01
	I.E.5. Network Adequacy Standards	I.E.5.08 – I.E.5.30
	I.E.7. Balance Billing	I.E.7.01
	I.G.4. Practice Guidelines	I.G.4.03
	I.G.5. Quality	I.G.5.01, I.G.5.03
	I.H.1. Grievance and Appeals System	I.H.1.11
	I.H.4. Who May File Appeals and Grievances	I.H.4.02
	I.H.9. Effectuation of Reversed Appeal Resolutions	I.H.9.01
	I.J.3. Subcontracts and Other Contracts and Written Agreements	I.J.3.01 – I.J.3.16
I.J.6. Insolvency	I.J.6.02 – I.J.6.04	
Contract Actions with an effective start date on or after 12/31/2020	I.I.6 Program or Activity No Longer Authorized by Law	I.I.6.01
Contract Actions with an effective start date on or after 07/01/2021	I.K. Health Information Systems and Enrollee Data	I.K.09

Each requirement in Section I contains: (1) an item number; (2) the contract requirement(s),³ (3) the entity types (i.e., MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity) to which the requirement applies; (4) the governing statutory, regulatory, and/or other policy citation(s); and (5) the date by which CMS will enforce the contract requirement.

Sections II and III of this guide provide additional resources to help states in their contract development efforts. Section II includes tips to aid states in their interpretation of federal requirements. Asterisks (*) are used in Section I to indicate contract requirements to which a tip or tips apply in Section II. Users should consult Section II of the guide to identify items that apply to each contract requirement according to its item number. Section III of the guide contains a glossary that describes commonly used terms and the applicable federal regulatory citation for each definition.

This guide is designed specifically for review of managed care plan (MCP)⁴ contracts serving the separate CHIP population—whether included in a single contract covering both the Medicaid and CHIP populations or in a separate contract covering only the CHIP population. The State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval provides separate guidance specific to the review of Medicaid managed care provisions.

Note that this guide is not an exhaustive list of all federal requirements and is only a tool to aid states in development of contracts with its MCOs, PIHPs, PAHPs, NEMT PAHPs, PCCMs and PCCM entities. For example, it does not describe all the federal managed care requirements a state must comply with, only those that are required in contracts with MCPs.

³ This guide includes the contract requirement number(s) that correspond to CMS’s internal review tool to aid in conversations between states and the Division of Managed Care Operations (DMCO) during contract review.

⁴ CMS utilizes the term “managed care plan” to encompass all types of managed care delivery (i.e. MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity) to which a federal requirement applies.

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Section I: CHIP Contract Requirements

I.A. Contract Completeness

- I.A.1.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract submission is signed and dated by all parties. [Existing standard]
- I.A.1.02 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract submission is complete. That is: 1) All pages, appendices, attachments, etc. were submitted to CMS. 2) Any documents incorporated by reference (including, but not limited to, state statute, state regulation, or other binding document, such as a member handbook) to comply with federal regulations and the requirements of this review tool were submitted to CMS. [Existing standard]
- I.A.1.03 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
If the contract submission is an amendment, CMS has received and validated amendments to base contracts. [Existing standard]
- I.A.1.04 [Applies to MCO, PIHP, PAHP]*
If the contract submission implements capitation rates or a change in the contract may impact 42 CFR 438.4, the Division of Managed Care Operations (DMCO) received the state's summary description of Medical Loss Ratio (MLR) reports received from the MCO(s), PIHP(s) and PAHP(s) under contract with the state. [42 CFR 457.1203(e); 42 CFR 438.74(a)] [Existing standard]
- I.A.1.05 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract includes provisions that define a sound and complete procurement contract, as required by 45 CFR part 75, as applicable. [42 CFR 457.940(c)] [Existing standard]

I.B. Enrollment and Disenrollment

I.B.1 No Discrimination

- I.B.1.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract requires the MCP to accept new enrollment from individuals in the order in which they apply without restriction, unless authorized by CMS, up to the limits set under the contract. [42 CFR 457.1201(d); 42 CFR 438.3(d)(1)] [Existing standard]
- I.B.1.02 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract prohibits the MCP from discriminating against individuals eligible to enroll on the basis of health status or need for health care services. [42 CFR 457.1201(d); 42 CFR 438.3(d)(3)] [Existing standard]
- I.B.1.03 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract prohibits the MCP from discriminating against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability. [42 CFR 457.1201(d); 42 CFR 438.3(d)(4)] [Existing standard]

I.B.1.04 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract prohibits the MCP from using any policy or practice that has the effect of discriminating against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability. [42 CFR 457.1201(d); 42 CFR 438.3(d)(4)] [Existing standard]

I.B.1.05 [Applies to PCCM]
The contract prohibits the MCP from discriminating in enrollment, disenrollment, and re-enrollment against individuals on the basis of health status or need for health care services. [42 CFR 457.1201(m); 42 CFR 438.3(q)(4)] [Existing standard]

I.B.2 Choice of Doctor

I.B.2.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract requires the MCP to allow each enrollee to choose his or her network provider to the extent possible and appropriate. [42 CFR 457.1201(j); 42 CFR 438.3(l)] [Existing standard]

I.B.3 Reenrollment

I.B.3.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
If specified by the federal authority (State Plan Amendment (SPA) or waiver) approved by CMS, the contract provides for automatic reenrollment of a recipient who is disenrolled solely because he or she loses CHIP eligibility for a period of 2 months or less. [42 CFR 457.1201(m); 42 CFR 457.1212; 42 CFR 438.56(g)] [Existing standard]

I.B.4 Disenrollment

I.B.4.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract specifies the reasons for which the MCP may request disenrollment of an enrollee. [42 CFR 457.1201(m); 42 CFR 457.1212; 42 CFR 438.56(b)(1)] [Existing standard]

I.B.4.02 - I.B.4.05 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract provides that the MCP may not request disenrollment because of:

- An adverse change in the enrollee's health status.
- The enrollee's utilization of medical services.
- The enrollee's diminished mental capacity.
- The enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the MCP's ability to furnish services to the enrollee or other enrollees).

[Section 1903(m)(2)(A)(v) of the Act; 42 CFR 457.1201(m); 42 CFR 457.1212; 42 CFR 438.56(b)(2)] [Existing standard]

I.B.4.06 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract specifies the methods by which the MCP assures the state that it only requests disenrollment for reasons that are permitted under the contract. [42 CFR 457.1201(m); 42 CFR 457.1212; 42 CFR 438.56(b)(3)] [Existing standard]

I.B.4.07 - I.B.4.10 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]

For states that limit disenrollment, the contract requires that enrollees have the right to disenroll from their MCP:

- For cause, at any time.
- Without cause 90 days after initial enrollment or during the 90 days following notification of enrollment, whichever is later.
- Without cause at least once every 12 months.
- Without cause upon reenrollment if a temporary loss of enrollment has caused the enrollee to miss the annual disenrollment period.

[42 CFR 457.1201(m); 42 CFR 457.1212; 42 CFR 438.56(c)(1); 42 CFR 438.56(c)(2)(i) - (iii)] [Existing standard]

I.B.4.11 [Applies to MCO]*

For states that limit disenrollment, the contract requires that enrollees have the right to disenroll from their MCP without cause when the state imposes intermediate sanctions on the MCP specified in 438.702(a)(4). [42 CFR 457.1201(m); 42 CFR 457.1212; 42 CFR 438.56(c)(2)(iv)] [Existing standard]

I.B.4.12 - I.B.4.13 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]

The contract allows enrollees to request disenrollment if:

- The enrollee moves out of the service area.
- The plan does not cover the service the enrollee seeks, because of moral or religious objections.

[42 CFR 457.1201(m); 42 CFR 457.1212; 42 CFR 438.56(d)(2)(i) - (ii)] [Existing standard]

I.B.4.14 [Applies to MCO, PIHP, PAHP, PCCM, PCCM entity]*

The contract allows enrollees to request disenrollment if the enrollee needs related services to be performed at the same time and not all related services are available within the provider network. The enrollee's primary care provider (PCP) or another provider must determine that receiving the services separately would subject the enrollee to unnecessary risk. [42 CFR 457.1201(m); 42 CFR 457.1212; 42 CFR 438.56(d)(2)(iii)] [Existing standard]

I.B.4.15 [Applies to MCO, PIHP, PAHP]

The contract allows enrollees who use Managed Long Term Services and Supports (MLTSS) to request disenrollment if a provider's change in status from an in-network to an out-of-network provider with the MCP would cause the enrollee to have to change their residential, institutional, or employment supports provider, and, as a result, the enrollee would experience a disruption in their residence or employment. [42 CFR 457.1201(m); 42 CFR 457.1212; 42 CFR 438.56(d)(2)(iv)] [Existing standard]

I.B.4.16 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]

The contract allows enrollees to request disenrollment for other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's care needs. [42 CFR 457.1201(m); 42 CFR 457.1212; 42 CFR 438.56(d)(2)(v)] [Existing standard]

I.B.5 Disenrollment Request Process

- I.B.5.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract specifies that a recipient (or his or her representative) must request disenrollment by submitting an oral or written request, as required by the state, to the state (or its agent) or the MCP, if the state allows the MCP to process disenrollment requests. [42 CFR 457.1201(m); 42 CFR 457.1212; 42 CFR 438.56(d)(1)(i) - (ii)] [Existing standard]
- I.B.5.02 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract specifies that the MCP may approve a request for disenrollment by or on behalf of the enrollee, if the state allows the MCP to process disenrollment requests, or refer the request to the state. [42 CFR 457.1201(m); 42 CFR 457.1212; 42 CFR 438.56(d)(3)(i)] [Existing standard]
- I.B.5.03 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract requires that the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCP refers the request to the state. [42 CFR 457.1201(m); 42 CFR 457.1212; 42 CFR 438.56(e)(1) - (2); 42 CFR 438.56(d)(3)(ii); 42 CFR 438.56(c)] [Existing standard]
- I.B.5.04 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract requires that if the entity or state agency (whichever is responsible) fails to make a disenrollment determination within the specified timeframes (i.e., the first day of the second month following the month in which the enrollee requests disenrollment or the MCP refers the request to the state), the disenrollment is considered approved for the effective date that would have been established had the state or MCP made a determination in the specified timeframe. [42 CFR 457.1201(m); 42 CFR 457.1212; 42 CFR 438.56(e)(1) - (2); 42 CFR 438.56(d)(3)(ii); 42 CFR 438.56(c)] [Existing standard]

I.B.6 Special Rules for American Indians

- I.B.6.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*
For Indian Managed Care Entities (IMCEs), the contract allows the MCP to restrict enrollment of Indians in the same manner as Indian Health Programs may restrict the delivery of services to Indians. [Section 1932(h)(3) of the Act; 42 CFR 457.1209; 42 CFR 438.14(d); State Medicaid Director Letter (SMDL) 10-001] [Existing standard]
- I.B.6.02 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract requires that any Indian enrolled in an MCP, that is not a IMCE, and eligible to receive services from an Indian Health Care Provider (IHCP) PCP participating as a network provider, is permitted to choose that IHCP as their PCP, as long as that provider has capacity to provide the services. [American Reinvestment and Recovery Act (ARRA) 5006(d); 42 CFR 457.1209; 42 CFR 438.14(b)(3); SMDL 10-001] [Existing standard]

I.C. Beneficiary Notification

I.C.1 Language and Format

I.C.1.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*

The contract requires the MCP to provide information to enrollees and potential enrollees in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees. [42 CFR 457.1207; 42 CFR 438.10(c)(1)] [Existing standard]

I.C.1.02 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]

The contract requires the MCP to have in place mechanisms to help enrollees and potential enrollees understand the requirements and benefits of their plan. [42 CFR 457.1207; 42 CFR 438.10(c)(7)] [Existing standard]

I.C.1.03 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The contract requires the MCP to make its written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices available in the prevalent non-English languages in its particular service area. [42 CFR 457.1207; 42 CFR 438.10(d)(3)] [Existing standard]

I.C.1.04 - I.C.1.07 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The contract requires that the MCP's written materials that are critical to obtaining services:

- Are available in alternative formats upon request of the potential enrollee or enrollee at no cost.
- Include taglines in the prevalent non-English languages in the state, and in a conspicuously visible font size, explaining the availability of written translation or oral interpretation to understand the information provided.*
- Include taglines in the prevalent non-English languages in the state and in a conspicuously visible font size that provide information on how to request auxiliary aids and services.*
- Include taglines in the prevalent non-English languages in the state and in a conspicuously visible font size that provide the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDY) telephone number of the MCP's member/customer service unit.*

[42 CFR 457.1207; 42 CFR 438.10(d)(3)] [Effective: 12/14/2020]

I.C.1.08 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]

The contract requires the MCP to make auxiliary aids and services available upon request of the potential enrollee or enrollee at no cost. [42 CFR 457.1207; 42 CFR 438.10(d)(3)] [Existing standard]

I.C.1.09 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The contract requires the MCP to make interpretation services, including oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language (ASL), free of charge to each enrollee. [42 CFR 457.1207; 42 CFR 438.10(d)(4)] [Existing standard]

I.C.1.10 - I.C.1.12 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The contract requires the MCP to notify its enrollees that:

- Oral interpretation is available for any language, and how to access those services.*
- Written translation is available in prevalent languages, and how to access those services.
- Auxiliary aids and services are available upon request at no cost for enrollees with disabilities, and how to access those services.

[42 CFR 457.1207; 42 CFR 438.10(d)(5)(i) - (iii)] [Existing standard]

I.C.1.13 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]

The contract requires the MCP to provide all written materials for potential enrollees and enrollees in an easily understood language and format. [42 CFR 457.1207; 42 CFR 438.10(d)(6)(i)] [Existing standard]

I.C.1.14 – I.C.1.16 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]

The contract requires the MCP to:

- Provide all written materials for potential enrollees and enrollees in a font size no smaller than 12 point.
- Make written materials for potential enrollees and enrollees available in alternative formats in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency.
- Make written materials for potential enrollees and enrollees available through auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency.

[42 CFR 457.1207; 42 CFR 438.10(d)(6)(ii) - (iii)] [Existing standard]

I.C.2 Enrollee Handbook

I.C.2.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The contract requires the MCP to use the state developed model enrollee handbook. [42 CFR 457.1207; 42 CFR 438.10(c)(4)(ii)] [Existing standard]

I.C.2.02 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The contract requires the MCP to provide each enrollee an enrollee handbook, which serves as a summary of benefits and coverage, within a reasonable time after receiving notice of the beneficiary's enrollment. [42 CFR 457.1207; 42 CFR 438.10(g)(1); 45 CFR 147.200(a)] [Existing standard]

I.C.2.03 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The content of the enrollee handbook must include information that enables the enrollee to understand how to effectively use the managed care program. [42 CFR 457.1207; 42 CFR 438.10(g)(2)] [Existing standard]

I.C.2.04 - I.C.2.07 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The MCP is required to utilize the model enrollee handbook developed by the state that includes information:

- On benefits provided by the MCP. This includes information about the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit and how to access component

services if individuals under age 21 entitled to the EPSDT benefit are enrolled in the MCP.*

- About how and where to access any benefits provided by the state, including EPSDT benefits delivered outside the MCP, if any.*
- About cost sharing on any benefits carved out of the MCP contract and provided by the state.*
- About how transportation is provided for any benefits carved out of the MCP contract and provided by the state.*

[42 CFR 457.1207; 42 CFR 438.10(g)(2)(i) - (ii)] [Existing standard]

I.C.2.08 - I.2.09 [Applies to MCO, PIHP, PAHP, PCCM entity]*

The MCP is required to utilize the model enrollee handbook developed by the state that includes detail that in the case of a counseling or referral service that the MCP does not cover because of moral or religious objections, the MCP inform enrollees:

- That the service is not covered by the MCP.*
- How they can obtain information from the state about how to access those services.*

[42 CFR 457.1207; 42 CFR 438.10(g)(2)(ii)(A) - (B); 42 CFR 438.102(b)(2)] [Existing standard]

I.C.2.10 - I.C.2.11 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The MCP is required to utilize the model enrollee handbook developed by the state that includes:

- The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.*
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's PCP.*

[42 CFR 457.1207; 42 CFR 438.10(g)(2)(iii) - (iv)] [Existing standard]

I.C.2.12 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The MCP is required to utilize the model enrollee handbook developed by the state that includes the extent to which, and how, after-hours care is provided. [42 CFR 457.1207; 42 CFR 438.10(g)(2)(v)] [Existing standard]

I.C.2.13 - I.C.2.17 [Applies to MCO, PIHP, PAHP, PCCM entity]*

The MCP is required to utilize the model enrollee handbook developed by the state that includes:

- How emergency care is provided.*
- Information regarding what constitutes an emergency medical condition.*
- Information regarding what constitutes an emergency service.*
- The fact that prior authorization is not required for emergency services.*
- The fact that the enrollee has a right to use any hospital or other setting for emergency care.*

[42 CFR 457.1207; 42 CFR 438.10(g)(2)(v)] [Existing standard]

I.C.2.18 - I.C.2.19 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The MCP is required to utilize the model enrollee handbook developed by the state that includes:

- Any restrictions on the enrollee's freedom of choice among network providers.*
- The extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers.*

[42 CFR 457.1207; 42 CFR 438.10(g)(2)(vi) - (vii)] [Existing standard]

I.C.2.20 [Applies to MCO, PIHP, PAHP, NEMT PAHP]*

The MCP is required to utilize the model enrollee handbook developed by the state that includes an explanation that the MCP cannot require an enrollee to obtain a referral before choosing a family planning provider. [42 CFR 457.1207; 42 CFR 438.10(g)(2)(vii)] [Existing standard]

I.C.2.21 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The MCP is required to utilize the model enrollee handbook developed by the state that includes cost sharing for services furnished by the MCP, if any is imposed under the state plan. [42 CFR 457.1207; 42 CFR 438.10(g)(2)(viii)] [Existing standard]

I.C.2.22 - I.C.2.27 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The MCP is required to utilize the model enrollee handbook developed by the state that includes enrollee rights and responsibilities, including the enrollee's right to:

- Receive information on beneficiary and plan information.*
- Be treated with respect and with due consideration for his or her dignity and privacy.*
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.*
- Participate in decisions regarding his or her health care, including the right to refuse treatment.*
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.*
- Request and receive a copy of their medical records and request that they be amended or corrected.*

[42 CFR 457.1207; 42 CFR 438.10(g)(2)(ix); 42 CFR 438.100(b)(2)(i) - (vi)] [Existing standard]

I.C.2.28 [Applies to MCO, PIHP, PAHP, NEMT PAHP]*

The MCP is required to utilize the model enrollee handbook developed by the state that includes enrollee rights and responsibilities, including the enrollee's right to obtain available and accessible health care services covered under the MCP contract. [42 CFR 457.1207; 42 CFR 438.10(g)(2)(ix); 42 CFR 438.100(b)(3)] [Existing standard]

I.C.2.29 [Applies to MCO, PIHP, PAHP, PCCM entity]*

The MCP is required to utilize the model enrollee handbook developed by the state that includes the process of selecting and changing the enrollee's PCP. [42 CFR 457.1207; 42 CFR 438.10(g)(2)(x)] [Existing standard]

I.C.2.30 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The MCP is required to utilize the model enrollee handbook developed by the state that includes grievance, appeal, and review procedures and timeframes in a state-developed or state-approved description. [42 CFR 457.1207; 42 CFR 438.10(g)(2)(xi)] [Existing standard]

I.C.2.31 - I.C.2.36 [Applies to MCO, PIHP, PAHP]*

The MCP is required to utilize the model enrollee handbook developed by the state that:

- Includes the enrollee's right to file grievances and appeals.*
- Includes the requirements and timeframes for filing a grievance or appeal.*
- Includes information on the availability of assistance in the filing process for grievances.*
- Includes information on the availability of assistance in the filing process for appeals.*
- Includes the enrollee's right to request a state review after the MCP has made a determination on an enrollee's appeal which is adverse to the enrollee.*
- Specifies that, when requested by the enrollee, benefits that the MCP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for state review within the timeframes specified for filing, and that the enrollee may, consistent with state policy, be required to pay the cost of services furnished while the appeal or state review is pending if the final decision is adverse to the enrollee.*

[42 CFR 457.1207; 42 CFR 438.10(g)(2)(xi)(A) - (E)] [Existing standard]

I.C.2.37 [Applies to MCO, PIHP]*

The MCP is required to utilize the model enrollee handbook developed by the state that includes how to exercise an advance directive. [42 CFR 457.1207; 42 CFR 438.10(g)(2)(xii); 42 CFR 438.3(j)] [Existing standard]

I.C.2.38 [Applies to PAHP]*

The MCP is required to utilize the model enrollee handbook developed by the state that includes how to exercise an advance directive, if the MCP includes any of the following providers in its network: hospitals, critical access hospitals, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), hospices, and religious nonmedical health care institutions. [42 CFR 457.1207; 42 CFR 438.10(g)(2)(xii); 42 CFR 438.3(j); 42 CFR 489.102(a)] [Existing standard]

I.C.2.39 - I.C.2.44 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The MCP is required to utilize the model enrollee handbook developed by the state that includes:

- How to access auxiliary aids and services, including additional information in alternative formats or languages.*
- The toll-free telephone number for member services.*
- The toll-free telephone number for medical management.*
- The toll-free telephone number for any other unit providing services directly to enrollees.*
- Information on how to report suspected fraud or abuse.*
- Any other content required by the state.*

[42 CFR 457.1207; 42 CFR 438.10(g)(2)(xiii) - (xvi)] [Existing standard]

I.C.2.45 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*
The contract requires the MCP to provide each enrollee notice of any significant change, as defined by the state, in the information specified in the enrollee handbook at least 30 days before the intended effective date of the change. [42 CFR 457.1207; 42 CFR 438.10(g)(4)]
[Existing standard]

I.C.2.46 [Applies to MCO, PIHP, PAHP, PCCM, PCCM entity]
The contract specifies that the MCP is required to utilize the model enrollee handbook and notices that describe the transition of care policies for enrollees and potential enrollees. [42 CFR 438.1216; 42 CFR 438.62(b)(3)] [Existing standard]

I.C.3 Enrollee Handbook Dissemination

I.C.3.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]
The contract specifies that handbook information provided to the enrollee is considered to be provided if the MCP:

- Mails a printed copy of the information to the enrollee's mailing address.
- Provides the information by email after obtaining the enrollee's agreement to receive the information by email.
- Posts the information on its website and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. OR
- Provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.

[42 CFR 457.1207; 42 CFR 438.10(g)(3)(i) - (iv)] [Existing standard]

I.C.4 Network Provider Directory

I.C.4.01 - I.C.4.08 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

For each of the following provider types covered under the contract (physicians, including specialists; hospitals; pharmacies; behavioral health providers; and Long-Term Services and Supports (LTSS) providers, as appropriate), the contract requires the MCP to make the following information on the MCP's network providers available to the enrollee in paper form upon request and electronic form:

- Names, as well as any group affiliations.*
- Street addresses.*
- Telephone numbers.*
- Website URLs, as appropriate.*
- Specialties, as appropriate.*
- Whether network providers will accept new enrollees.*
- The cultural and linguistic capabilities of network providers, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office.*
- Whether network providers' offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment.*

[42 CFR 457.1207; 42 CFR 438.10(h)(1)(i) – (viii); 42 CFR 438.10(h)(2)] [Existing standard.]

The 2020 Final Rule deleted “and whether the provider has completed cultural competence training” from 42 CFR 438.10(h)(1)(vii) effective 12/14/2020].

I.C.4.09 - I.C.4.10 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The contract requires that the MCP's provider network information included in:

- A paper provider directory must be updated at least monthly, if the MCP does not have a mobile-enabled electronic directory, or quarterly, if the MCP has a mobile-enabled, electronic provider directory.*
- A mobile-enabled electronic provider directory must be updated no later than 30 calendar days after the MCP receives updated provider information.*

[42 CFR 457.1207; 42 CFR 438.10(h)(3)(i)(A) – (B), 42 CFR 438.10(h)(3)(ii)] [Effective: 12/14/2020]

I.C.4.11 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The contract requires that provider directories must be made available on the MCP's website in a machine readable file and format as specified by the Secretary. [42 CFR 457.1207; 42 CFR 438.10(h)(4)] [Existing standard]

I.C.5 Formulary

I.C.5.01 - I.C.5.03 [Applies to MCO, PIHP, PAHP, PCCM entity]*

The contract requires the MCP to provide:

- Information in electronic or paper form about which generic and name brand medications are covered.*
- Information in electronic or paper form about what tier each medication is on.*
- Formulary drug lists on the MCP's website in a machine readable file and format as specified by the Secretary.*

[42 CFR 457.1207; 42 CFR 438.10(i)(1) - (3)] [Existing standard]

I.C.6 Provider Terminations and Incentives

I.C.6.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]

The contract requires the MCP to make a good faith effort to give written notice of termination of a contracted provider to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the enrollee must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice. [42 CFR 457.1207; 42 CFR 438.10(f)(1)] [Effective: 12/14/2020]

I.C.6.02 [Applies to MCO, PIHP, PAHP, PCCM entity]

The contract requires the MCP to make available, upon request, any physician incentive plans in place. [42 CFR 457.1207; 42 CFR 438.10(f)(3); 42 CFR 438.3(i)] [Existing standard]

I.C.7 Marketing

I.C.7.01 - I.C.7.07 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*

The contract:

- Prohibits the MCP from distributing marketing materials without first obtaining state approval.

- Requires the MCP to distribute marketing materials to its entire service area as indicated in the contract.
- Requires that the MCP does not seek to influence enrollment in conjunction with the sale or offering of any private insurance.*
- Prohibits the MCP from directly or indirectly engaging in door-to-door, telephone, e-mail, texting, or other cold-call marketing activities.
- Specifies how the MCP ensures to the state that its marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the recipients or the state.
- Requires that the MCP's materials cannot contain any assertion or statement (whether written or oral) that the recipient must enroll in the MCP to obtain benefits or to not lose benefits.
- Requires that the MCP's materials cannot contain any assertion or statement (whether written or oral) that the MCP is endorsed by CMS, the Federal or state government, or a similar entity.

[42 CFR 457.1224; 42 CFR 438.104(b)(1)(i) - (ii); 42 CFR 438.104(b)(1)(iv) - (v); 42 CFR 438.104(b)(2)(i) - (ii)] [Existing standard]

I.C.8 General Information Requirements

I.C.8.01 - I.C.8.06 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*

The contract requires that if the MCP chooses to provide required information electronically to enrollees:

- It must be in a format that is readily accessible.*
- The information must be placed in a location on the MCP's website that is prominent and readily accessible.*
- The information must be provided in an electronic form which can be electronically retained and printed.*
- The information is consistent with content and language requirements.*
- The MCP must notify the enrollee that the information is available in paper form without charge upon request.*
- The MCP must provide, upon request, information in paper form within 5 business days.*

[42 CFR 457.1207; 42 CFR 438.10(c)(6)(i) - (v)] [Existing standard]

I.C.8.07 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to notify enrollees when it adopts a policy to discontinue coverage of a counseling or referral service based on moral or religious objections at least 30 day prior to the effective date of the policy for any particular service. [42 CFR 457.1207; 42 CFR 457.1222; 42 CFR 438.102(b)(1)(i)(B); 42 CFR 438.10(g)(4)] [Existing standard]

I.C.8.08 - I.C.8.27 [Applies to MCO, PIHP, PAHP, PCCM entity]

The contract requires the MCP to use the state-developed definition for the following terms: appeal; durable medical equipment; emergency medical condition; emergency medical transportation; emergency room care; emergency services; grievance; habilitation services and devices; home health care; hospice services; hospitalization; hospital outpatient care;

physician services; prescription drug coverage; prescription drugs; primary care physician; primary care provider; rehabilitation services and devices; skilled nursing care; and specialist. [42 CFR 457.1207; 42 CFR 438.10(c)(4)(i)] [Existing standard]

I.C.8.28 - I.C.8.39 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]

The contract requires the MCP to use the state-developed definition for the following terms: co-payment; excluded services; health insurance; medically necessary; network; non-participating provider; plan; preauthorization; participating provider; premium; provider; urgent care. [42 CFR 457.1207; 42 CFR 438.10(c)(4)(i)] [Existing standard]

I.C.8.40 [Applies to MCO, PIHP, PAHP]*

The contract requires that the MCP disseminate practice guidelines to enrollees and potential enrollees upon request. [42 CFR 457.1233(c); 42 CFR 438.236(c)] [Existing standard]

I.C.8.41 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]

The contract requires the MCP to use state developed enrollee notices. [42 CFR 457.1207; 42 CFR 438.10(c)(4)(ii)] [Existing standard]

I.D. Payment

I.D.1 General

I.D.1.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP]*

The contract specifies that the final capitation rates are identified and developed, and payment is made in accordance with 42 CFR 438.3(c). [42 CFR 457.1201(c)] [Existing standard]

I.D.1.02 [Applies to MCO, PIHP, PAHP, NEMT PAHP]*

The contract specifies that capitation payments may only be made by the state and retained by the MCP for CHIP eligible enrollees. [42 CFR 457.1201(c); 42 CFR 438.3(c)(2)] [Existing standard]

I.D.1.03 [Applies to MCO, PIHP, PAHP]*

The contract specifies that rates are based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles as defined at 42 CFR 457.10. [42 CFR 457.1203(a)] [Existing standard]

I.D.2 Medical Loss Ratio (MLR)

I.D.2.01 [Applies to MCO, PIHP, PAHP]*

The contract specifies that the MCP is required to calculate/report an MLR for each MLR reporting year, consistent with MLR standards. [42 CFR 457.1203(f); 42 CFR 438.8(a)] [Existing standard]

I.D.2.02 [Applies to MCO, PIHP, PAHP]*

If a state elects to mandate a remittance with its MLR for its MCPs, the contract specifies that the minimum MLR must be equal to or higher than 85 percent. [42 CFR 457.1203(f); 42 CFR 438.8(c)] [Existing standard]

I.D.2.03 [Applies to MCO, PIHP, PAHP]*

The contract specifies that the MLR calculation for each MCP in a MLR reporting year is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)). The numerator of an MCP's MLR for a MLR reporting year is the sum of the MCP's incurred claims, expenditures for activities that improve health care quality, and fraud prevention activities. See 42 CFR 438.8(e) for more details. The denominator of the MLR equals the MCP's adjusted premium revenue. The adjusted premium revenue is the MCP's premium revenue minus the MCP's Federal, State, and local taxes and licensing and regulatory fees, and is aggregated in accordance with 42 CFR 438.8(i). See 42 CFR 438.8(f) for more details. Given the complexity of the MLR calculation as required by 42 CFR 438.8, states may choose to reference the CFR rather than outline all relevant provisions within the MCP contracts. [42 CFR 457.1203(f); 42 CFR 438.8(d) - (f)] [Existing standard]

I.D.2.04 - I.D.2.05 [Applies to MCO, PIHP, PAHP]*

The contract specifies that:

- Each MCP expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses.*
- Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis.*

[42 CFR 457.1203(f); 42 CFR 438.8(g)(1)(i) - (ii)] [Existing standard]

I.D.2.06 - I.D.2.08 [Applies to MCO, PIHP, PAHP]*

The contract specifies that:

- Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.*
- Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.*
- Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.*

[42 CFR 457.1203(f); 42 CFR 438.8(g)(2)(i) - (iii)] [Existing standard]

I.D.2.09 - I.D.2.12 [Applies to MCO, PIHP, PAHP]*

The contract specifies that:

- The MCP may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible.*
- The credibility adjustment is added to the reported MLR calculation before calculating any remittances, if required by the state.*
- The MCP may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.*
- If an MCP's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.*

[42 CFR 457.1203(f); 42 CFR 438.8(h)(1) - (3)] [Existing standard]

- I.D.2.13 [Applies to MCO, PIHP, PAHP]*
The contract specifies that the MCP will aggregate data for all CHIP eligibility groups covered under the contract with the state unless the state requires separate reporting and a separate MLR calculation for specific populations. [42 CFR 457.1203(f); 42 CFR 438.8(i)] [Existing standard]
- I.D.2.14 [Applies to MCO, PIHP, PAHP]*
The contract specifies that, if required by the state, the MCP must provide a remittance for a MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR standard of 85 percent or higher. [42 CFR 457.1203(f); 42 CFR 438.8(j); 42 CFR 438.8(c)] [Existing standard]
- I.D.2.15 - I.D.2.29 [Applies to MCO, PIHP, PAHP]*
The contract specifies that the MCP must submit a MLR report to the state that includes, for each MLR reporting year:
- Total incurred claims.*
 - Expenditures on quality improving activities.*
 - Fraud prevention activities as defined in 42 CFR 438.8(e)(4).*
 - Non-claims costs.*
 - Premium revenue.*
 - Taxes.*
 - Licensing fees.*
 - Regulatory fees.*
 - Methodology(ies) for allocation of expenditures.*
 - Any credibility adjustment applied.*
 - The calculated MLR.*
 - Any remittance owed to the state, if applicable.*
 - A comparison of the information reported with the audited financial report.*
 - A description of the aggregation method used to calculate total incurred claims.*
 - The number of member months.*
- [42 CFR 457.1203(f); 42 CFR 438.8(k)(1)(i) - (xiii); 42 CFR 438.3(m); 42 CFR 438.8(i)]
[Existing standard]
- I.D.2.30 [Applies to MCO, PIHP, PAHP]*
The contract specifies that the MCP must submit the MLR report in a timeframe and manner determined by the state, which must be within 12 months of the end of the MLR reporting year. [42 CFR 457.1203(f); 42 CFR 438.8(k)(2); 42 CFR 438.8(k)(1)] [Existing standard]
- I.D.2.31 [Applies to MCO, PIHP, PAHP]*
The contract specifies that the MCP must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the MCP within 180 days of the end of the MLR reporting year or within 30 days of being requested by the MCP, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting. [42 CFR 457.1203(f); 42 CFR 438.8(k)(3)] [Existing standard]

I.D.2.32 - I.D.2.33 [Applies to MCO, PIHP, PAHP]*

The contract specifies that, in any instance where a state makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the state, the MCP must:

- Re-calculate the MLR for all MLR reporting years affected by the change.*
- Submit a new MLR report meeting the applicable requirements.*

[42 CFR 457.1203(f); 42 CFR 438.8(m); 42 CFR 438.8(k)] [Existing standard]

I.D.2.34 [Applies to MCO, PIHP, PAHP]*

The contract specifies that the MCP must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports. [42 CFR 457.1203(f); 42 CFR 438.8(n); 42 CFR 438.8(k)] [Existing standard]

I.D.3 Payment for Indian Health Care Providers (IHCP)

I.D.3.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]

For contracts involving IHCPs, the contract requires that the MCP will meet the requirements of fee for service (FFS) timely payment for all Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) providers in its network, including the paying of 90% of all clean claims from practitioners (i.e. those who are in individual or group practice or who practice in shared health facilities) within 30 days of the date of receipt; and paying 99 percent of all clean claims from practitioners (who are in individual or group practice or who practice in shared health facilities) within 90 days of the date of receipt. [ARRA 5006(d); 42 CFR 457.1209; 42 CFR 438.14(b)(2)(iii); 42 CFR 447.45; 42 CFR 447.46; SMDL 10-001] [Existing standard]

I.D.3.02 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]

The contract specifies that IHCPs which are enrolled in Medicaid as Federally Qualified Health Centers (FQHC) but are not participating providers of an MCP must be paid an amount equal to the amount the MCP would pay a FQHC that is a network provider but is not an IHCP, including any supplemental payment from the state to make up the difference between the amount the MCP pays and what the IHCP FQHC would have received under FFS. [42 CFR 457.1209; 42 CFR 438.14(c)(1)] [Existing standard]

I.D.3.03 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]

The contract specifies that when an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of an MCP, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service (IHS), or in the absence of a published encounter rate, the amount it would receive if the services were provided under the state plan's FFS payment methodology. [42 CFR 457.1209; 42 CFR 438.14(c)(2)] [Existing standard]

I.E. Providers and Provider Network

I.E.1 Network Adequacy

I.E.1.01 - I.E.1.02 [Applies to PCCM]

The contract requires the MCP to:

- Provide reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions.
- Make arrangements with or referrals to, a sufficient number of physicians and other practitioners to ensure that the services under the contract can be furnished promptly and without compromising the quality of care.

[42 CFR 457.1201(m); 42 CFR 438.3(q)(1); 42 CFR 438.3(q)(3); 42 CFR 438.3(r)] [Existing standard]

I.E.1.03 [Applies to MCO, PIHP, PAHP, NEMT PAHP]

The contract requires that the MCP maintain and monitor a network of appropriate providers that is supported by written agreements. [42 CFR 457.1230(a); 42 CFR 438.206(b)(1)] [Existing standard]

I.E.1.04 [Applies to MCO, PIHP, PAHP, NEMT PAHP]

The contract requires that the MCP maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities. [42 CFR 457.1230(a); 42 CFR 438.206(b)(1)] [Existing standard]

I.E.1.05 [Applies to MCO, PIHP, PAHP]

The contract requires that the MCP demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. [42 CFR 457.1230(a); 42 CFR 438.206(b)(7)] [Existing standard]

I.E.1.06 [Applies to MCO, PIHP, PAHP]*

The contract requires the MCP to give assurances and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the state's standards for access and timeliness of care. [42 CFR 457.1230(b); 42 CFR 438.207(a); 42 CFR 438.68; 42 CFR 438.206(c)(1)] [Existing standard]

I.E.1.07 [Applies to MCO, PIHP, PAHP]*

The contract requires the MCP to submit documentation to the state, in a format specified by the state, to demonstrate that it offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees for the service area. [42 CFR 457.1230(b); 42 CFR 438.207(b)(1)] [Existing standard]

I.E.1.08 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to submit documentation to the state, in a format specified by the state, to demonstrate that it maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. [42 CFR 457.1230(b); 42 CFR 438.207(b)(2)] [Existing standard]

- I.E.1.09 [Applies to MCO, PIHP, PAHP]
The contract requires the MCP to submit documentation as specified by the state, but no less frequently than the following: 1) at the time it enters into a contract with the state; 2) on an annual basis; 3) at any time there has been a significant change (as defined by the state) in the MCP's operations that would affect the adequacy of capacity and services, including changes in MCP services, benefits, geographic service area, composition of or payments to its provider network, or at the enrollment of a new population in the MCP. [42 CFR 457.1230(b); 42 CFR 438.207(b) - (c)] [Existing standard]
- I.E.1.10 [Applies to PCCM entity]
The contract restricts enrollment to recipients who reside sufficiently near one of the PCCM entity's delivery sites to reach that site within a reasonable time using available and affordable modes of transportation. [42 CFR 457.1201(m); 42 CFR 438.3(q)(2); 42 CFR 438.3(r)] [Existing standard]

I.E.2 No Discrimination

- I.E.2.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
The contract prohibits MCPs from discriminating against any provider (limiting their participation, reimbursement or indemnification) who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. [42 CFR 457.1208; 42 CFR 438.12(a)(1)] [Existing standard]

I.E.3 Provider Selection

- I.E.3.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
The contract requires the MCP to give written notice of the reason for its decision when it declines to include individual or groups of providers in its provider network. [42 CFR 457.1208; 42 CFR 438.12(a)(1)] [Existing standard]
- I.E.3.02 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
The contract requires the MCP to implement written policies and procedures for selection and retention of network providers. [42 CFR 457.1208; 42 CFR 457.1233(a); 42 CFR 438.12(a)(2); 42 CFR 438.214(a)] [Existing standard]
- I.E.3.03 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
In all contracts with network providers, the MCP must follow the state's uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, substance use disorder, and LTSS providers, as appropriate. [42 CFR 457.1208; 42 CFR 457.1233(a); 42 CFR 438.12(a)(2); 42 CFR 438.214(b)(1)] [Existing standard]
- I.E.3.04 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
In all contracts with network providers, the MCP must follow a documented process for credentialing and recredentialing of network providers. [42 CFR 457.1208; 42 CFR 457.1233(a); 42 CFR 438.12(a)(2); 42 CFR 438.214(b)(2)] [Existing standard]
- I.E.3.05 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
In all contracts with network providers, the MCP's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or

specialize in conditions that require costly treatment. [42 CFR 457.1208; 42 CFR 457.1233(a); 42 CFR 438.12(a)(2); 42 CFR 438.214(c)] [Existing standard]

I.E.3.06 [Applies to MCO, PIHP, PAHP, NEMT PAHP]

In all contracts with network providers, the MCP must comply with any additional provider selection requirements established by the state. [42 CFR 457.1208; 42 CFR 457.1233(a); 42 CFR 438.12(a)(2); 42 CFR 438.214(e)] [Existing standard]

I.E.3.07 [Applies to MCO, PIHP, PAHP, NEMT PAHP]

The contract does not require the MCP to contract with more providers than necessary to meet the needs of its enrollees. [42 CFR 457.1208; 42 CFR 438.12(b)(1)] [Existing standard]

I.E.3.08 [Applies to MCO, PIHP, PAHP, NEMT PAHP]

The contract does not preclude the MCP from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. [42 CFR 457.1208; 42 CFR 438.12(b)(2)] [Existing standard]

I.E.3.09 [Applies to MCO, PIHP, PAHP, NEMT PAHP]

The contract does not preclude the MCP from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees. [42 CFR 457.1208; 42 CFR 438.12(b)(3)] [Existing standard]

I.E.3.10 [Applies to MCO, PIHP, PAHP]

The contract requires that the MCP demonstrate that its network providers are credentialed as required under 42 CFR 438.214. [42 CFR 457.1230(a); 42 CFR 438.206(b)(6)] [Existing standard]

I.E.4 Anti-gag

I.E.4.01 - I.E.4.04 [Applies to MCO, PIHP, PAHP]

The contract requires that the MCP does not prohibit or restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient regarding:

- The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- Any information the enrollee needs to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

[Section 1932(b)(3)(A) of the Act; 42 CFR 457.1222; 42 CFR 438.102(a)(1)(i) - (iv)]
[Existing standard]

I.E.4.05 [Applies to MCO, PIHP, PAHP]

The contract requires that the MCP take no punitive action against a provider who either requests an expedited resolution or supports an enrollee's appeal. [42 CFR 457.1260(f); 42 CFR 438.410(b)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.E.5 Network Adequacy Standards

I.E.5.01 - I.E.5.06 [Applies to MCO, PIHP, PAHP]

The contract requires that:

- The MCP and its network providers meet the state standards for timely access to care and services, taking into account the urgency of need for services.
- The MCP's network providers offer hours of operation that are no less than the hours offered to commercial enrollees or are comparable to Medicaid FFS, if the provider serves only CHIP enrollees.
- The MCP make services available 24 hours a day, 7 days a week, when medically necessary.
- The MCP establish mechanisms to ensure that its network providers comply with the timely access requirements.
- The MCP monitor network providers regularly to determine compliance with the timely access requirements.
- The MCP take corrective action if it, or its network providers, fail to comply with the timely access requirements.

[42 CFR 457.1230(a); 42 CFR 438.206(c)(1)(i) - (vi)] [Existing standard]

I.E.5.07 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for CHIP enrollees with physical or mental disabilities. [42 CFR 457.1230(a); 42 CFR 438.206(c)(3)] [Existing standard]

I.E.5.08 - I.E.5.19 [Applies to MCO, PIHP, PAHP]

The contract requires that the MCP will adhere to the quantitative network adequacy standards developed by the state in all geographic areas in which the MCP operates for the following provider types, if the provider type is covered under the contract:

- Adult PCPs
- Pediatric PCPs.
- Obstetrics and Gynecology (OB/GYN) providers.
- Adult mental health providers.
- Adult substance use disorder providers.
- Pediatric mental health providers.
- Pediatric substance use disorder providers.
- Adult specialists (designated by the state).
- Pediatric specialists (designated by the state).
- Hospitals.
- Pharmacies.
- Pediatric dental providers.

[42 CFR 457.1218; 42 CFR 438.68(b)(1)(i) - (vii)] [Existing standard. The 2020 Final Rule replaced "time and distance standards" with "quantitative network adequacy standards" at 42 CFR 457.1218, cross-referenced at 42 CFR 438.68(b)(1) effective 12/14/2020.]

I.E.5.20 [Applies to MCO, PIHP, PAHP]

For MCPs that provide LTSS services, the contract requires that the MCP will adhere to the

quantitative network adequacy standards for LTSS provider types developed by the state. [42 CFR 457.1218; 42 CFR 438.68(b)(2)(i)] [Existing standard. The 2020 Final Rule replaced “time and distance standards” with “quantitative network adequacy standards” at 42 CFR 457.1218, cross-referenced at 42 CFR 438.68(b)(1) effective 12/14/2020.]

I.E.5.21 [Applies to MCO, PIHP, PAHP]

For MCPs that provide LTSS services, the contract requires that the MCP will meet state quantitative network adequacy standards in all geographic areas in which the MCP operates for LTSS services. States are permitted to have varying standards for the same provider type based on geographic areas. [42 CFR 457.1218; 42 CFR 438.68(b)(3); 42 CFR 438.68(b)(2)] [Existing standard]

I.E.5.22 [Applies to MCO, PIHP, PAHP]

If the state has developed an exceptions process for MCPs for the state-developed quantitative network adequacy standards, the contract describes the standards by which any exceptions will be evaluated and approved. [42 CFR 457.1218; 42 CFR 438.68(d)(1)] [Existing standard]

I.E.6 Provider Notification of Grievance and Appeals Rights

I.E.6.01 - I.E.6.03 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to inform providers and subcontractors, at the time they enter into a contract, about:

- Enrollee grievance, appeal, and fair hearing procedures and timeframes as specified in 42 CFR 438.400 through 42 CFR 438.424 and described in the Grievance and Appeals section of this State Guide.
- The enrollee’s right to file grievances and appeals and the requirements and timeframes for filing.
- The availability of assistance to the enrollee with filing grievances and appeals.

[42 CFR 457.1260(g); 42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(A) - (C)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.E.6.04 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to inform providers and subcontractors, at the time they enter into a contract, about the enrollee's right to request a state review after the MCP has made a determination on an enrollee's appeal which is adverse to the enrollee. [42 CFR 457.1260(g); 42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(D)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.E.6.05 [Applies to MCO, PIHP, PAHP]

The contract requires that the MCP must inform providers and subcontractors, at the time they enter into a contract, about the enrollee’s right to request continuation of benefits that the MCP seeks to reduce or terminate during an appeal or state review filing, if filed within the allowable timeframes, although the enrollee may be liable for the cost of any continued benefits while the appeal or state review is pending if the final decision is adverse to the enrollee. [42 CFR 457.1260(g); 42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(E)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.E.7 Balance Billing

- I.E.7.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]
The contract obligates the MCP to require that subcontractors and referral providers not bill enrollees, for covered services, any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing by providers). [Section 1932(b)(6) of the Act; 42 CFR 457.1233(b); 42 CFR 438.230(c)(1) - (2)] [Existing standard for MCO, PIHP, PAHP, and NEMT PAHP. New requirement for PCCM entity, effective 12/14/2020]

I.E.8 Physician Incentive Plan

- I.E.8.01 [Applies to MCO, PIHP, PAHP]
The contract requires that the MCP may only operate a physician incentive plan if no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an incentive to reduce or limit medically necessary services to an enrollee. [Section 1903(m)(2)(A)(x) of the Act; 42 CFR 457.1201(h); 42 CFR 422.208(c)(1); 42 CFR 438.3(i)] [Existing standard]
- I.E.8.02 [Applies to MCO, PIHP, PAHP]*
The contract requires that if the MCP puts a physician/physician group at substantial financial risk for services not provided by the physician/physician group, the MCP must ensure that the physician/physician group has adequate stop-loss protection. [Section 1903(m)(2)(A)(x) of the Act; 42 CFR 457.1201(h); 42 CFR 422.208(c)(2); 42 CFR 438.3(i)] [Existing standard]

I.E.9 Network Requirements Involving Indians, Indian Health Care Providers (IHCPs), and Indian Managed Care Entities (IMCEs)

- I.E.9.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*
The contract requires the MCP to demonstrate that there are sufficient IHCPs participating in the provider network to ensure timely access to services available under the contract from such providers for Indian enrollees who are eligible to receive services. [42 CFR 457.1209; 42 CFR 438.14(b)(1); 42 CFR 438.14(b)(5)] [Existing standard]
- I.E.9.02 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]
The contract requires that IHCPs, whether participating or not, be paid for covered services provided to Indian enrollees, who are eligible to receive services at a negotiated rate between the MCP and IHCP or, in the absence of a negotiated rate, at a rate not less than the level and amount of payment the managed care entity would make for the services to a participating provider that is not an IHCP. [42 CFR 457.1209; 42 CFR 438.14(b)(2)(i) - (ii)] [Existing standard]
- I.E.9.03 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]
The contract requires that Indian enrollees are permitted to obtain covered services from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive such services. [42 CFR 457.1209; 42 CFR 438.14(b)(4)] [Existing standard]
- I.E.9.04 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]
The contract requires that the MCP must permit an out-of-network IHCP to refer an Indian enrollee to a network provider. [42 CFR 457.1209; 42 CFR 438.14(b)(6)] [Existing standard]

I.E.10 Practice guidelines

I.E.10.01 [Applies to MCO, PIHP, PAHP]*

The contract requires that the MCP disseminate practice guidelines to all affected providers.
[42 CFR 457.1233(c); 42 CFR 438.236(c)] [Existing standard]

I.F. Coverage

I.F.1 Emergency and Post-Stabilization Services

I.F.1.01 - I.F.1.02 [Applies to MCO, PIHP, PAHP]*

The contract requires the MCP to cover and pay for:

- Emergency services.*
- Post-stabilization care services.*

[Section 1852(d)(2) of the Act; 42 CFR 457.1228; 42 CFR 438.114(b); 42 CFR 422.113(c)]
[Existing standard]

I.F.1.03 - I.F.1.05 [Applies to MCO, PIHP, PAHP]*

The contract:

- Requires the MCP to cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCP.*
- Prohibits the MCP from denying payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.*
- Prohibits the MCP from denying payment for treatment obtained when a representative of the MCP instructs the enrollee to seek emergency services.*

[Section 1932(b)(2) of the Act; 42 CFR 457.1228; 42 CFR 438.114(c)(1)(i); 42 CFR 438.114(c)(1)(ii)(A) - (B)] [Existing standard]

I.F.1.06 [Applies to PCCM, PCCM entity]*

The contract requires the MCP to allow enrollees to obtain emergency services outside the primary care case management system regardless of whether the case manager referred the enrollee to the provider that furnished the services. [42 CFR 457.1228; 42 CFR 438.114(c)(2)]
[Existing standard]

I.F.1.07 - I.F.1.08 [Applies to MCO, PIHP, PAHP]*

The contract prohibits the MCP from:

- Limiting what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.*
- Refusing to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's PCP, MCP, or applicable state entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.*

[42 CFR 457.1228; 42 CFR 438.114(d)(1)(i) - (ii)] [Existing standard]

I.F.1.09 [Applies to MCO, PIHP, PAHP]*

The contract provides that the MCP may not hold an enrollee who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition. [42 CFR 457.1228; 42 CFR 438.114(d)(2)] [Existing standard]

I.F.1.10 - I.F.1.11 [Applies to MCO, PIHP, PAHP]*

The contract provides that:

- The MCP is responsible for coverage and payment of services until the attending emergency physician, or the provider actually treating the enrollee, determines that the enrollee is sufficiently stabilized for transfer or discharge.*
- The determination of the attending emergency physician, or the provider actually treating the enrollee, of when the enrollee is sufficiently stabilized for transfer or discharge is binding on the MCP and state for coverage and payment of emergency and poststabilization services.*

[42 CFR 457.1228; 42 CFR 438.114(d)(3)] [Existing standard]

I.F.1.12 - I.F.1.16 [Applies to MCO, PIHP, PAHP]*

The contract requires the MCP to cover post-stabilization care services:

- Obtained within or outside the MCP network that are:
 - Pre-approved by an MCP plan provider or representative.*
 - Not pre-approved by an MCP provider or representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MCP for pre-approval of further post-stabilization care services.*
- Administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCP network when the MCP:
 - Did not respond to a request for pre-approval within 1 hour.*
 - Could not be contacted.*
 - Representative and the treating physician could not reach agreement concerning the enrollee's care and an MCP physician was not available for consultation.*

[42 CFR 457.1228; 42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i) - (ii); 42 CFR 422.113(c)(2)(iii)(A) - (C)] [Existing standard]

I.F.1.17 [Applies to MCO, PIHP, PAHP]*

The contract requires the MCP to limit charges to enrollees for post-stabilization care services to an amount no greater than what the MCP would charge the enrollee if he or she obtained the services through the MCP. [42 CFR 457.1288; 42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv)] [Existing standard]

I.F.1.18 - I.F.1.21 [Applies to MCO, PIHP, PAHP]*

The contract provides that the MCP's financial responsibility for post-stabilization care services it has not pre-approved ends when:

- An MCP physician with privileges at the treating hospital assumes responsibility for the enrollee's care.*
- An MCP physician assumes responsibility for the enrollee's care through transfer.*

- An MCP representative and the treating physician reach an agreement concerning the enrollee's care.*
- The enrollee is discharged.*

[42 CFR 457.1228; 42 CFR 438.114(e); 42 CFR 422.113(c)(3)(i) - (iv)] [Existing standard]

I.F.2 Delivery Network

I.F.2.01 [Applies to MCO, PIHP, PAHP]*

If a female enrollee's designated primary care physician is not a women's health specialist, the contract requires the MCP to provide the enrollee with direct access to a women's health specialist within the provider network for covered routine and preventive women's health care services. [42 CFR 457.1230(a); 42 CFR 438.206(b)(2)] [Existing standard]

I.F.2.02 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to provide for a second opinion from a network provider, or arrange for the enrollee to obtain a second opinion outside the network, at no cost to the enrollee. [42 CFR 457.1230(a); 42 CFR 438.206(b)(3)] [Existing standard]

I.F.2.03 [Applies to MCO, PIHP, PAHP]

The contract requires that if the MCP's provider network is unable to provide necessary medical services covered under the contract to a particular enrollee, the MCP must adequately and timely cover the services out of network, for as long as the MCP's provider network is unable to provide them. [42 CFR 457.1230(a); 42 CFR 438.206(b)(4)] [Existing standard]

I.F.2.04 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to coordinate payment with out-of-network providers and ensure the cost to the enrollee is no greater than it would be if the services were furnished within the network. [42 CFR 457.1230(a); 42 CFR 438.206(b)(5)] [Existing standard]

I.F.2.05 [Applies to MCO, PIHP, PAHP]*

The contract requires the MCP to use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in the same classification. [42 CFR 457.1201(1); 42 CFR 457.496(d)(5)] [Existing standard]

I.F.3 Services Not Covered Based on Moral Objections

I.F.3.01 [Applies to MCO, PIHP, PAHP]

The contract specifies that an MCP that would otherwise be required to provide, reimburse for, or provide coverage of a counseling or referral service is not required to do so if the MCP objects to the service on moral or religious grounds. [Section 1932(b)(3)(B)(i) of the Act; 42 CFR 457.1222; 42 CFR 438.102(a)(2)] [Existing standard]

I.F.3.02 [Applies to MCO, PIHP, PAHP]

The contract requires an MCP that elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, to furnish information about the services it does not cover to the state with its application for a

Medicaid contract. [Section 1932(b)(3)(B)(i) of the Act; 42 CFR 457.1222; 42 CFR 438.102(b)(1)(i)(A)(1)] [Existing standard]

I.F.3.03 [Applies to MCO, PIHP, PAHP]

The contract requires an MCP that elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, to furnish information about the services it does not cover to the state whenever it adopts such a policy during the term of the contract. [Section 1932(b)(3)(B)(i) of the Act; 42 CFR 457.1222; 42 CFR 438.102(b)(1)(i)(A)(2)] [Existing standard]

I.F.4 Amount, Duration and Scope

I.F.4.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP]

The contract identifies, defines, and specifies the amount, duration, and scope of each service the MCP is required to offer. [42 CFR 457.1230(d); 42 CFR 438.210(a)(1)] [Existing standard]

I.F.4.02 [Applies to MCO, PIHP, PAHP, NEMT PAHP]

The contract requires that each service the MCP is required to provide be furnished in an amount, duration and scope that is no less than the amount, duration and scope for the same services provided under FFS Medicaid. [42 CFR 457.1230(d); 42 CFR 438.210(a)(2)] [Existing standard]

I.F.4.03 [Applies to MCO, PIHP, PAHP, NEMT PAHP]

The contract requires that the MCP provide services for enrollees under the age of 21 to the same extent that services are furnished to individuals under the age of 21 under FFS CHIP (if applicable). [42 CFR 457.1230(d); 42 CFR 438.210(a)(2)] [Existing standard]

I.F.4.04 [Applies to MCO, PIHP, PAHP, NEMT PAHP]

The contract requires the MCP to ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. [42 CFR 457.1230(d); 42 CFR 438.210(a)(3)(i)] [Existing standard]

I.F.4.05 [Applies to MCO, PIHP, PAHP, NEMT PAHP]

The contract prohibits the MCP from arbitrarily denying or reducing the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the enrollee. [42 CFR 457.1230(d); 42 CFR 438.210(a)(3)(ii)] [Existing standard]

I.F.4.06 [Applies to MCO, PIHP, PAHP, NEMT PAHP]

The contract allows the MCP to place appropriate limits on a service on the basis of criteria applied under the CHIP State Plan, such as medical necessity. [42 CFR 457.1230(d); 42 CFR 438.210(a)(4)(i)] [Existing standard]

I.F.4.07 [Applies to MCO, PIHP, PAHP, NEMT PAHP]

The contract allows the MCP to place appropriate limits on a service for utilization control, provided the services furnished can reasonably achieve their purpose. [42 CFR 457.1230(d); 42 CFR 438.210(a)(4)(ii)(A)] [Existing standard]

- I.F.4.08 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
The contract allows the MCP to place appropriate limits on a service for utilization control, provided the services supporting individuals with ongoing or chronic conditions or who require LTSS are authorized in a manner that reflects the enrollee’s ongoing need for such services and supports. [42 CFR 457.1230(d); 42 CFR 438.210(a)(4)(ii)(B)] [Existing standard]
- I.F.4.09 [Applies to MCO, PIHP, PAHP]
The contract allows the MCP to place appropriate limits on a service for utilization control, provided family planning services are provided in a manner that protects and enables the enrollee’s freedom to choose the method of family planning to be used. [42 CFR 457.1230(d); 42 CFR 438.210(a)(4)(ii)(C)] [Existing standard]
- I.F.4.10 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
The contract specifies that the MCP may cover, in addition to services covered under the state plan, any services necessary for compliance with the requirements for parity in MH/SUD benefits in 42 CFR 457.496, and the contract identifies the types and amount, duration and scope of services consistent with the analysis of parity compliance conducted by either the state or the MCO. [42 CFR 457.1201(e); 42 CFR 438.3(e)(1)(ii)] [Existing standard]
- I.F.4.11 - I.F.4.15 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
The contract specifies that the MCP may cover services or settings for enrollees that are in lieu of those covered under the state plan if:
- The state determines that the alternative service or setting is a medically appropriate substitute for the covered service or setting under the state plan.
 - The state determines that the alternative service or setting is a cost effective substitute for the covered service or setting under the state plan.
 - The enrollee is not required by the MCP to use the alternative service or setting.
 - The approved in lieu of services are authorized and identified in the MCP contract.
 - The approved in lieu of services are offered to enrollees at the option of the MCP.
- [42 CFR 457.1201(e); 42 CFR 438.3(e)(2)(i) - (iii)] [Existing standard]

I.F.5 Parity in Mental Health and Substance Use Disorder (MH/SUD) Benefits

This requirement applies to all states:

- I.F.5.01 [Applies to MCO, PIHP, PAHP]
The contract specifies the necessary documentation and reporting required from the MCP to the state to establish and demonstrate compliance with 42 CFR 457.1201(l) and 42 CFR 457.496 regarding parity in MH/SUD benefits. [61 Fed. Reg. 18413, 18414 and 18415 (March 30, 2016)] [Existing standard]

The following requirements described at items I.F.5.02 through I.F.5.08 apply depending on the state’s benefit limitations and financial requirements:

- I.F.5.02 [Applies to MCO, PIHP, PAHP]*
The contract specifies that if the MCP does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits provided to enrollees through a contract with the state, it may not impose an aggregate lifetime or annual dollar limit,

respectively, on mental health or substance use disorder benefits. [42 CFR 457.1201(l); 42 CFR 457.496(c)(1)] [Existing standard]

I.F.5.03 [Applies to MCO, PIHP, PAHP]*

The contract specifies that if the MCP includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits provided to enrollees through a contract with the state, it must either apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is more restrictive than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits. [42 CFR 457.1201(l); 42 CFR 457.496(c)(2)] [Existing standard]

I.F.5.04 [Applies to MCO, PIHP, PAHP]*

The contract specifies that if the MCP includes an aggregate lifetime limit or annual dollar amount that applies to one-third or more but less than two-thirds of all medical/surgical benefits provided to enrollees through a contract with the state, it must either impose no aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits; or impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits in accordance with 42 CFR 438.496(c)(4)(B). [42 CFR 457.1201(l); 42 CFR 457.496(c)(4)] [Existing standard]

I.F.5.05 [Applies to MCO, PIHP, PAHP]*

The contract specifies that the MCP must not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees (whether or not the benefits are furnished by the same MCP). [42 CFR 457.1201(l); 42 CFR 457.496(d)(2)(i)] [Existing standard]

I.F.5.06 [Applies to MCO, PIHP, PAHP]

The contract specifies that if an MCO enrollee is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits must be provided to the MCO enrollee in every classification in which medical/surgical benefits are provided. [42 CFR 457.1201(l); 42 CFR 457.496(d)(2)(ii)] [Existing standard]

I.F.5.07 [Applies to MCO, PIHP, PAHP]

The contract specifies that the MCP may not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(3)(iii)] [Existing standard]

- I.F.5.08 [Applies to MCO, PIHP, PAHP]*
The contract specifies that the MCP may not impose Non-Quantitative Treatment Limitations (NQTLs) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the MCP as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(4)] [Existing standard]

I.F.6 Enrollee Rights

- I.F.6.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract requires the MCP to have written policies guaranteeing each enrollee's right to receive information on the managed care program and plan into which he/she is enrolled. [42 CFR 457.1220; 42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(i)] [Existing standard]
- I.F.6.02 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract requires the MCP to have written policies guaranteeing each enrollee's right to be treated with respect and with due consideration for his or her dignity and privacy. [42 CFR 457.1220; 42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(ii)] [Existing standard]
- I.F.6.03 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract requires the MCP to have written policies guaranteeing each enrollee's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. [42 CFR 457.1220; 42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(iii)] [Existing standard]
- I.F.6.04 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract requires the MCP to have written policies guaranteeing each enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment. [42 CFR 457.1220; 42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(iv)] [Existing standard]
- I.F.6.05 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract requires the MCP to have written policies guaranteeing each enrollee's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. [42 CFR 457.1220; 42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(v)] [Existing standard]
- I.F.6.06 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*
The contract requires the MCP to have written policies guaranteeing each enrollee's right to request and receive a copy of his or her medical records, and to request that they be amended or corrected. [42 CFR 457.1220; 42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(vi)] [Existing standard]

- I.F.6.07 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract requires that each enrollee is free to exercise his or her rights without the MCP or its network providers treating the enrollee adversely. [42 CFR 457.1220; 42 CFR 438.100(a)(1); 42 CFR 438.100(c)] [Existing standard]

I.G. Quality and Utilization Management

I.G.1 External Quality Review (EQR)

- I.G.1.01 [Applies to MCO, PIHP, PAHP, PCCM entity]*
The contract requires the MCP to undergo annual, external independent reviews of the quality, timeliness, and access to the services covered under each contract. [42 CFR 457.1250(a); 42 CFR 457.1240(f); 42 CFR 457.1201(n)(2); 42 CFR 438.350] [Existing standard]

I.G.2 Care Coordination

- I.G.2.01 - I.G.2.02 [Applies to MCO, PIHP, PAHP]

The contract requires that the MCP:

- Implement procedures to ensure that each enrollee has an ongoing source of care appropriate to their needs.
- Formally designate a person or entity as primarily responsible for coordinating services accessed by the enrollee.

[42 CFR 457.1230(c); 42 CFR 438.208(b)(1)] [Existing standard]

- I.G.2.03 [Applies to MCO, PIHP, PAHP]

The contract requires that the enrollee be provided information on how to contact their designated person or entity. [42 CFR 457.1230(c); 42 CFR 438.208(b)(1)] [Existing standard]

- I.G.2.04 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to implement procedures to coordinate the services the MCP furnishes to the enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. [42 CFR 457.1230(c); 42 CFR 438.208(b)(2)(i)] [Existing standard]

- I.G.2.05 [Applies to MCO, PIHP, PAHP]*

The contract requires the MCP to implement procedures to coordinate services the MCP furnishes to the enrollee with the services the enrollee receives from any other MCO, PIHP, or PAHP. [42 CFR 457.1230(c); 42 CFR 438.208(b)(2)(ii)] [Existing standard]

- I.G.2.06 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to implement procedures to coordinate the services the MCP furnishes to the enrollee with the services the enrollee receives in FFS Medicaid [42 CFR 457.1230(c); 42 CFR 438.208(b)(2)(iii)] [Existing standard]

- I.G.2.07 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to implement procedures to coordinate the services the MCP furnishes to the enrollee with the services the enrollee receives from community and social support providers [42 CFR 457.1230(c); 42 CFR 438.208(b)(2)(iv)] [Existing standard]

I.G.2.08 - I.G.2.09 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to:

- Make a best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees.
- Make subsequent attempts to conduct an initial screening of each enrollee's needs if the initial attempt to contact the enrollee is unsuccessful.

[42 CFR 457.1230(c); 42 CFR 438.208(b)(3)] [Existing standard]

I.G.2.10 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to share with the state or other MCOs, PIHPs, and PAHPs serving the enrollee the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities. [42 CFR 457.1230(c); 42 CFR 438.208(b)(4)] [Existing standard]

I.G.2.11 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to ensure that each provider furnishing services to enrollees maintains and shares an enrollee health record in accordance with professional standards [42 CFR 457.1230(c); 42 CFR 438.208(b)(5)] [Existing standard]

I.G.2.12 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to use and disclose individually identifiable health information, such as medical records and any other health or enrollment information that identifies a particular enrollee, in accordance with the confidentiality requirements in 45 CFR parts 160 and 164. [42 CFR 457.1230(c); 42 CFR 438.208(b)(6); 42 CFR 438.224; 45 CFR 160; 45 CFR 164] [Existing standard]

I.G.2.13 [Applies to MCO, PIHP, PAHP]*

The contract specifies that the MCP will implement a transition of care policy that is consistent with federal requirements and at least meets the state defined transition of care policy. [42 CFR 457.1216; 42 CFR 438.62(b)(1) - (2)] [Existing standard]

I.G.3 Authorization and Utilization Management

I.G.3.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP]

The contract requires that the MCP and its subcontractors have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services. [42 CFR 457.1230(d); 42 CFR 438.210(b)(1)] [Existing standard]

I.G.3.02 [Applies to MCO, PIHP, PAHP, NEMT PAHP]

The contract requires the MCP to have in effect mechanisms to ensure consistent application of review criteria for authorization decisions. [42 CFR 457.1230(d); 42 CFR 438.210(b)(2)(i)] [Existing standard]

I.G.3.03 [Applies to MCO, PIHP, PAHP, NEMT PAHP]

The contract requires the MCP to consult with the requesting provider for medical services when appropriate. [42 CFR 457.1230(d); 42 CFR 438.210(b)(2)(ii)] [Existing standard]

- I.G.3.04 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
The contract requires that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs. [42 CFR 457.1230(d); 42 CFR 438.210(b)(3)] [Existing standard]
- I.G.3.05 [Applies to MCO, PIHP, PAHP]*
The contract requires that the MCP's prior authorization requirements comply with the requirements for parity in MH/SUD in 42 CFR 457.496(d)(4)(i). [42 CFR 457.496(d)(4)(i)] [Existing standard]
- I.G.3.06 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
The contract requires that for standard authorization decisions, the MCP provide notice as expeditiously as the enrollee's condition requires and within state-established timeframes that may not exceed 14 calendar days after receipt of request for service, with a possible extension of 14 days if the enrollee or provider requests an extension or the MCP justifies the need for additional information and how the extension is in the enrollee's interest. [42 CFR 457.1230(d); 42 CFR 438.210(d)(1)] [Existing standard]
- I.G.3.07 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
The contract requires that when a provider indicates, or the MCP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service. [42 CFR 457.1230(d); 42 CFR 438.210(d)(2)] [Existing standard]
- I.G.3.08 [Applies to MCO, PIHP, PAHP]
The contract requires that for all covered outpatient drug authorization decisions, each MCP contract must provide notice as described in section 1927(d)(5)(A) of the Act. Under this section, the plan may require as a condition of coverage or payment for a covered outpatient drug for which Federal Financial Participation (FFP) is available the approval of the drug before its dispensing for any medically accepted indication only if the system providing for such approval provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization. [42 CFR 457.1230(d); 42 CFR 438.210(d)(3)] [Existing standard]
- I.G.3.09 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
The contract specifies that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for denying, limiting, or discontinuing medically necessary services to any enrollee. [42 CFR 457.1230(d); 42 CFR 438.210(e)] [Existing standard]

I.G.4 Practice Guidelines

- I.G.4.01 [Applies to MCO, PIHP, PAHP]
The contract requires the MCP to adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field. [42 CFR 457.1233(c); 42 CFR 438.236(b)(1)] [Existing standard]
- I.G.4.02 [Applies to MCO, PIHP, PAHP]
The contract requires the MCP to adopt practice guidelines that consider the needs of the enrollees. [42 CFR 457.1233(c); 42 CFR 438.236(b)(2)] [Existing standard]
- I.G.4.03 [Applies to MCO, PIHP, PAHP]
The contract requires the MCP to adopt practice guidelines in consultation with network providers. [42 CFR 457.1233(c); 42 CFR 438.236(b)(3)] [Effective: 12/14/2020]
- I.G.4.04 [Applies to MCO, PIHP, PAHP]
The contract requires the MCP to review and update practice guidelines periodically as appropriate. [42 CFR 457.1233(c); 42 CFR 438.236(b)(4)] [Existing standard]
- I.G.4.05 [Applies to MCO, PIHP, PAHP]
The contract requires that decisions regarding utilization management, enrollee education, coverage of services, and other areas to which practice guidelines apply should be consistent with such practice guidelines. [42 CFR 457.1233(c); 42 CFR 438.236(d)] [Existing standard]

I.G.5 Quality

- I.G.5.01 [Applies to MCO, PIHP, PAHP, PCCM entity]*
The contract requires that the MCP establish and implement an ongoing Comprehensive Quality Assessment and Performance Improvement (QAPI) program for the services it furnishes to its enrollees. [42 CFR 457.1240(b); 42 CFR 457.1240(b)(2); 42 CFR 438.330(a)(1); 42 CFR 438.330(a)(3)] [Existing standard for MCO, PIHP, and PAHP. New requirement for PCCM entity, effective 12/14/2020]
- I.G.5.02 [Applies to MCO, PIHP, PAHP]
The contract requires that the comprehensive QAPI program must include Performance Improvement Projects (PIP), including any required by the state or CMS, that focus on clinical and non-clinical areas. [42 CFR 457.1240(b); 42 CFR 438.330(b)(1); 42 CFR 438.330(d)(1); 42 CFR 438.330(a)(2)] [Existing standard]
- I.G.5.03 [Applies to MCO, PIHP, PAHP, PCCM entity]*
The contract requires that the comprehensive QAPI program must include collection and submission of performance measurement data, including any required by the state or CMS. [42 CFR 457.1240(b); 42 CFR 438.330(b)(2); 42 CFR 438.330(c); 42 CFR 457.1201(n)(2); 42 CFR 438.330(a)(2)] [Existing standard for MCO, PIHP, and PAHP. New requirement for PCCM entity, effective 12/14/2020]

- I.G.5.04 [Applies to MCO, PIHP, PAHP, PCCM entity]*
The contract requires that the comprehensive QAPI program must include mechanisms to detect both underutilization and overutilization of services. [42 CFR 457.1240(b); 42 CFR 457.1240(f); 42 CFR 457.1201(n)(2); 42 CFR 438.330(b)(3)] [Existing standard]
- I.G.5.05 [Applies to MCO, PIHP, PAHP]
The contract requires that the comprehensive QAPI program must include mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the state in the quality strategy. [42 CFR 457.1240(b); 42 CFR 438.330(b)(4); 42 CFR 438.340] [Existing standard]
- I.G.5.06 [Applies to MCO, PIHP, PAHP, PCCM entity]*
The contract requires that each MCP annually: measure and report to the state on its performance, using the standard measures required by the state; submit to the state data, specified by the state, which enables the state to calculate the MCP's performance using the standard measures identified by the state under paragraph (c)(1); OR perform a combination of these activities. [42 CFR 457.1240(b); 42 CFR 457.1240(f); 42 CFR 457.1201(n)(2); 42 CFR 438.330(c)(1) - (2)] [Existing standard]
- I.G.5.07 [Applies to MCO, PIHP, PAHP]
The contract requires that each PIP be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. [42 CFR 457.1240(b); 42 CFR 438.330(d)(2)] [Existing standard]
- I.G.5.08 [Applies to MCO, PIHP, PAHP]
The contract requires that each PIP include measurement of performance using objective quality indicators. [42 CFR 457.1240(b); 42 CFR 438.330(d)(2)(i)] [Existing standard]
- I.G.5.09 [Applies to MCO, PIHP, PAHP]
The contract requires that each PIP include implementation of interventions to achieve improvement in the access to and quality of care. [42 CFR 457.1240(b); 42 CFR 438.330(d)(2)(ii)] [Existing standard]
- I.G.5.10 [Applies to MCO, PIHP, PAHP]
The contract requires that each PIP include an evaluation of the effectiveness of the interventions based on the performance measures collected as part of the PIP. [42 CFR 457.1240(b); 42 CFR 438.330(d)(2)(iii)] [Existing standard]
- I.G.5.11 [Applies to MCO, PIHP, PAHP]
The contract requires that each PIP include planning and initiation of activities for increasing or sustaining improvement. [42 CFR 457.1240(b); 42 CFR 438.330(d)(2)(iv)] [Existing standard]
- I.G.5.12 [Applies to MCO, PIHP, PAHP]
The contract requires that the MCP report the status and results of each PIP to the state as requested, but not less than once per year. [42 CFR 457.1240(b); 42 CFR 438.330(d)(1) and (3)] [Existing standard]

- I.G.5.13 [Applies to MCO, PIHP, PAHP, PCCM entity]*
At the state's option, the contract requires that the MCP develop a process to evaluate the impact and effectiveness of its own QAPI. [42 CFR 457.1240(b); 42 CFR 457.1240(f); 42 CFR 457.1201(n)(2); 42 CFR 438.330(e)(2); 42 CFR 438.310(c)(2)] [Existing standard]

I.G.6 Cultural Competence

- I.G.6.01 [Applies to MCO, PIHP, PAHP]
The contract requires that the MCP participate in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. [42 CFR 457.1230(a); 42 CFR 438.206(c)(2)] [Existing standard]

I.G.7 Special Health Care Needs: Assessment and Treatment Plans

- I.G.7.01 [Applies to MCO, PIHP, PAHP]
The contract requires that the MCP implement mechanisms to comprehensively assess each enrollee identified as having special health care needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. [42 CFR 457.1230(c); 42 CFR 438.208(c)(2)] [Existing standard]
- I.G.7.02 [Applies to MCO, PIHP, PAHP]
The contract requires that the MCP implement mechanisms to comprehensively assess each CHIP enrollee identified as needing LTSS to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. [42 CFR 457.1230(c); 42 CFR 438.208(c)(2)] [Existing standard]
- I.G.7.03 [Applies to MCO, PIHP, PAHP]
The contract requires that the assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the state or the MCP as appropriate. [42 CFR 457.1230(c); 42 CFR 438.208(c)(2)] [Existing standard]
- I.G.7.04 [Applies to MCO, PIHP, PAHP]
The contract requires that MCPs produce a treatment or service plan for enrollees who require LTSS. [42 CFR 457.1230(c); 42 CFR 438.208(c)(3)] [Existing standard]
- I.G.7.05 [Applies to MCO, PIHP, PAHP]
If the state requires MCPs to produce a treatment or service plan for enrollees with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring, the contract requires that the MCP produce such a treatment or service plan. [42 CFR 457.1230(c); 42 CFR 438.208(c)(3)] [Existing standard]
- I.G.7.06 - I.G.7.10 [Applies to MCO, PIHP, PAHP]*
The contract requires that, for enrollees who require LTSS:
- The MCP must include a treatment or service plan developed by an individual meeting LTSS services coordination requirements with enrollee participation, and in consultation with any providers caring for the enrollee.

- The plan be developed by a person trained in person-centered planning using a person-centered process and plan as defined in 42 CFR 441.301(c)(1) and (2).*
- The treatment or service plan be approved by the MCP in a timely manner, if this approval is required by the MCP.
- The plan be developed in accordance with any applicable state quality assurance and utilization review standards
- The treatment or service plan be reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee.

[42 CFR 457.1230(c); 42 CFR 438.208(c)(3)(i) - (v); 42 CFR 441.301(c)(1) - (3)] [Existing standard]

I.G.7.11 - I.G.7.13 [Applies to MCO, PIHP, PAHP]

The contract requires that, for enrollees with special health care needs as required by the state:

- The treatment or service plan be approved by the MCP in a timely manner, if this approval is required by the MCP.
- The plan be developed in accordance with any applicable state quality assurance and utilization review standards.
- The treatment or service plan be reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee.

[42 CFR 457.1230(c); 42 CFR 438.208(c)(3)(iii) - (v); 42 CFR 441.301(c)(3)] [Existing standard]

I.G.7.14 [Applies to MCO, PIHP, PAHP]*

For enrollees with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the contract requires that the MCP have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs. [42 CFR 457.1230(c); 42 CFR 438.208(c)(4)] [Existing standard]

I.G.8 Accreditation

I.G.8.01 [Applies to MCO, PIHP, PAHP]

The contract requires that each MCP inform the state as to whether it has been accredited by a private independent accrediting entity. [42 CFR 457.1240(c); 42 CFR 438.332(a)] [Existing standard]

I.G.8.02 - I.G.8.04 [Applies to MCO, PIHP, PAHP]

The contract requires that each MCP that has received accreditation by a private independent accrediting entity must authorize the private independent accrediting entity to provide the state a copy of its most recent accreditation review, including:

- Its accreditation status, survey type, and level (as applicable);
- Recommended actions or improvements, corrective action plans, and summaries of findings; and
- The expiration date of the accreditation.

[42 CFR 457.1240(c); 42 CFR 438.332(b)(1) - (3)] [Existing standard]

I.H. Grievances and Appeals

I.H.1 Grievance and Appeals System

I.H.1.01 [Applies to MCO, PIHP, PAHP]

The contract requires that the MCP have a grievance and appeal system in place for enrollees [42 CFR 457.1260(b)(1); 42 CFR 438.402(a)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.1.02 [Applies to MCO, PIHP, PAHP]

The contract requires that the MCP has only one level of appeal for enrollees. [42 CFR 457.1260(b)(1); 42 CFR 438.402(b)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.1.03 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to give enrollees any reasonable assistance in completing grievance and appeal forms and other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with Teletypewriter Telephone/Telecommunication Device for the Deaf (TTY/TDD) and interpreter capability. [42 CFR 457.1260(d); 42 CFR 438.406(a)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.1.04 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to acknowledge receipt of each grievance and appeal of adverse benefit determinations. [42 CFR 457.1260(d); 42 CFR 438.406(b)(1)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.1.05 - I.H.1.06 [Applies to MCO, PIHP, PAHP]

The contract requires that the MCP ensure that decision makers on grievances and appeals of adverse benefit determinations were not:

- Involved in any previous level of review or decision-making.
- Subordinates of any individual who was involved in a previous level of review or decision-making.

[42 CFR 457.1260(d); 42 CFR 438.406(b)(2)(i)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.1.07 - I.H.1.09 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to ensure that decision makers on grievances and appeals of adverse benefit determinations are individuals with appropriate clinical expertise, as determined by the state, in treating the enrollee's condition or disease:

- If the decision involves an appeal of a denial based on lack of medical necessity.
- If the decision involves a grievance regarding denial of expedited resolution of an appeal.
- If the decision involves a grievance or appeal involving clinical issues.

[42 CFR 457.1260(d); 42 CFR 438.406(b)(2)(ii)(A) - (C)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

- I.H.1.10 [Applies to MCO, PIHP, PAHP]
The contract requires the MCP to ensure that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. [42 CFR 457.1260(d); 42 CFR 438.406(b)(2)(iii)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]
- I.H.1.11 [Applies to MCO, PIHP, PAHP, PCCM, PCCM entity]*
If the state requires the enrollee to seek redress through the MCP's grievance system before the state makes a decision on the enrollee's request for disenrollment, the contract requires the MCP to complete review of the grievance in time to permit the disenrollment to be effective no later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCP refers the request to the state. [42 CFR 457.1201(m); 42 CFR 457.1212; 42 CFR 438.56(d)(5)(ii); 42 CFR 438.56(e)(1); 42 CFR 438.228(a)] [Effective: no later than 12/14/2020]

I.H.2 Notice of Adverse Benefit Determination Requirements

- I.H.2.01 [Applies to MCO, PIHP, PAHP]*
The contract requires that the MCP's notice of adverse benefit determination explain the adverse benefit determination the MCP has made or intends to make. [42 CFR 457.1260(c)(1); 42 CFR 438.404(b)(1)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]
- I.H.2.02 [Applies to MCO, PIHP, PAHP]*
The contract requires that the MCP provide timely written notice to the enrollee of an adverse benefit determination. [42 CFR 457.1260(c)(3)] [Existing standard. The federal regulatory citation changed 12/14/2020]
- I.H.2.03 [Applies to MCO, PIHP, PAHP]*
The contract requires that the MCP's notice of adverse benefit determination explain the reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. [42 CFR 457.1260(c)(1); 42 CFR 438.404(b)(2)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]
- I.H.2.04 [Applies to MCO, PIHP, PAHP]*
The contract requires that the MCP's notice of adverse benefit determination explain the enrollee's right to request an appeal of the MCP's adverse benefit determination, including information on exhausting the MCP's one level of appeal and the right to request a state external review after receiving notice that the adverse benefit determination is upheld. [42 CFR 457.1260(c)(2)(i); 42 CFR 457.1260(b)(1); Subpart K of 42 CFR 457; 42 CFR 438.402(b)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

- I.H.2.05 [Applies to MCO, PIHP, PAHP]*
The contract requires that the MCP's notice of adverse benefit determination explain the procedures for exercising the enrollee's rights to appeal. [42 CFR 457.1260(c)(2)(ii)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]
- I.H.2.06 [Applies to MCO, PIHP, PAHP]*
The contract requires that the MCP's notice of adverse benefit determination explain the circumstances under which an appeal process can be expedited and how to request it. [42 CFR 457.1260(c)(1); 42 CFR 438.404(b)(5)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.3 Notice of Adverse Benefit Determination Timing

- I.H.3.01 [Applies to MCO, PIHP, PAHP]
The contract requires the MCP to provide timely written notice of an adverse benefit determination to enrollees. [42 CFR 457.1260(c)(3)] [Effective 12/14/2020]
- I.H.3.02 [Applies to MCO, PIHP, PAHP]
The contract requires that for cases in which a provider indicates, or the MCP determines, that following the standard authorization timeframe could seriously jeopardize the enrollee's life or health or his/her ability to attain, maintain, or regain maximum function, the MCP must make an expedited service authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service. [42 CFR 457.1260(c)(3); 42 CFR 438.404(c)(6); 42 CFR 438.210(d)(2)(i)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]
- I.H.3.03 [Applies to MCO, PIHP, PAHP]
The contract provides that the MCP may extend the 72 hour expedited service authorization decision time period by up to 14 calendar days if the enrollee requests an extension, or if the MCP justifies (to the state agency, upon request) a need for additional information and how the extension is in the enrollee's interest. [42 CFR 1260(c)(3); 42 CFR 438.210(d)(2)(ii); 42 CFR 438.404(c)(6)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]
- I.H.3.04 [Applies to MCO, PIHP, PAHP]
The contract requires the MCP to give notice of adverse benefit determination on the date of determination when the action is a denial of payment. [42 CFR 1260(c)(1); 42 CFR 438.404(c)(2)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.4 Who May File Appeals and Grievances

- I.H.4.01 [Applies to MCO, PIHP, PAHP]*
The contract requires the MCP to allow enrollees to file a grievance or request an appeal with the MCP. [42 CFR 457.1260(b)(2)(i); Subpart K of 42 CFR 457] [Existing standard. The federal regulatory citation changed effective 12/14/2020]
- I.H.4.02 [Applies to MCO, PIHP, PAHP]
The contract requires the MCP to allow enrollees to request a state external review in

accordance with the terms of Subpart K of 42 CFR 457 after receiving notice that the adverse benefit decision was upheld by the MCP under 457.1260(e). [42 CFR 457.1260(b)(2); Subpart K of 42 CFR 457] [Effective: 12/14/2020]

I.H.4.03 [Applies to MCO, PIHP, PAHP]

If state law permits and with written consent of the enrollee, the contract requires the MCP to allow providers or authorized representatives to request an appeal or file a grievance, or request a state external review in accordance with the terms of Subpart K of 42 CFR 457. [42 CFR 457.1260(b)(3)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.5 Timeframes for Filing Appeals

I.H.5.01 [Applies to MCO, PIHP, PAHP]

The contract requires that in the case that the MCP fails to adhere to notice and timing requirements, the enrollee is deemed to have exhausted the MCP's appeals process, and the enrollee may initiate a state external review. [42 CFR 457.1260(e)(3); Subpart K of 42 CFR 457; 42 CFR 438.408)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.5.02 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to allow the enrollee to file an appeal to the MCP within 60 calendar days from the date on the adverse benefit determination notice. [42 CFR 457.1260(b)(1); 42 CFR 438.402(c)(2)(ii)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.5.03 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to allow the provider or authorized representative acting on behalf of the enrollee, as state law permits, to file an appeal to the MCP within 60 calendar days from the date on the adverse benefit determination notice. [42 CFR 457.1260(b)(1); 42 CFR 1260(b)(3); 42 CFR 438.402(c)(2)(ii)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.6 Process for Filing an Appeal or Expedited Appeal Request

I.H.6.01 [Applies to MCO, PIHP, PAHP]

The contract requires that the MCP allow the enrollee to request an appeal either orally or in writing. [42 CFR 457.1260(b)(1); 42 CFR 438.402(c)(3)(ii)] [Existing standard, the 2020 Final Rule deleted the requirement for oral appeals to be followed up in writing]

I.H.6.02 [Applies to MCO, PIHP, PAHP]

The contract requires that the MCP allow the provider or authorized representative acting on behalf of the enrollee, as state law permits, to request an appeal either orally or in writing. [42 CFR 457.1260(b)(3); 42 CFR 457.1260(b)(1); 42 CFR 438.402(c)(3)(ii); Subpart K of 42 CFR 457] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.6.03 [Applies to MCO, PIHP, PAHP]*

The contract requires the MCP to ensure that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals. [42 CFR 457.1260(d); 42 CFR 438.406(b)(3)]

[Existing standard, the 2020 Final Rule deleted the requirement for oral appeals to be followed up in writing]

I.H.6.04 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. [42 CFR 457.1260(d); 42 CFR 438.406(b)(4)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.6.05 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to provide the enrollee and his or her representative the enrollee's case file (including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCP (or at the direction of the MCP)) in connection with the appeal of the adverse benefit determination. [42 CFR 457.1260(d); 42 CFR 438.406(b)(5)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.6.06 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to provide the enrollee and his or her representative the enrollee's case file free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions. For standard resolution of an appeal and notice to the affected parties, the MCP must comply with the state-established timeframe that is no longer than 30 calendar days from the day the MCP receives the appeal. For expedited resolution of an appeal and notice to affected parties, the MCP must comply with the state-established timeframe that is no longer than 72 hours after the MCP receives the appeal. [42 CFR 457.1260(d); 42 CFR 438.406(b)(5); 42 CFR 438.408(b) - (c)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.6.07 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to consider the enrollee, his/her representative, or the legal representative of a deceased enrollee's estate as parties to an appeal. [42 CFR 457.1260(d); 42 CFR 438.406(b)(6)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.6.08 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to establish and maintain an expedited review process for appeals, when the MCP determines (for a request from the enrollee) or when the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. [42 CFR 457.1260(f); 42 CFR 438.410(a)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.6.09 [Applies to MCO, PIHP, PAHP]*

The contract requires the MCP to inform enrollees of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments in the case of an expedited appeal resolution. The MCP must inform enrollees of this sufficiently in

advance of the resolution timeframe for appeals. [42 CFR 457.1260(d); 42 CFR 438.406(b)(4); 42 CFR 438.408(b); 42 CFR 438.408(c)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.6.10 [Applies to MCO, PIHP, PAHP]

The contract requires that if the MCP denies a request for expedited resolution of an appeal, it must transfer the appeal to the standard timeframe of no longer than 30 calendar days from the day the MCP receives the appeal (with a possible 14-day extension). [42 CFR 457.1260(f); 42 CFR 438.410(c); 42 CFR 438.408(b)(2); 42 CFR 438.408(c)(2)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.7 Timeframes for Resolving Appeals and Expedited Appeals

I.H.7.01 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to resolve each appeal and provide notice, as expeditiously as the enrollee's health condition requires, within state-established timeframes not to exceed 30 calendar days from the day the MCP receives the appeal. [42 CFR 457.1260(e)(1)-(2); 42 CFR 438.408(b)(2)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.7.02 – I.H.7.03 [Applies to MCO, PIHP, PAHP]

The contract provides that the MCP may extend the timeframe for processing an appeal by up to 14 calendar days if the enrollee requests the extension, or if the MCP shows that there is need for additional information and how the delay is in the enrollee's interest (upon state request). [42 CFR 457.1260(e)(1); 42 CFR 438.408(c)(1)(i)-(ii); 42 CFR 438.408(b)(2)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.7.04 - I.H.7.06 [Applies to MCO, PIHP, PAHP]

The contract specifies that if the MCP extends the timeline for an appeal not at the request of the enrollee, it must:

- Make reasonable efforts to give the enrollee prompt oral notice of the delay.
- Give the enrollee written notice, within 2 calendar days, of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
- Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

[42 CFR 457.1260(e)(1); 42 CFR 438.408(c)(2)(i) - (iii); 42 CFR 438.408(b)(2)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.7.07 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to resolve each expedited appeal and provide notice, as expeditiously as the enrollee's health condition requires, within state-established timeframes not to exceed 72 hours after the MCP receives the expedited appeal request. [42 CFR 457.1260(e)(1)-(2); 42 CFR 438.408(b)(3)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.7.08 - I.H.7.09 [Applies to MCO, PIHP, PAHP]

The contract provides that the MCP may extend the timeframe for processing an expedited

appeal by up to 14 calendar days:

- If the enrollee requests the extension; or
- If the MCP shows that there is need for additional information and that the delay is in the enrollee's interest (upon state request).

[42 CFR 457.1260(e)(1); 42 CFR 438.408(c)(1)(i) - (ii); 42 CFR 438.408(b)(3)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.7.10 - I.H.7.12 [Applies to MCO, PIHP, PAHP]

The contract requires that if the MCP extends the timeline for processing an expedited appeal not at the request of the enrollee, it must:

- Make reasonable efforts to give the enrollee prompt oral notice of the delay.
- Give the enrollee written notice, within 2 calendar days, of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
- Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

[42 CFR 457.1260(e)(1)-(2); 42 CFR 438.408(c)(2)(i) - (iii); 42 CFR 438.408(b)(3)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.8 Notice of Resolution for Appeals

I.H.8.01 - I.H.8.04 [Applies to MCO, PIHP, PAHP]*

The contract requires that the MCP provide written notice of the resolution of the appeals process:

- In a format and language that, at a minimum, meets applicable notification standards.*
- And include the results of the appeal resolution.
- And include the date of the appeal resolution.

For appeal decisions not wholly in the enrollee's favor, the contract requires the MCP to include the following in the written resolution notice:

- The right to request a state external review in accordance with the terms of 42 CFR Subpart K.
- How to request a state external review.
- The right to request and receive benefits pending the state external review

[42 CFR 457.1260(e)(1); 42 CFR 457.1260(e)(4); 42 CFR 438.408(b); 42 CFR 438.408(c)(1)-(2); 42 CFR 438.408(d)(2)(i); 42 CFR 438.10; 42 CFR 438.408(e)(1) – (2)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.8.05 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to provide written notice, and make reasonable efforts to provide oral notice, of the resolution of an expedited appeal. [42 CFR 457.1260(e)(1); 42 CFR 438.408(d)(2)(ii)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.9 Effectuation of Reversed Appeal Resolutions

I.H.9.01 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the

date the MCP receives notice reversing the determination, when the MCP or State external review process reverses a decision to deny, limit, or delay services. [42 CFR 457.1260(i)] [Effective: 12/14/2020]

I.H.10 Grievances

I.H.10.01 [Applies to MCO, PIHP, PAHP]

The contract specifies that an enrollee may file a grievance with an MCP at any time. [42 CFR 457.1260(b)(1); 42 CFR 438.402(c)(2)(i)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.10.02 [Applies to MCO, PIHP, PAHP]

The MCP contract specifies that an enrollee may file a grievance either orally or in writing. [42 CFR 457.1260(b)(1); 42 CFR 438.402(c)(3)(i)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.10.03 [Applies to MCO, PIHP, PAHP]

The MCP contract specifies whether enrollees may file grievances only with the MCP or if the enrollee can also file a grievance directly with the state. [42 CFR 457.1260(b)(1); 42 CFR 438.402(c)(3)(i)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.10.04 [Applies to MCO, PIHP, PAHP]

The contract requires that the MCP resolve each grievance and provide notice, as expeditiously as the enrollee's health condition requires, within state-established timeframes not to exceed 90 calendar days from the day the MCP receives the grievance. [42 CFR 457.1260(e)(1)-(2); 42 CFR 438.408(a); 42 CFR 438.408(b)(1)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.10.05 - I.H.10.06 [Applies to MCO, PIHP, PAHP]

The contract provides that the MCP may extend the timeframe for processing a grievance by up to 14 calendar days:

- If the enrollee requests the extension; or
- If the MCP shows that there is need for additional information and that the delay is in the enrollee's interest (upon state request).

[42 CFR 457.1260(e)(1); 42 CFR 438.408(c)(1)(i) - (ii); 42 CFR 438.408(b)(1)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.10.07 - I.H.10.08 [Applies to MCO, PIHP, PAHP]

The contract provides that if the MCP extends the timeline for a grievance not at the request of the enrollee, it must:

- Make reasonable efforts to give the enrollee prompt oral notice of the delay.
- Give the enrollee written notice, within 2 calendar days, of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

[42 CFR 457.1260(e)(1); 42 CFR 438.408(c)(2)(i) - (ii); 42 CFR 438.408(b)(1)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.10.09 [Applies to MCO, PIHP, PAHP]*

The contract specifies the state established method that the MCP will use to notify an enrollee of the resolution of a grievance in a format and language that, at a minimum, meets applicable notification standards. [42 CFR 457.1260(e)(1); 42 CFR 438.408(d)(1); 42 CFR 438.10] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.11 Grievance and Appeal Recordkeeping Requirements

I.H.11.01 [Applies to MCO, PIHP, PAHP]

The contract requires that the MCP maintain records of grievances and appeals. [42 CFR 457.1260(h); 42 CFR 438.416(a)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.11.02 - I.H.11.07 [Applies to MCO, PIHP, PAHP]

The contract requires that the MCP's record of each grievance or appeal include:

- A general description of the reason for the appeal or grievance.
- The date received.
- The date of each review or, if applicable, review meeting.
- Resolution information for each level of the appeal or grievance, if applicable.
- The date of resolution at each level, if applicable.
- The name of the covered person for whom the appeal or grievance was filed.

[42 CFR 457.1260(h); 42 CFR 438.416(b)(1) - (6)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.H.11.08 [Applies to MCO, PIHP, PAHP]

The contract requires that the MCP's record of each grievance or appeal be accurately maintained in a manner accessible to the state and available upon request to CMS. [42 CFR 457.1260(h); 42 CFR 438.416(c)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.I. Program Integrity

I.I.1 Exclusions

I.I.1.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP]*

The contract requires that the MCP not employ or contract with providers excluded from participation in Federal health care programs. [42 CFR 457.1233(a); 42 CFR 438.214(d)(1)] [Existing standard]

I.I.2 Requirements, Procedures, and Reporting

I.I.2.01 [Applies to MCO, PIHP, PAHP, PCCM, PCCM entity]*

The contract requires the MCP to submit encounter data. [42 CFR 457.1285; 42 CFR 438.604(a)(1); 42 CFR 438.606; 42 CFR 438.818] [Existing standard]

I.I.2.02 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to submit data on the basis of which the state determines the compliance of the MCP with the MLR requirement. [42 CFR 457.1285; 42 CFR 438.604(a)(3); 42 CFR 438.606; 42 CFR 438.8] [Existing standard]

- I.I.2.03 [Applies to MCO, PIHP, PAHP]
The contract requires the MCP to submit data on the basis of which the state determines that the MCP has made adequate provision against the risk of insolvency. [42 CFR 457.1285; 42 CFR 438.604(a)(4); 42 CFR 438.606; 42 CFR 438.116] [Existing standard]
- I.I.2.04 [Applies to MCO, PIHP, PAHP]
The contract requires the MCP to submit documentation on which the state bases its certification that the MCP complied with the state's requirements for availability and accessibility of services, including the adequacy of the provider network. [42 CFR 457.1285; 42 CFR 438.604(a)(5); 42 CFR 438.606; 42 CFR 438.207(b); 42 CFR 438.206] [Existing standard]
- I.I.2.05 - I.I.2.11 [Applies to MCO, PIHP, PAHP, PCCM, PCCM entity]
The contract requires the MCP to submit:
- The name and address of any person (individual or corporation) with an ownership or control interest in the managed care entity and its subcontractors. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
 - The date of birth and Social Security Number (SSN) of any individual with an ownership or control interest in the MCP and its subcontractors.
 - Other tax identification number of any corporation with an ownership or control interest in the MCP and any subcontractor in which the MCP has a 5 percent or more interest.
 - Information on whether an individual or corporation with an ownership or control interest in the MCP is related to another person with ownership or control interest in the MCP as a spouse, parent, child, or sibling.
 - Information on whether a person or corporation with an ownership or control interest in any subcontractor in which the MCP has a 5 percent or more interest is related to another person with ownership or control interest in the MCP as a spouse, parent, child, or sibling.
 - The name of any other disclosing entity in which an owner of the MCP has an ownership or control interest.
 - The name, address, date of birth, and SSN of any managing employee of the MCP.
- [42 CFR 457.1285; 42 CFR 438.604(a)(6); 42 CFR 438.606; 42 CFR 455.104(b)(1)(i) - (iii); 42 CFR 455.104(b)(2) - (4); 42 CFR 438.230; 42 CFR 438.608(c)(2)] [Existing standard]
- I.I.2.12 [Applies to MCO, PIHP, PAHP, PCCM, PCCM entity]
The contract requires the MCP to submit any other data, documentation, or information relating to the performance of the entity's obligations as required by the state or Secretary. [42 CFR 457.1285; 42 CFR 438.604(b); 42 CFR 438.606] [Existing standard]
- I.I.2.13 [Applies to MCO, PIHP, PAHP, PCCM, PCCM entity]*
The contract requires that the individual who submits data to the state provide a certification, which attests, based on best information, knowledge and belief that the data, documentation and information are accurate, complete and truthful. [42 CFR 457.1285; 42 CFR 438.604; 42 CFR 438.606(b)] [Existing standard]

I.I.2.14 [Applies to MCO, PIHP, PAHP, PCCM, PCCM entity]*
The contract requires that data, documentation, or information submitted to the state by the MCP are certified by one of the following:

- The MCP's Chief Executive Officer (CEO).
- The MCP's Chief Financial Officer (CFO).
- An individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification.

[42 CFR 457.1285; 42 CFR 438.604; 42 CFR 438.606(a)] [Existing standard]

I.I.2.15 [Applies to MCO, PIHP, PAHP, PCCM, PCCM entity]*
The contract requires the MCP to submit certification concurrently with the submission of data, documentation, or information. [42 CFR 457.1285; 42 CFR 438.606(c); 42 CFR 438.604(a) - (b)] [Existing standard]

I.I.2.16 - I.I.2.23 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract prohibits the MCP from knowingly having:

- A director, officer, or partner who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- A person with ownership of 5% or more of the MCP's equity who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- A network provider who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- An employment, consulting, or other agreement for the provision of MCP contract items or services with a person who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

[Section 1932(d)(1) of the Act; 42 CFR 457.1285; 42 CFR 438.610(a)(1) - (2); 42 CFR 438.610(c)(1); 42 CFR 438.610(c)(3) - (4); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549] [Existing standard]

I.I.2.24 - I.I.2.25 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract prohibits the MCP from knowingly having a subcontractor of the MCP who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-

procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. [Section 1932(d)(1) of the Act; 42 CFR 457.1285; 42 CFR 438.610(a)(1) - (2); 42 CFR 438.610(c)(2); Exec. Order No. 12549] [Existing standard]

I.I.2.26 - I.I.2.36 [Applies to MCO, PIHP, PAHP, PCCM, PCCM entity]

The contract requires the MCP to provide written disclosure of any:

- Director, officer, or partner who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- Subcontractor of the MCP who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- Person with ownership of 5% or more of the MCP's equity who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- Network provider who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- Employment, consulting, or other agreement for the provision of MCP contract items or services with a person who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- An individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.

[Section 1932(d)(1) of the Act; 42 CFR 457.1285; 42 CFR 438.608(c)(1); 42 CFR 438.610(a)(1) - (2); 42 CFR 438.610(b); 42 CFR 438.610(c)(1) - (4); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549] [Existing standard]

I.I.2.37 [Applies to MCO, PIHP, PAHP, PCCM, PCCM entity]*

The contract requires the MCP to ensure that all network providers are enrolled with the state as Medicaid providers consistent with provider disclosure, screening, and enrollment requirements. [42 CFR 457.1285; 42 CFR 438.608(b); 42 CFR 455.100 - 106; 42 CFR 455.400 - 470] [Existing standard]

- I.I.2.38 [Applies to MCO, PIHP, PAHP, PCCM, PCCM entity]
The contract requires the MCP and any subcontractor to report to the state within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract. [42 CFR 457.1285; 42 CFR 438.608(c)(3)] [Existing standard]
- I.I.2.39 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
The contract requires the MCP to submit audited financial reports specific to the Medicaid contract on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. [42 CFR 457.1201(k); 42 CFR 438.3(m)] [Existing standard]
- I.I.2.40 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract requires that the MCP include an attestation to the accuracy, completeness, and truthfulness of claims and payment data, under penalty of perjury. [42 CFR 457.1201(o); 42 CFR 457.1201(n)(2)] [Existing standard]
- I.I.2.41 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract specifies that the MCP must guarantee that it will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources. [42 CFR 457.1201(p)] [Existing standard]

I.I.3 Disclosure

- I.I.3.01 [Applies to MCO, PIHP, PAHP, PCCM, PCCM entity]
The contract requires the MCP and subcontractors to disclose to the state any persons or corporations with an ownership or control interest in the MCP that:
- Has direct, indirect, or combined direct/indirect ownership interest of 5% or more of the MCP's equity;
 - Owns 5% or more of any mortgage, deed of trust, note, or other obligation secured by the MCP if that interest equals at least 5% of the value of the MCP's assets;
 - Is an officer or director of an MCP organized as a corporation; or
 - Is a partner in an MCP organized as a partnership.
- [Section 1124(a)(2)(A) of the Act; section 1903(m)(2)(A)(viii) of the Act; 42 CFR 457.1285; 42 CFR 438.608(c)(2); 42 CFR 455.100 - 104] [Existing standard]
- I.I.3.02 [Applies to MCO, PIHP, PAHP, PCCM entity]
The contract requires the MCP and subcontractors to disclose information on individuals or corporations with an ownership or control interest in the MCP to the state at the following times:
- When the MCP submits a proposal in accordance with the state's procurement process.
 - When the MCP executes a contract with the state.
 - When the state renews or extends the MCP contract.
 - Within 35 days after any change in ownership of the MCP.
- [Section 1124(a)(2)(A) of the Act; section 1903(m)(2)(A)(viii) of the Act; 42 CFR 457.1285; 42 CFR 438.608(c)(2); 42 CFR 455.100 - 103; 42 CFR 455.104(c)(3)] [Existing standard]

I.I.3.03 [Applies to PCCM]

The contract requires the MCP and subcontractors to disclose information on individuals or corporations with an ownership or control interest in the MCP to the state at the following times:

- When the provider or disclosing entity submits a provider application.
- When the provider or disclosing entity executes a provider agreement with the state.
- Upon request of the state during the revalidation of the provider enrollment.
- Within 35 days after any change in ownership of the disclosing entity.

[Section 1124(a)(2)(A) of the Act; section 1903(m)(2)(A)(viii) of the Act; 42 CFR 457.1285; 42 CFR 438.608(c)(2); 42 CFR 455.100 - 103; 42 CFR 455.104(c)(1) and (4)] [Existing standard]

I.I.4 Compliance Program

I.I.4.01 - I.I.4.07 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCP for coverage of services and payment of claims under the contract between the state and the MCP, to implement and maintain a compliance program that must include:

- Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements.
- A Compliance Officer (CO) who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the CEO and the Board of Directors (BoD).
- A Regulatory Compliance Committee (RCC) on the BoD and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract.
- A system for training and education for the CO, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract.
- Effective lines of communication between the CO and the organization's employees.
- Enforcement of standards through well-publicized disciplinary guidelines.
- The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

[42 CFR 457.1285; 42 CFR 438.608(a); 42 CFR 438.608(a)(1)(i) - (vii)] [Existing standard]

I.I.4.08 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCP for coverage of services and payment of claims under the contract between the state and the MCP, to implement and maintain arrangements or

procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. [42 CFR 457.1285; 42 CFR 438.608(a)(2)] [Existing standard]

I.I.4.09 - I.I.4.10 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCP for coverage of services and payment of claims under the contract between the state and the MCP, to implement and maintain arrangements or procedures for prompt notification to the state when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including changes in the enrollee's residence or the death of the enrollee. [42 CFR 457.1285; 42 CFR 438.608(a)(3)] [Existing standard]

I.I.4.11 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCP for coverage of services and payment of claims under the contract between the state and the MCP, to implement and maintain arrangements or procedures for notification to the state when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCP. [42 CFR 457.1285; 42 CFR 438.608(a)(4)] [Existing standard]

I.I.4.12 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCP for coverage of services and payment of claims under the contract between the state and the MCP, to implement and maintain arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis. [42 CFR 457.1285; 42 CFR 438.608(a)(5)] [Existing standard]

I.I.4.13 [Applies to MCO, PIHP, PAHP]

For MCPs that make or receive annual payments under the contract of at least \$5,000,000, the contract requires the MCP or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCP for coverage of services and payment of claims under the contract between the state and the MCP, to implement and maintain written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act (FCA) and other Federal and state laws, including information about rights of employees to be protected as whistleblowers. [Section 1902(a)(68) of the Act; 42 CFR 457.1285; 42 CFR 438.608(a)(6)] [Existing standard]

I.I.4.14 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCP for coverage of services and payment of claims under the contract between the state and the MCP, to implement and maintain arrangements or procedures that include provision for the prompt referral of any potential fraud, waste, or abuse that the MCP identifies to the state Medicaid program integrity unit or any potential

fraud directly to the state Medicaid Fraud Control Unit (MFCU). [42 CFR 457.1285; 42 CFR 438.608(a)(7)] [Existing standard]

I.I.4.15 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCP for coverage of services and payment of claims under the contract between the state and the MCP, to implement and maintain arrangements or procedures that include provision for the MCP's suspension of payments to a network provider for which the state determines there is a credible allegation of fraud. [42 CFR 457.1285; 42 CFR 438.608(a)(8); 42 CFR 455.23] [Existing standard]

I.I.5 Treatment of Recoveries

I.I.5.01 [Applies to MCO, PIHP, PAHP]

The contract requires that the MCP specify the retention policies for the treatment of recoveries of all overpayments from the MCP to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse. [42 CFR 457.1285; 42 CFR 438.608(d)(1)(i)] [Existing standard]

I.I.5.02 [Applies to MCO, PIHP, PAHP]

The contract requires that the MCP specify the process, timeframes, and documentation required for reporting the recovery of all overpayments. [42 CFR 457.1285; 42 CFR 438.608(d)(1)(ii)] [Existing standard]

I.I.5.03 [Applies to MCO, PIHP, PAHP]

The contract requires that the MCP specify the process, timeframes, and documentation required for payment of recoveries of overpayments to the state in situations where the MCP is not permitted to retain some or all of the recoveries of overpayments. [42 CFR 457.1285; 42 CFR 438.608(d)(1)(iii)] [Existing standard]

I.I.5.04 [Applies to MCO, PIHP, PAHP]

The contract requires the MCP to have, and require the use of, a mechanism for a network provider to report to the MCP when it has received an overpayment, to return the overpayment to the MCP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCP in writing of the reason for the overpayment. [42 CFR 457.1285; 42 CFR 438.608(d)(2)] [Existing standard]

I.I.5.05 [Applies to MCO, PIHP, PAHP, PCCM, PCCM entity]

The contract requires the MCP to submit the annual report of overpayment recoveries. [42 CFR 457.1285; 42 CFR 438.604(a)(7); 42 CFR 438.606; 42 CFR 438.608(d)(3)] [Existing standard]

I.I.6 Program/Activity No Longer Authorized by Law

I.I.6.01 [Applies to MCO, PIHP, PAHP NEMT PAHP, PCCM entity]

Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the MCP must do no work on that part after the effective date of the loss of program authority. The state must

adjust either capitation rates if using risk-based contract or payments if using a non-risk contract to remove costs that are specific to any program or activity that is no longer authorized by law. If the MCP works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the MCP will not be paid for that work. If the state paid the MCP in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if the MCP worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the MCP, the MCP may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority. [[Letter to State Medicaid Directors](#) dated 9/4/2020.] [Effective: 12/31/2020]

I.J. General Terms and Conditions

I.J.1 Inspection

- I.J.1.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract requires that the state, CMS, the Office of the Inspector General (OIG), the Comptroller General, and their designees be allowed to inspect and audit any records or documents of the MCP at any time. [42 CFR 457.1201(g); 42 CFR 438.3(h)] [Existing standard]
- I.J.1.02 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract requires that the state, CMS, the OIG, the Comptroller General, and their designees be allowed to inspect and audit any records or documents of the MCP's subcontractors at any time. [42 CFR 457.1201(g); 42 CFR 438.3(h)] [Existing standard]
- I.J.1.03 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract requires that the state, CMS, the OIG, the Comptroller General, and their designees be allowed to inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted at any time. [42 CFR 457.1201(g); 42 CFR 438.3(h)] [Existing standard]
- I.J.1.04 - J.1.05 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract requires that the state, CMS, the OIG, the Comptroller General and their designees have the right to audit records or documents of the MCP or the MCP's subcontractors for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. [42 CFR 457.1201(g); 42 CFR 438.3(h)] [Existing standard]
- I.J.1.06 [Applies to MCO, PIHP, PAHP, NEMT PAHP]*
The contract requires that the MCP and the MCP's subcontractors retain, as applicable, enrollee grievance and appeal records in 42 CFR 438.416, base data in 42 CFR 438.5(c), MLR reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604 (except 438.604(a)(2)), 438.606, 438.608, and 438.610 for a period of no less than 10 years. [42 CFR 457.1201(q); 42 CFR 438.3(u)] [Existing standard]

I.J.2 Compliance with State and Federal Laws

- I.J.2.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract requires the MCP to comply with all applicable Federal and state laws and regulations including:
- Title VI of the Civil Rights Act (CRA) of 1964.
 - The Age Discrimination Act of 1975.
 - The Rehabilitation Act of 1973.
 - Title IX of the Education Amendments of 1972 (regarding education programs and activities).
 - The Americans with Disabilities Act.
 - Section 1557 of the Patient Protection and Affordable Care Act (ACA).
- [42 CFR 457.1201(f); 42 CFR 457.1220; 42 CFR 438.3(f)(1); 42 CFR 438.100(d)] [Existing standard]
- I.J.2.02 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]
The contract requires the MCP to comply with any applicable Federal and state laws that pertain to enrollee rights and ensure that its employees and contracted providers observe and protect those rights. [42 CFR 457.1220; 42 CFR 438.100(a)(2)] [Existing standard]

I.J.3 Subcontracts and Other Contracts and Written Agreements

- I.J.3.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*
The contract requires that in any contract or written agreement that the MCP has with any individual or entity that relates directly or indirectly to the performance of the MCP's obligations under its contract, the MCP must maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the state, notwithstanding any relationship(s) that the MCP may have with the individual or entity. [42 CFR 457.1201(i); 42 CFR 457.1233(b); 42 CFR 438.230(b)(1)] [Existing standard for MCO, PIHP, PAHP, and NEMT PAHP. New requirement for PCCM entity, effective 12/14/2020]
- I.J.3.02 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*
The contract requires that in any contract or written agreement that the MCP has with any individual or entity that relates directly or indirectly to the performance of the MCP's obligations under its contract, if any of the MCP's activities or obligations under the contract with the state are delegated to the individual or entity, the activities and obligations, and related reporting responsibilities, are specified in the contract or written agreement between the MCP and the individual or entity. [42 CFR 457.1201(i); 42 CFR 457.1233(b); 42 CFR 438.230(c)(1)(i) - (ii)] [Existing standard for MCO, PIHP, PAHP, and NEMT PAHP. New requirement for PCCM entity, effective 12/14/2020]
- I.J.3.03 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*
The contract requires that in any contract or written agreement that the MCP has with any individual or entity that relates directly or indirectly to the performance of the MCP's obligations under its contract, if any of the MCP's activities or obligations under the contract with the state are delegated to the individual or entity, the contract or written arrangement between the MCP and the individual or entity must either provide for revocation of the delegation of activities or obligations, or specify other remedies, in instances where the state

or the MCP determines that the individual or entity has not performed satisfactorily. [42 CFR 457.1201(i); 42 CFR 457.1233(b); 42 CFR 438.230(c)(1)(iii)] [Existing standard for MCO, PIHP, PAHP, and NEMT PAHP. New requirement for PCCM entity, effective 12/14/2020]

I.J.3.04 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The contract specifies that in any contract or written agreement that the MCP has with any individual or entity that relates directly or indirectly to the performance of the MCP's obligations under its contract, the contract or written agreement between the MCP and the individual or entity requires the individual or entity to comply with all applicable CHIP laws, regulations, including applicable subregulatory guidance and contract provisions. [42 CFR 457.1201(i); 42 CFR 457.1233(b); 42 CFR 438.230(c)(2)] [Existing standard for MCO, PIHP, PAHP, and NEMT PAHP. New requirement for PCCM entity, effective 12/14/2020]

I.J.3.05 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The contract specifies that in any contract or written agreement that the MCP has with any individual or entity that relates directly or indirectly to the performance of the MCP's obligations under its contract, the contract or written agreement between the MCP and the individual or entity requires the individual or entity to agree that the state, CMS, the Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the individual or entity, or of the individual or entity's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCP's contract with the state. [42 CFR 457.1201(i); 42 CFR 457.1233(b); 42 CFR 438.230(c)(3)(i)] [Existing standard for MCO, PIHP, PAHP, and NEMT PAHP. New requirement for PCCM entity, effective 12/14/2020]

I.J.3.06 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The contract specifies that in any contract or written agreement that the MCP has with any individual or entity that relates directly or indirectly to the performance of the MCP's obligations under its contract, the contract or written agreement between the MCP and the individual or entity requires the individual or entity to make available, for the purposes of an audit, evaluation, or inspection by the state, CMS, the DHHS Inspector General, the Comptroller General or their designees, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its CHIP enrollees. [42 CFR 457.1201(i); 42 CFR 457.1233(b); 42 CFR 438.230(c)(3)(ii)] [Existing standard for MCO, PIHP, PAHP, and NEMT PAHP. New requirement for PCCM entity, effective 12/14/2020]

I.J.3.07 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The contract specifies that in any contract or written agreement that the MCP has with any individual or entity that relates directly or indirectly to the performance of the MCP's obligations under its contract, the contract or written agreement requires the individual or entity to agree that the right to audit by the state, CMS, the DHHS Inspector General, the Comptroller General or their designees, will exist through 10 years from the final date of the

contract period or from the date of completion of any audit, whichever is later. [42 CFR 457.1201(i); 42 CFR 457.1233(b); 42 CFR 438.230(c)(3)(iii)] [Existing standard for MCO, PIHP, PAHP, and NEMT PAHP. New requirement for PCCM entity, effective 12/14/2020]

I.J.3.08 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The contract specifies that in any contract or written agreement that the MCP has with any individual or entity that relates directly or indirectly to the performance of the MCP's obligations under its contract, the contract or written agreement between the MCP and the individual or entity requires that if the state, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of fraud or similar risk, the state, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the individual or entity at any time. [42 CFR 457.1201(i); 42 CFR 457.1233(b); 42 CFR 438.230(c)(3)(iv)] [Existing standard for MCO, PIHP, PAHP, and NEMT PAHP. New requirement for PCCM entity, effective 12/14/2020]

I.J.3.09 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*

The contract requires the MCP to maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the state, notwithstanding any relationship(s) that the MCP may have with any subcontractor. [42 CFR 457.1233(b); 42 CFR 438.230(b)(1)] [Existing standard for MCO, PIHP, PAHP, NEMT PAHP, and PCCM. New requirement for PCCM entity, effective 12/14/2020]

I.J.3.10 - I.J.3.11 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*

The contract requires that if any of the MCP's activities or obligations under the contract with the state are delegated to a subcontractor:

- The activities and obligations, and related reporting responsibilities, are specified in the contract or written agreement between the MCP and the subcontractor.*
- The contract or written arrangement between the MCP and the subcontractor must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the state or the MCP determines that the subcontractor has not performed satisfactorily.*

[42 CFR 457.1233(b); 42 CFR 438.230(c)(1)(i) - (iii)] [Existing standard for MCO, PIHP, PAHP, NEMT PAHP, and PCCM. New requirement for PCCM entity, effective 12/14/2020]

I.J.3.12 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*

The contract specifies that contracts between the MCP and subcontractors require the subcontractor to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. [42 CFR 457.1233(b); 42 CFR 438.230(c)(2)] [Existing standard for MCO, PIHP, PAHP, NEMT PAHP, and PCCM. New requirement for PCCM entity, effective 12/14/2020]

I.J.3.13 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*

The contract specifies that contracts between the MCP and subcontractors require the subcontractor to agree that the state, CMS, the DHHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of

amounts payable under the MCP's contract with the state. [42 CFR 457.1233(b); 42 CFR 438.230(c)(3)(i)] [Existing standard for MCO, PIHP, PAHP, NEMT PAHP, and PCCM. New requirement for PCCM entity, effective 12/14/2020]

- I.J.3.14 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*
The contract specifies that contracts between the MCP and subcontractors require the subcontractor to make available, for the purposes of an audit, evaluation, or inspection by the state, CMS, the DHHS Inspector General, the Comptroller General or their designees, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its CHIP enrollees. [42 CFR 457.1233(b); 42 CFR 438.230(c)(3)(ii)] [Existing standard for MCO, PIHP, PAHP, NEMT PAHP, and PCCM. New requirement for PCCM entity, effective 12/14/2020]
- I.J.3.15 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*
The contract specifies that contracts between the MCP and subcontractors require the subcontractor to agree that the right to audit by the state, CMS, the DHHS Inspector General, the Comptroller General or their designees, will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. [42 CFR 457.1233(b); 42 CFR 438.230(c)(3)(iii)] [Existing standard for MCO, PIHP, PAHP, NEMT PAHP, and PCCM. New requirement for PCCM entity, effective 12/14/2020]
- I.J.3.16 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*
The contract specifies that contracts between the MCP and subcontractors require that if the state, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of fraud or similar risk, the state, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. [42 CFR 457.1233(b); 42 CFR 438.230(c)(3)(iv)] [Existing standard for MCO, PIHP, PAHP, NEMT PAHP, and PCCM. New requirement for PCCM entity, effective 12/14/2020]

I.J.4 Sanctions

- I.J.4.01 [Applies to MCO]
The contract provides that if the MCP fails to substantially provide medically necessary services to an enrollee that the MCP is required to provide under law or under its contract with the state, the state may impose a civil monetary penalty of up to \$25,000 for each failure to provide services. The state may also:
- Appoint temporary management to the MCP.
 - Grant enrollees the right to disenroll without cause.
 - Suspend all new enrollments to the MCP after the date the Secretary or the state notifies the MCP of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.
 - Suspend payments for new enrollments to the MCP until CMS or the state is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
- [Sections 1903(m)(5)(A)(i); 1903(m)(5)(B); 1932(e)(1)(A)(i); 1932(e)(2)(A)(i) of the Act; 42 CFR 457.1270(a); 42 CFR 438.700(b)(1); 42 CFR 438.702(a); 42 CFR 438.704(b)(1)]
[Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.J.4.02 [Applies to MCO]

The contract provides that if the MCP imposes premiums or charges on enrollees that are in excess of those permitted in the Medicaid program, the state may impose a civil monetary penalty of up to \$25,000 or double the amount of the excess charges (whichever is greater).

The state may also:

- Appoint temporary management to the MCP.
- Grant enrollees the right to disenroll without cause.
- Suspend all new enrollments to the MCP after the date the Secretary or the state notifies the MCP of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.
- Suspend payments for new enrollments to the MCP until CMS or the state is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

[Sections 1903(m)(5)(A)(ii); 1903(m)(5)(B); 1932(e)(1)(A)(ii); 1932(e)(2)(A)(iii) of the Act; 42 CFR 457.1270(a); 42 CFR 438.700(b)(2); 42 CFR 438.702(a); 42 CFR 438.704(c)]

[Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.J.4.03 [Applies to MCO]*

The contract provides that if the MCP discriminates among enrollees on the basis of their health status or need for health services, the state may impose a civil monetary penalty of up to \$100,000 for each determination of discrimination. The state may impose a civil monetary penalty of up to \$15,000 for each individual the MCP did not enroll because of a discriminatory practice, up to the \$100,000 maximum. The state may also:

- Appoint temporary management to the MCP.
- Grant enrollees the right to disenroll without cause.
- Suspend all new enrollments to the MCP after the date the Secretary or the state notifies the MCP of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.
- Suspend payments for new enrollments to the MCP until CMS or the state is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

[Sections 1903(m)(5)(A)(iii); 1903(m)(5)(B); 1932(e)(1)(A)(iii); 1932(e)(2)(A)(ii) & (iv) of the Act; 42 CFR 457.1270(a); 42 CFR 438.700(b)(3); 42 CFR 438.702(a); 42 CFR

438.704(b)(2) and (3)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.J.4.04 [Applies to MCO]

The contract provides that if the MCP misrepresents or falsifies information that it furnishes to CMS or to the state, the state may impose a civil monetary penalty of up to \$100,000 for each instance of misrepresentation. The state may also:

- Appoint temporary management to the MCP.
- Grant enrollees the right to disenroll without case.
- Suspend all new enrollments to the MCP after the date the Secretary or the state notifies the MCP of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.
- Suspend payments for new enrollments to the MCP until CMS or the state is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

[Sections 1932(e)(1)(iv); 1903(m)(5)(A)(iv)(I); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(I); 1932(e)(2)(A)(ii) of the Act; 42 CFR 457.1270(a); 42 CFR 438.700(b)(4); 42 CFR 438.702(a); 42 CFR 438.704(b)(2)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.J.4.05 [Applies to MCO]

The contract provides that if the MCP misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider, the state may impose a civil monetary penalty of up to \$25,000 for each instance of misrepresentation. The state may also:

- Appoint temporary management to the MCP.
- Grant enrollees the right to disenroll without case.
- Suspend all new enrollments to the MCP after the date the Secretary or the state notifies the MCP of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.
- Suspend payments for new enrollments to the MCP until CMS or the state is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

[Sections 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i) of the Act; 42 CFR 457.1270(a); 42 CFR 438.702(a); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.J.4.06 [Applies to MCO]*

The contract provides that if the MCP fails to comply with the Medicare physician incentive plan requirements, the state may impose a civil monetary penalty of up to \$25,000 for each failure to comply. The state may also:

- Appoint temporary management to the MCP.
- Grant enrollees the right to disenroll without case.
- Suspend all new enrollments to the MCP after the date the Secretary or the state notifies the MCP of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.
- Suspend payments for new enrollments to the MCP until CMS or the state is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

[Sections 1903(m)(5)(A)(v); 1903(m)(5)(B); 1932(e)(1)(A)(v); 1932(e)(2)(A)(i) of the Act; 42 CFR 457.1270(a); 42 CFR 438.700(b)(6); 42 CFR 438.702(a); 42 CFR 438.704(b)(1)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.J.4.07 [Applies to MCO]

The contract provides that if the MCP distributes marketing materials that have not been approved by the state or that contain false or misleading information, either directly or indirectly through any agent or independent contractor, the state may impose a civil monetary penalty of up to \$25,000 for each distribution. [Sections 1932(e)(1)(A); 1932(e)(2)(A)(i) of the Act; 42 CFR 457.1270(a); 42 CFR 438.700(c); 42 CFR 438.704(b)(1)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.J.4.08 [Applies to MCO]

The contract provides that if the MCP violates any other applicable requirements in sections 1903(m) or 1932 of the Act or any implementing regulations, the state may impose only the following sanctions:

- Grant enrollees the right to disenroll without cause.
- Suspend all new enrollments to the MCP after the date the Secretary or the state notifies the MCP of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.
- Suspend payments for all new enrollments to the MCP until CMS or the state is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

[Sections 1932(e)(2)(C); 1932(e)(2)(D); 1932(e)(2)(E) of the Act; 42 CFR 457.1270(a); 42 CFR 438.700(d)(1); 42 CFR 438.702(a)(3) - (5)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.J.4.09 [Applies to MCO]

The contract provides that the state may impose additional sanctions provided for under state statutes or regulations to address noncompliance. [42 CFR 457.1270(a); 42 CFR 438.702(b)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.J.4.10 - I.J.4.15 [Applies to MCO]*

The MCP contract specifies that the state will deny payments for new enrollees when, and for so long as, payment for those enrollees is denied by CMS based on the state's recommendation, when:

- The MCP fails substantially to provide medically necessary services that the MCP is required to provide, under law or under its contract with the state, to an enrollee covered under the contract.
- The MCP imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
- The MCP acts to discriminate among enrollees on the basis of their health status or need for health care services.*
- The MCP misrepresents or falsifies information that it furnishes to CMS or to the state.
- The MCP misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.
- The MCP fails to comply with the requirements for PIPs, as set forth (for Medicare) in 42 CFR 422.208 and 42 CFR 422.210.

[Section 1903(m)(5)(B)(ii) of the Act; 42 CFR 457.1270(a); 42 CFR 438.700(b)(1) - (6); 42 CFR 438.726(b); 42 CFR 438.730(e)(1)(i)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.J.4.16 [Applies to MCO]

The contract specifies that the state will deny payments for new enrollees when, and for so long as, payment for those enrollees is denied by CMS. CMS may deny payment to the state for new enrollees if its determination is not timely contested by the MCP. [42 CFR 457.1270(a); 42 CFR 438.726(b); 42 CFR 438.730(e)(1)(ii)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.J.4.17 [Applies to MCO]

The contract specifies the circumstances under which the state will impose optional temporary management. Temporary management may only be imposed when the state finds, through onsite surveys, enrollee or other complaints, financial status, or any other source:

- There is continued egregious behavior by the MCP, including but not limited to behavior that is described at 42 CFR 438.700, or that is contrary to any of the requirements of this subpart;
- There is substantial risk to enrollees' health; or
- The sanction is necessary to ensure the health of the MCP's enrollees in one of two circumstances:
 - While improvements are made to remedy violations that require sanctions; or
 - Until there is an orderly termination or reorganization of the MCP.

[Section 1932(e)(2)(B)(i) of the Act; 42 CFR 457.1270(b); 42 CFR 438.700] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.J.4.18 [Applies to MCO]

The contract specifies that the state must impose mandatory temporary management (regardless of any other sanction that may be imposed) if it finds that the MCP has repeatedly failed to meet substantive requirements in Part 457 Subpart L. The state may not delay the imposition of temporary management to provide a hearing and may not terminate temporary management until it determines that the MCP can ensure the sanctioned behavior will not reoccur. [Section 1932(e)(2)(B)(ii) of the Act; 42 CFR 457.1270(c); 42 CFR 438.706(c) - (d)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.J.4.19 [Applies to MCO]

The contract specifies that the state must grant enrollees the right to terminate MCP enrollment without cause when an MCP repeatedly fails to meet substantive requirements in Part 457 Subpart L, and must notify the affected enrollees of their right to terminate. [Section 1932(e)(2)(B)(ii) of the Act; 42 CFR 457.1270(c); 42 CFR 457.1270(a); 42 CFR 438.702(a)(3)] [Existing standard. The federal regulatory citation changed effective 12/14/2020]

I.J.5 Termination

I.J.5.01 [Applies to MCO]

The contract specifies that the state may terminate an MCP contract, and place enrollees into a different MCP or provide CHIP benefits through other state plan authority, if the state determines that the MCP has failed to carry out the substantive terms of its contracts or meet the applicable requirements of sections 1932, 1903(m) or 1905(t) of the Act. [Sections 1903(m); 1905(t); 1932 of the Act; 42 CFR 457.1270; 42 CFR 438.708(a); 42 CFR 438.708(b)]

I.J.6 Insolvency

I.J.6.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP]

The contract specifies that CHIP enrollees are not held liable for the MCP's debts, in the event the MCP becomes insolvent. [Section 1932(b)(6) of the Act; 42 CFR 457.1226; 42 CFR 438.106(a)] [Existing standard]

I.J.6.02 - J.6.03 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]

The contract specifies that CHIP enrollees are not held liable for covered services provided to the enrollee:

- For which the state does not pay the MCP
- For which the state or MCP does not pay the provider that furnished the service under a contractual, referral, or other arrangement [Section 1932(b)(6) of the Act; 42 CFR 457.1226; 42 CFR 457.1233(b); 42 CFR 438.106(b)(1)-(2); 42 CFR 438.230] [Existing standard for MCO, PIHP, PAHP, and NEMT PAHP. New requirement for PCCM entity, effective 12/14/2020]

I.J.6.04 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]

The contract specifies that CHIP enrollees are not held liable for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the enrollee would owe if the MCP covered the services directly. [Section 1932(b)(6) of the Act; 42 CFR 457.1226; 42 CFR 457.1233(b); 42 CFR 438.106(c); 42 CFR 438.230] [Existing standard for MCO, PIHP, PAHP, and NEMT PAHP. New requirement for PCCM entity, effective 12/14/2020]

I.J.7 Privacy

I.J.7.01 [Applies to MCO, PIHP, PAHP]

The contract requires that, for individual medical records and any other health and enrollment information maintained with respect to enrollees, that identifies particular enrollees (in any form), the MCP must comply with state procedures to abide by all applicable Federal and state laws regarding confidentiality and disclosure, including those laws addressing the confidentiality of information about minors and the privacy of minors, and privacy of individually identifiable health information. [42 CFR 457.1233(e); 42 CFR 457.1110(a)] [Existing standard]

I.J.7.02 [Applies to MCO, PIHP, PAHP]

The contract requires that, for individual medical records and any other health and enrollment information maintained with respect to enrollees, that identifies particular enrollees (in any form), the MCP must comply with state procedures in compliance with Subpart F of 42 CFR 431. [42 CFR 457.1233(e); 42 CFR 457.1110(b)] [Existing standard]

I.J.7.03 [Applies to MCO, PIHP, PAHP]

The contract requires that, for individual medical records and any other health and enrollment information maintained with respect to enrollees, that identifies particular enrollees (in any form), the MCP must comply with state procedures to maintain the records and information in a timely and accurate manner. [42 CFR 457.1233(e); 42 CFR 457.1110(c)] [Existing standard]

I.J.7.04 [Applies to MCO, PIHP, PAHP]

The contract requires that, for individual medical records and any other health and enrollment information maintained with respect to enrollees, that identifies particular enrollees (in any form), the MCP must comply with state procedures that specify and make available to any enrollee requesting it, the purposes for which information is maintained or used. [42 CFR 457.1233(e); 42 CFR 457.1110(d)(1)] [Existing standard]

- I.J.7.05 [Applies to MCO, PIHP, PAHP]
The contract requires that, for individual medical records and any other health and enrollment information maintained with respect to enrollees, that identifies particular enrollees (in any form), the MCP must comply with state procedures that specify and make available to any enrollee requesting it, to whom and for what purposes the information will be disclosed outside the state. [42 CFR 457.1233(e); 42 CFR 457.1110(d)(2)] [Existing standard]
- I.J.7.06 [Applies to MCO, PIHP, PAHP]
The contract requires that, for individual medical records and any other health and enrollment information maintained with respect to enrollees, that identifies particular enrollees (in any form), the MCP must comply with state procedures that, except as provided by Federal and state law, ensure that each enrollee may request and receive a copy of records and information pertaining to the enrollee in a timely manner. [42 CFR 457.1233(e); 42 CFR 457.1110(e)] [Existing standard]
- I.J.7.07 [Applies to MCO, PIHP, PAHP]
The contract requires that, for individual medical records and any other health and enrollment information maintained with respect to enrollees, that identifies particular enrollees (in any form), the MCP must comply with state procedures that, except as provided by Federal and state law, ensure that each enrollee may request and receive a copy of records and information pertaining to the enrollee and that an enrollee may request that such records or information be supplemented or corrected. [42 CFR 457.1233(e); 42 CFR 457.1110(e)] [Existing standard]

I.K. Health Information Systems and Enrollee Data

- I.K.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
The contract requires that the MCP maintain a health information system that collects, analyzes, integrates, and reports data to CMS. [42 CFR 457.1233(d); 42 CFR 438.242(a)] [Existing standard]
- I.K.02 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
The contract requires that the MCP's health information system provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for reasons other than loss of CHIP eligibility. [42 CFR 457.1233(d); 42 CFR 438.242(a)] [Existing standard]
- I.K.03 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
The contract requires that the MCP comply with Section 6504(a) of the ACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of section 1903(r)(1)(F) of the Act [Section 6504(a) of the ACA; Section 1903(r)(1)(F) of the Act; 42 CFR 457.1233(d); 42 CFR 438.242(b)(1)] [Existing standard]

- I.K.04 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
The contract requires that the MCP collect data on enrollee and provider characteristics as specified by the state and on all services furnished to enrollees through an encounter data system or other methods as may be specified by the state. [42 CFR 457.1233(d); 42 CFR 438.242(b)(2)] [Existing standard]
- I.K.05 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
The contract requires that the MCP verify the accuracy and timeliness of data reported by providers, including data from network providers the MCP is compensating on the basis of capitation payments. [42 CFR 457.1233(d); 42 CFR 438.242(b)(3)(i)] [Existing standard]
- I.K.06 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
The contract requires that the MCP screen the data received from providers for completeness, logic, and consistency. [42 CFR 457.1233(d); 42 CFR 438.242(b)(3)(ii)] [Existing standard]
- I.K.07 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
The contract requires that the MCP collect data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for state Medicaid quality improvement and care coordination efforts. [42 CFR 457.1233(d); 42 CFR 438.242(b)(3)(iii)] [Existing standard]
- I.K.08 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
The contract requires the MCP to make all collected data available to the state and upon request to CMS. [42 CFR 457.1233(d); 42 CFR 438.242(b)(4)] [Existing standard]
- I.K.09 [Applies to MCO, PIHP, PAHP, NEMT PAHP]
The contract requires that the MCP implement an Application Programming Interface (API) that meets the criteria specified at 42 CFR 431.60 and include(s):
- Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and beneficiary cost-sharing pertaining to such claims, no later than one (1) business day after a claim is processed;
 - Encounter data, including encounter data from any network providers the MCP is compensating on the basis of capitation payments and adjudicated claims and encounter data from any subcontractors no later than one (1) business day after receiving the data from providers
 - Clinical data, including laboratory results, if the MCP maintains any such data, no later than one (1) business day after the data is received by the State; and
 - Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the effective date of any such information or updates to such information.
- [42 CFR 438.242(b)(5); 42 CFR 457.1233(d)(2)] [Effective: No later than 7/1/2021]

I.K.10 – I.K.12 [Applies to MCO, PIHP, PAHP, NEMT PAHP]

The contract must provide for:

- Collection and maintenance of sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees.
- Submission of enrollee encounter data to the state at a frequency and level of detail to be specified by CMS and the state, based on program administration, oversight, and program integrity needs.
- Submission of all enrollee encounter data, including allowed amount and paid amount, that the state is required to report to CMS under 42 CFR 438.818. [Effective 12/14/2020]
- Specifications for submitting encounter data to the state in standardized Accredited Standards Committee (ASC) X12N 837 and National Council for Prescription Drug Programs (NCPDP) formats, and the ASC X12N 835 format as appropriate.

[42 CFR 457.1233(d); 42 CFR 438.242(c)(1) - (4); 42 CFR 438.818] [Existing standard]

I.L. State Obligations

I.L.1 Enrollee and Potential Enrollee Information

I.L.1.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]*

The contract specifies the prevalent non-English languages spoken by enrollees and potential enrollees in the state and each MCP service area, identified by the state, and provides that information to the MCP. [42 CFR 457.1207; 42 CFR 438.10(d)(1)] [Existing standard]

I.L.1.02 [Applies to MCO, PIHP, PAHP, NEMT PAHP]*

If the MCP does not cover counseling or referral services because of moral or religious objections and chooses not to furnish information on how and where to obtain such services, the contract specifies that the state will provide that information to potential enrollees. [42 CFR 457.1207; 42 CFR 438.10(e)(2)(v)(C)] [Existing standard]

I.L.2 Contract Sanctions and Terminations

I.L.2.01 [Applies to MCO]*

The contract specifies that, if the state imposes a civil monetary penalty on the MCP for charging premiums or charges in excess of the amounts permitted under Medicaid, the state will deduct the amount of the overcharge from the penalty and returns it to the affected enrollee. [42 CFR 457.1270; 42 CFR 438.704(c)] [Existing standard]

I.L.2.02 [Applies to MCO]*

The contract specifies that, if the state imposes temporary management because an MCO has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Act or 42 CFR 438, the state must notify affected enrollees of their right to terminate enrollment without cause. [42 CFR 457.1270; 42 CFR 438.706(b)] [Existing standard]

I.L.2.03 [Applies to MCO]*

The contract specifies that the state will provide the MCP with timely written notice before imposing any intermediate sanction (other than required temporary management) that explains the basis and nature of the sanction. [42 CFR 457.1270; 42 CFR 438.710(a)(1)] [Existing standard]

I.L.2.04 [Applies to MCO]*

The contract specifies that the state will provide the MCP with timely written notice before imposing any intermediate sanction (other than required temporary management) that explains any appeal rights the state elects to provide. [42 CFR 457.1270; 42 CFR 438.710(a)(2)]
[Existing standard]

I.L.2.05 - I.L.2.11 [Applies to MCO]*

The contract specifies that:

- The state will provide the MCP with a pre-termination hearing before terminating the MCP contract.
- The state must give the MCP a written notice of its intent to terminate and the reason for termination.
- The state must provide the MCP with the time and place of the pre-termination hearing.
- The state must provide the MCP written notice of the decision affirming or reversing the proposed termination of the contract.
- For an affirming decision, the state must provide the effective date for contract termination.
- For an affirming decision, the state must give the enrollees of the MCP notice of the termination.
- For an affirming decision, the state must inform enrollees of their options for receiving Medicaid services following the effective date of termination.

[42 CFR 457.1270; 42 CFR 438.710(b); 42 CFR 438.710(b)(2)(i) - (iii); 42 CFR 438.10]
[Existing standard]

I.L.2.12 - I.L.2.13 [Applies to MCO]*

After the MCP is notified that the state intends to terminate the contract, the contract permits the state to:

- Give the MCP's enrollees notice of the state's intent to terminate the contract.
- Allow enrollees to disenroll immediately without cause.

[Section 1932(e)(4) of the Act; 42 CFR 457.1270; 42 CFR 438.722(a) - (b)] [Existing standard]

I.L.3 Payment

I.L.3.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*

The contract specifies that when the amount the IHCP receives from an MCP is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the IHS, the state must make a supplemental payment to the IHCP to make up the difference between the amount the MCP pays and the amount the IHCP would have received under FFS or the applicable encounter rate. [42 CFR 457.1209; 42 CFR 438.14(c)(3)] [Existing standard]

I.L.4 Identifying Special Healthcare Needs or Who Need LTSS

I.L.4.01 [Applies to MCO, PIHP, PAHP]*

The contract requires the state, the enrollment broker, or the MCP to identify persons with special health care needs as defined by the state. [42 CFR 457.1230(c); 42 CFR 438.208(c)(1)]
[Existing standard]

- I.L.4.02 [Applies to MCO, PIHP, PAHP]*
The contract requires the state, the enrollment broker, or the MCP to identify persons who need LTSS as defined by the state. [42 CFR 457.1230(c); 42 CFR 438.208(c)(1)] [Existing standard]

I.L.5 Program Integrity

- I.L.5.01 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*
The contract provides that if the state learns that an MCP has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the MCP has relationship with an individual who is an affiliate of such an individual, the state may continue an existing agreement with the MCP unless the Secretary directs otherwise. [42 CFR 457.1285; 42 CFR 438.610(d)(2); 42 CFR 438.610(a); Exec. Order No. 12549] [Existing standard]
- I.L.5.02 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*
The contract provides that if the state learns that an MCP has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act, the state may continue an existing agreement with the MCP unless the Secretary directs otherwise. [42 CFR 457.1285; 42 CFR 438.610(d)(2); 42 CFR 438.610(b)] [Existing standard]
- I.L.5.03 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*
The contract provides that if the state learns that an MCP has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the MCP has relationship with an individual who is an affiliate of such an individual, the state may not renew or extend the existing agreement with the MCP unless the Secretary provides to the state and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation. [42 CFR 457.1285; 42 CFR 438.610(d)(3); 42 CFR 438.610(a); Exec. Order No. 12549] [Existing standard]
- I.L.5.04 [Applies to MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*
The contract provides that if the state learns that an MCP has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act, the state may not renew or extend the existing agreement with the MCP unless the Secretary provides to the state and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation. [42 CFR 457.1285; 42 CFR 438.610(d)(3); 42 CFR 438.610(b)] [Existing standard]

- I.L.5.05 [Applies to MCO, PIHP, PAHP, PCCM, PCCM entity]*
The contract specifies that the state will screen and enroll, and periodically revalidate all MCP network providers as Medicaid providers. [42 CFR 457.1285; 42 CFR 438.602(b)(1)] [Existing standard]
- I.L.5.06 [Applies to MCO, PIHP, PAHP]*
The contract specifies that MCPs may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to 120 days but must terminate a network provider immediately upon notification from the state that the network provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the provider, and notify affected enrollees. [42 CFR 457.1285; 42 CFR 438.602(b)(2)] [Existing standard]
- I.L.5.07 [Applies to MCO, PIHP, PAHP, PCCM, PCCM entity]*
The contract specifies that the state will review the ownership and control disclosures submitted by the MCP and any of the MCP's subcontractors. [42 CFR 457.1285; 42 CFR 438.602(c); 42 CFR 438.608(c)] [Existing standard]
- I.L.5.08 [Applies to MCO, PIHP, PAHP, PCCM, PCCM entity]*
The contract specifies that the state will ensure that the MCP is not located outside of the United States. [42 CFR 457.1285; 42 CFR 438.602(i)] [Existing standard]

I.M. Parity Documentation

The following requirements apply to all States with a separate CHIP program:

See the Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs (<https://www.medicaid.gov/sites/default/files/2019-12/parity-toolkit.pdf>) for more information.

I.M.1 Services Outside an MCO Delivery System

- I.M.1 [Applies to MCO, PIHP, PAHP]*
If the state is providing any services to MCO enrollees using a delivery system other than the MCO delivery system, the state must provide documentation of how the requirements of 42 CFR 457.496 regarding parity in MH/SUD benefits are met with the submission of the MCO contract. [42 CFR 457.1201(l); 42 CFR 438.3(n)(2)] [Existing standard]

I.M.2 Defining Medical/Surgical and MH/SUD Benefits

- I.M.2.01 - I.M.2.03 [Applies to MCO, PIHP, PAHP]*
The documentation includes state's definition of and lists the services included under:
- Medical/surgical benefits*
 - Mental health benefits*
 - Substance use disorder benefits*
- [42 CFR 457.1201(l); 42 CFR 457.496(a)] [Existing standard]

The following requirement is applicable to EPSDT only states. The following requirement is applicable to the portion(s) of the contract where EPSDT is provided in CHIP:

I.M.3 EPSDT Services

EPSDT services for separate CHIP populations is an optional benefit that states may elect to cover under the CHIP state plan. States may be deemed compliant with parity requirements if they provide EPSDT in CHIP consistent with Medicaid statutory requirements cross-referenced at 42 CFR 457.496(b). If states provide EPSDT in CHIP, the following requirements apply. [Section 1902(a)(43); Section 1905(r); Section 2103(c)(6)(B) of the Act]

I.M.3 [Applies to MCO, PIHP, PAHP]*

Does the contract indicate that EPSDT (consistent with the requirements of 42 CFR 457.496(b)) is being provided by the MCP to enrollees, including language that describes the MCE's responsibility to meet all of the EPSDT statutory requirements, such as:

- a. Providing vision services, hearing services, dental services and other screening services, such as a comprehensive physical exam or immunizations, at intervals that meet reasonable standards of medical/dental practice or as medically necessary to determine the existence of a physical or mental illness or conditions (Section 1905(r)(1) - (r)(4) of the Act)
- b. Providing all necessary health care, diagnostic services, and treatments as defined in section 1905(a) to correct or ameliorate medical or physical conditions or illnesses, regardless of whether the service is covered under the state plan (Section 1905(r)(5) of the Act)
- c. Informing all eligible families of the availability of the EPSDT benefit, and providing or arranging for any requested screenings or corrective treatments that have been found as a result of the screening services (Section 1902(a)(43) of the Act)
- d. Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5) of the Act)
- e. EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5) of the Act)

[42 CFR 457.1201(l); 42 CFR 457.496(b)] [Existing standard]

The following requirements described in subsections I.M.4 through I.M.17 apply depending on the state's benefit limitations and financial requirements:

I.M.4 Covered Benefits

If the State child health plan does not provide EPSDT to separate CHIP populations consistent with Medicaid statutory requirements, the State must conduct a parity analysis of the benefit packages provided to separate CHIP populations. For states conducting the full parity analysis, the following requirements apply.

I.M.4.01 [Applies to MCO, PIHP, PAHP]*

The state's documentation must include a table of all covered medical/surgical benefits, mental health benefits, and substance use disorder benefits by classification (inpatient, outpatient, with an optional sub-classification for office visits if applicable, emergency care,

and prescription drugs). The table must include at least one mental health and one substance use disorder benefit in each classification in which there is a medical/surgical benefit. [42 CFR 457.1201(l); 42 CFR 457.496(d)(2)(ii)] [Existing standard]

I.M.4.02 [Applies to MCO, PIHP, PAHP]*

The state's documentation must explain whether the state's state plan covers MH/SUD benefits in each classification in which there is a medical/surgical benefit or if the state added a mental health or substance use disorder benefit to the state plan to meet the requirement in 42 CFR 457.496(d)(2)(ii). [42 CFR 457.1201(l); 42 CFR 457.496(d)(2)(ii)] [Existing standard]

I.M.5 Classification of Benefits

If EPSDT is not provided to all separate CHIP populations consistent with Medicaid statutory requirements and the state is not deemed compliant with parity requirements for those populations, the following requirement applies. [42 CFR 457.496(b)]

I.M.5 [Applies to MCO, PIHP, PAHP]*

The documentation must describe the standard used by the state to determine each classification of benefits (inpatient; outpatient, with an optional sub-classification for office visits; emergency care; and prescription drugs) and how the standard was applied to med/surg and MH/SUD. [42 CFR 457.1201(l); 42 CFR 457.496(d); 42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B)] [Existing standard]

I.M.6 Aggregate and Lifetime Dollar Limits

If EPSDT is not provided to all separate CHIP populations consistent with Medicaid statutory requirements, the State must conduct a full parity analysis of the benefit packages provided to separate CHIP populations that do not receive EPSDT. For states conducting the full parity analysis, the following requirements apply. This rule applies to sections I.M.6 – I.M.17. [42 CFR 457.496(b)]

I.M.6.01 [Applies to MCO, PIHP, PAHP]

The state's documentation indicates that an MCP may not impose an aggregate lifetime dollar limit on MH/SUD benefits. [42 CFR 457.1201(l); 42 CFR 457.496(c)] [Existing standard]

I.M.6.02 [Applies to MCO, PIHP, PAHP]

The state's documentation indicates that an MCP may impose an aggregate lifetime dollar limit on MH/SUD benefits. [42 CFR 457.1201(l); 42 CFR 457.496(c)] [Existing standard]

I.M.6.02.1 [Applies to MCO, PIHP, PAHP]*

The state's documentation must establish, for each applicable benefit package, whether an aggregate lifetime dollar limit applies to 1) less than one-third of all medical/surgical benefits; 2) at least two-thirds of all medical/surgical benefits; or 3) greater than or equal to one-third but less than two-thirds of all medical/surgical benefits. [42 CFR 457.1201(l); 42 CFR 457.496(c)] [Existing standard]

I.M.6.02.1.A [Applies to MCO, PIHP, PAHP]*

The documentation must describe the total dollar amount of payments expected to be paid for medical/surgical benefits for MCP enrollees during the contract year and the data source. [42 CFR 457.1201(l); 42 CFR 457.496(c)(3)] [Existing standard]

I.M.6.02.1.B [Applies to MCO, PIHP, PAHP]*

The documentation must describe the percentage of medical/surgical benefits to which an aggregate lifetime dollar limit is expected to be applied during the contract year and the method used to determine the percentage. [42 CFR 457.1201(l); 42 CFR 457.496(c)] [Existing standard]

I.M.6.02.1.C [Applies to MCO, PIHP, PAHP]*

The documentation must describe the contract year for which the expected payments are being calculated. [42 CFR 457.1201(l); 42 CFR 457.496(c)] [Existing standard]

I.M.6.03 [Applies to MCO, PIHP, PAHP]*

If the state's documentation establishes that an aggregate lifetime dollar limit applies to less than one-third of all medical/surgical benefits, an MCP may not apply an aggregate lifetime dollar limit on mental health or substance use disorder benefits. See I.F.5.01 of this guide. [42 CFR 457.1201(l); 42 CFR 457.496(c)(1)] [Existing standard]

I.M.6.04 [Applies to MCO, PIHP, PAHP]*

If the state's documentation establishes that an aggregate lifetime dollar limit applies to at least two-thirds of all medical/surgical benefits, an MCP may: 1) apply the aggregate lifetime dollar limit that would otherwise apply to medical/surgical benefits to both medical/surgical and MH/SUD benefits in a manner that does not distinguish between the types of benefits; or 2) apply an aggregate lifetime dollar limit on MH/SUD benefits that is no more restrictive than the aggregate lifetime dollar limit applied to medical/surgical benefits. See I.F.5.02 of this guide. [42 CFR 457.1201(l); 42 CFR 457.496(c)(1)] [Existing standard]

I.M.6.05 [Applies to MCO, PIHP, PAHP]*

If the state's documentation establishes that if an aggregate lifetime dollar limit applies to greater than or equal to one-third, but less than two-thirds of all medical/surgical benefits, an MCP may 1) either apply no aggregate lifetime dollar limit on mental health or substance use disorder benefits; or 2) impose an aggregate lifetime dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits in accordance with 42 CFR 457.496(c)(4). See I.F.5.03 of this guide. See also I.M.5.06. [42 CFR 457.1201(l); 42 CFR 457.496(c)(4)] [Existing standard]

I.M.6.06 [Applies to MCO, PIHP, PAHP]*

If the state's documentation establishes that an aggregate lifetime dollar limit applies to greater than or equal to one-third but less than two-thirds of all medical/surgical benefits, an MCP may impose an aggregate lifetime dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits in accordance with 42 CFR 457.496(c)(4)(i)(B). The state's documentation must include how the state determined the average aggregate lifetime dollar limit by specifying the methodology used. [42 CFR 457.1201(l); 42 CFR 457.496(c)(4)(i)(B)] [Existing standard]

I.M.7 Annual Dollar Limits

I.M.7.01 [Applies to MCO, PIHP, PAHP]

The state's documentation indicates that an MCP may not impose an annual dollar limit on any mental health or substance use disorder benefits. [42 CFR 457.1201(l); 42 CFR 457.496(c)] [Existing standard]

I.M.7.02 [Applies to MCO, PIHP, PAHP]

The state's documentation indicates that an MCP may impose an annual dollar limit on MH/SUD benefits. [42 CFR 457.1201(l); 42 CFR 457.496(c)] [Existing standard]

I.M.7.02.1 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may impose an annual dollar limit on MH/SUD benefits, the state's documentation must establish, for each applicable benefit package, whether an annual dollar limit applies to 1) less than one-third of all medical/surgical benefits; 2) at least two-thirds of all medical/surgical benefits; or 3) greater than or equal to one-third but less than two-thirds of all medical/surgical benefits. [42 CFR 457.1201(l); 42 CFR 457.496(c)] [Existing standard]

I.M.7.02.1.A [Applies to MCO, PIHP, PAHP]*

The documentation must describe the total dollar amount of payments expected to be paid for medical/surgical benefits for MCP enrollees during the contract year and the data source. [42 CFR 457.1201(l); 42 CFR 457.496(c)] [Existing standard]

I.M.7.02.1.B [Applies to MCO, PIHP, PAHP]*

The documentation must describe the percentage of medical/surgical benefits to which an annual dollar limit is expected to be applied during the contract year and the method used to determine the percentage. [42 CFR 457.1201(l); 42 CFR 457.496(c)] [Existing standard]

I.M.7.02.1.C [Applies to MCO, PIHP, PAHP]*

The documentation must describe the contract year for which the expected payments are being calculated. [42 CFR 457.1201(l); 42 CFR 457.496(c)] [Existing standard]

I.M.7.03 [Applies to MCO, PIHP, PAHP]*

If the state's documentation establishes that an annual dollar limit applies to less than one-third of all medical/surgical benefits, an MCP may not apply an annual dollar limit on mental health or substance use disorder benefits. See I.F.5.01 of this guide. [42 CFR 457.1201(l); 42 CFR 457.496(c)(1)] [Existing standard]

I.M.7.04 [Applies to MCO, PIHP, PAHP]*

If the state's documentation establishes that an aggregate lifetime or annual dollar limit applies to at least two-thirds of all medical/surgical benefits, an MCP may: 1) apply the aggregate lifetime or annual dollar limit that would otherwise apply to medical/surgical benefits to both medical/surgical and MH/SUD benefits in a manner that does not distinguish between the types of benefits; or 2) applies an aggregate lifetime or annual dollar limit on MH/SUD benefits that is no more restrictive than the aggregate lifetime or dollar limit applied to medical/surgical benefits. [42 CFR 457.1201(l); 42 CFR 457.496(c)(2)] [Existing standard]

I.M.7.05 [Applies to MCO, PIHP, PAHP]*

If the state's documentation establishes that an aggregate lifetime or annual dollar limit applies to greater than or equal to one-third, but less than two-thirds of all medical/surgical benefits, an MCP may 1) either apply no aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits; or 2) impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits in accordance with 42 CFR 457.496(c)(4)(i)(B). [42 CFR 457.1201(l); 42 CFR 457.496(c)(4)] [Existing standard]

I.M.7.06 [Applies to MCO, PIHP, PAHP]*

If the state's documentation establishes that an aggregate lifetime or annual dollar limit applies to greater than or equal to one-third but less than two-thirds of all medical/surgical benefits, an MCP may impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits in accordance with 42 CFR 457.496(c)(4)(i)(B). The state's documentation must include how the state determined the average aggregate lifetime or annual dollar limit by specifying the methodology used. [42 CFR 457.1201(l); 42 CFR 457.496(c)(4)(i)(B)] [Existing standard]

In the context of parity, for sections I.M.8 through I.M.11, financial requirements refer to copayments, deductibles, coinsurance out-of-pocket maximums and other forms of cost-sharing. Parity requirements do not apply to premiums. [42 CFR 457.496(d)(1)(ii)]

I.M.8 Financial Requirements Inpatient Classification

I.M.8.01 [Applies to MCO, PIHP, PAHP]*

The state's documentation indicates that an MCP may not apply any financial requirements (excluding premiums) to mental health or substance use disorder benefits in the inpatient classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.8.02 [Applies to MCO, PIHP, PAHP]*

The state's documentation indicates that an MCP may apply any financial requirements (excluding premiums) to mental health or substance use disorder benefits in the inpatient classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.8.02.01 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a financial requirement other than premiums to MH/SUD benefits, the state's documentation must show the type and level of financial requirement that applies to each specific MH/SUD benefit in the inpatient classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(1)(ii) - (iii)] [Existing standard]

I.M.8.02.02 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a financial requirement other than premiums to MH/SUD benefits, the state's documentation must show all the medical/surgical benefits in the inpatient classification and the applicable type and level of financial requirement. [42 CFR 457.1201(l); 42 CFR 457.496(d)(1)(ii) - (iii)] [Existing standard]

I.M.8.02.03 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a financial requirement other than premiums to MH/SUD benefits, the state's documentation must describe the methodology to determine that the financial requirement type applies to substantially all medical/surgical benefits in the inpatient classification. (Applies to at least 2/3rds of expected payments in the inpatient classification.) [42 CFR 457.1201(l); 42 CFR 457.496(d)(3)(i)(A)] [Existing standard]

I.M.8.02.04 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a financial requirement other than premiums to MH/SUD benefits, the state's documentation must describe the methodology to determine that the financial requirement level is the predominant level of financial requirement applied to medical/surgical benefits in the inpatient classification. (The least restrictive level that applies to at least half of the expected payments for the benefits subject to the type of financial requirement.) This methodology should use the same reasonable methodology that was applied to identify the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement. [42 CFR 457.1201(l); 42 CFR 457.496(d)(3)(i)(B); 42 CFR 457.496(d)(3)(i)(E)] [Existing standard]

I.M.8.02.05 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a financial requirement other than premiums to MH/SUD benefits, the state's documentation must describe the data used and the steps and assumptions to calculate the projected payments in the inpatient classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.9 Financial Requirements Outpatient Classification or Outpatient Sub-classifications (if applicable)

I.M.9.01 [Applies to MCO, PIHP, PAHP]*

The state's documentation indicates that an MCP may not apply any financial requirements (excluding premiums) to mental health or substance use disorder benefits in the outpatient classification or outpatient sub-classifications. [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.9.02 [Applies to MCO, PIHP, PAHP]*

The state's documentation indicates that an MCP may apply any financial requirements (excluding premiums) to mental health or substance use disorder benefits in the outpatient classification or outpatient sub-classifications. [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.9.02.01 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a financial requirement other than premiums to MH/SUD benefits, the state's documentation must show the type and level of financial requirement that applies to each specific MH/SUD benefit in the outpatient classification or outpatient sub-classifications. [42 CFR 457.1201(l); 42 CFR 457.496(d)(1)(ii) - (iii)] [Existing standard]

I.M.9.02.02 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a financial requirement other than premiums to MH/SUD benefits, the state's documentation must show all the medical/surgical benefits in the outpatient classification or outpatient sub-classifications and the applicable type and level of financial requirement. [42 CFR 457.1201(l); 42 CFR 457.496(d)(1)(ii) - (iii)] [Existing standard]

I.M.9.02.03 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a financial requirement other than premiums to MH/SUD benefits, the state's documentation must describe the methodology to determine that the financial requirement type applies to substantially all medical/surgical benefits in the outpatient classification or outpatient sub-classifications. (Applies to at least 2/3rds of expected payments in the outpatient classification or outpatient sub-classifications.) [42 CFR 457.1201(l); 42 CFR 457.496(d)(3)(i)(A)] [Existing standard]

I.M.9.02.04 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a financial requirement other than premiums to MH/SUD benefits, the state's documentation must describe the methodology to determine that the financial requirement level is the predominant level of financial requirement applied to medical/surgical benefits in the outpatient classification or outpatient sub-classifications. (The least restrictive level that applies to at least half of the expected payments for the benefits subject to the type of financial requirement.) This methodology should use the same reasonable methodology that was applied to identify the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement. [42 CFR 457.1201(l); 42 CFR 457.496(d)(3)(i)(B); 42 CFR 457.496(d)(3)(i)(E)] [Existing standard]

I.M.9.02.05 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a financial requirement other than premiums to MH/SUD benefits, the state's documentation must describe the data used and the steps and assumptions to calculate the projected payments in the outpatient classification or outpatient sub-classifications. [42 CFR 457.1201(l); 42 CFR 457.496(d)]

I.M.10 Financial Requirements Emergency Care Classification

I.M.10.01 [Applies to MCO, PIHP, PAHP]*

The state's documentation indicates that an MCP may not apply any financial requirements (excluding premiums) to mental health or substance use disorder benefits in the emergency classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.10.02 [Applies to MCO, PIHP, PAHP]*

The state's documentation indicates that an MCP may apply any financial requirements (excluding premiums) to mental health or substance use disorder benefits in the emergency classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.10.02.01 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a financial requirement other than premiums to MH/SUD benefits, the state's documentation must show the type and level

of financial requirement that applies to each specific MH/SUD benefit in the emergency classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(1)(ii) - (iii)] [Existing standard]

I.M.10.02.02 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a financial requirement other than premiums to MH/SUD benefits, the state's documentation must show all the medical/surgical benefits in the emergency classification and the applicable type and level of financial requirement. [42 CFR 457.1201(l); 42 CFR 457.496(d)(1)(ii) - (iii)] [Existing standard]

I.M.10.02.03 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a financial requirement other than premiums to MH/SUD benefits, the state's documentation must describe the methodology to determine that the financial requirement type applies to substantially all medical/surgical benefits in the emergency classification. (Applies to at least 2/3rds of expected payments in the emergency classification.) [42 CFR 457.1201(l); 42 CFR 457.496(d)(3)(i)(A)] [Existing standard]

I.M.10.02.04 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a financial requirement other than premiums to MH/SUD benefits, the state's documentation must describe the methodology to determine that the financial requirement level is the predominant level of financial requirement applied to medical/surgical benefits in the emergency classification. (The least restrictive level that applies to at least half of the expected payments for the benefits subject to the type of financial requirement.) This methodology should use the same reasonable methodology that was applied to identify the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement. [42 CFR 457.1201(l); 42 CFR 457.496(d)(3)(i)(B); 42 CFR 457.496(d)(3)(i)(E)] [Existing standard]

I.M.10.02.05 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a financial requirement other than premiums to MH/SUD benefits, the state's documentation must describe the data used and the steps and assumptions to calculate the projected payments in the emergency classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.11 Financial Requirements Prescription Drugs Classification

I.M.11.01 [Applies to MCO, PIHP, PAHP]*

The state's documentation indicates that an MCP may not apply any financial requirements (excluding premiums) to mental health or substance use disorder benefits in the prescription drugs classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.11.02 [Applies to MCO, PIHP, PAHP]*

The state's documentation indicates that an MCP may apply any financial requirements (excluding premiums) to mental health or substance use disorder benefits in the prescription drugs classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.11.02.01 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a financial requirement other than premiums to MH/SUD benefits, the state's documentation must show the type and level of financial requirement that applies to each specific MH/SUD benefit in the prescription drugs classification or drug tier (if multi-tiered pharmacy benefits are used as described below). [42 CFR 457.1201(l); 42 CFR 457.496(d)(1)(ii) - (iii)] [Existing standard]

I.M.11.02.02 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a financial requirement other than premiums to MH/SUD benefits, the state's documentation must show all the medical/surgical benefits in the prescription drug classification or drug tier (if multi-tiered pharmacy benefits are used as described below) and the applicable type and level of financial requirement. [42 CFR 457.1201(l); 42 CFR 457.496(d)(1)(ii) - (iii)] [Existing standard]

I.M.11.02.03 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a financial requirement other than premiums to MH/SUD benefits, the state's documentation must describe the methodology to determine that the financial requirement type applies to substantially all medical/surgical benefits in the prescription drug classification or drug tier (if multi-tiered pharmacy benefits are used as described below). (Applies to at least 2/3rds of expected payments in the prescription drug classification.) [42 CFR 457.1201(l); 42 CFR 457.496(d)(3)(i)(A)] [Existing standard]

I.M.11.02.04 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a financial requirement other than premiums to MH/SUD benefits, the state's documentation must describe the methodology to determine that the financial requirement level is the predominant level of financial requirement applied to medical/surgical benefits in the prescription drug classification or drug tier (if multi-tiered pharmacy benefits are used as described below). (The least restrictive level that applies to at least half of the expected payments for the benefits subject to the type of financial requirement.) This methodology should use the same reasonable methodology that was applied to identify the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement. [42 CFR 457.1201(l); 42 CFR 457.496(d)(3)(i)(B); 42 CFR 457.496(d)(3)(i)(E)] [Existing standard]

I.M.11.02.05 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a financial requirement other than premiums to MH/SUD benefits, the state's documentation must describe the data used and the steps and assumptions to calculate the projected payments in the prescription drug classification or drug tier (if multi-tiered pharmacy benefits are used as described below). [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.12 Quantitative Treatment Limitation for the Inpatient Classification

I.M.12.01 [Applies to MCO, PIHP, PAHP]

The state's documentation indicates that an MCP may not apply any quantitative treatment limitations to mental health or substance use disorder benefits in the inpatient classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.12.02 [Applies to MCO, PIHP, PAHP]

The state's documentation indicates that an MCP may apply any quantitative treatment limitations to mental health or substance use disorder benefits in the inpatient classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.12.02.01 [Applies to MCO, PIHP, PAHP]

If the state's documentation indicates that an MCP may apply a quantitative treatment limitation to MH/SUD benefits, the state's documentation must show the type and level of quantitative treatment limitation that applies to each specific MH/SUD benefit in the inpatient classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(1)(ii) - (iii)] [Existing standard]

I.M.12.02.02 [Applies to MCO, PIHP, PAHP]

If the state's documentation indicates that an MCP may apply a quantitative treatment limitation to MH/SUD benefits, the state's documentation must show all the medical/surgical benefits in the inpatient classification and the applicable type and level of quantitative treatment limitation. [42 CFR 457.1201(l); 42 CFR 457.496(d)(1)(ii) - (iii)] [Existing standard]

I.M.12.02.03 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a quantitative treatment limitation to MH/SUD benefits, the state's documentation must describe the methodology to determine that the quantitative treatment limitation applies to substantially all medical/surgical benefits in the inpatient classification. (Applies to at least 2/3rds of expected payments in the inpatient classification.) [42 CFR 457.1201(l); 42 CFR 457.496(d)(3)(i)(A)] [Existing standard]

I.M.12.02.04 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a quantitative treatment limitation to MH/SUD benefits, the state's documentation must describe the methodology to determine that the quantitative treatment limitation level is the predominant quantitative treatment limitation level applied to medical/surgical benefits in the inpatient classification. (The least restrictive level that applies to at least half of the expected payments for the benefits subject to the type of quantitative treatment limitation.) This methodology should use the same reasonable methodology that was applied to identify the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation. [42 CFR 457.1201(l); 42 CFR 457.496(d)(3)(i)(B); 42 CFR 457.496(d)(3)(i)(E)] [Existing standard]

I.M.12.02.05 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a quantitative treatment limitation to MH/SUD benefits, the state's documentation must describe the data used and the

steps and assumptions to calculate the projected payments in the inpatient classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.13 Quantitative Treatment Limitations for the Outpatient Classification or Outpatient Sub-classifications (if applicable)

I.M.13.01 [Applies to MCO, PIHP, PAHP]*

The state's documentation indicates that an MCP may not apply any quantitative treatment limitations to mental health or substance use disorder benefits in the outpatient classification or outpatient sub-classifications. [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.13.02 [Applies to MCO, PIHP, PAHP]*

The state's documentation indicates that an MCP may apply any quantitative treatment limitations to mental health or substance use disorder benefits in the outpatient classification or outpatient sub-classifications. [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.13.02.01 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a quantitative treatment limitation to MH/SUD benefits, the state's documentation must show the type and level of quantitative treatment limitation that applies to each specific MH/SUD benefit in the outpatient classification or outpatient sub-classifications. [42 CFR 457.1201(l); 42 CFR 457.496(d)(1)(ii) - (iii)] [Existing standard]

I.M.13.02.02 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a quantitative treatment limitation to MH/SUD benefits, the state's documentation must show all the medical/surgical benefits in the outpatient classification or outpatient sub-classifications and the applicable type and level of quantitative treatment limitation. [42 CFR 457.1201(l); 42 CFR 457.496(d)(1)(ii) - (iii)] [Existing standard]

I.M.13.02.03 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a quantitative treatment limitation to MH/SUD benefits, the state's documentation must describe the methodology to determine that the quantitative treatment limitation applies to substantially all medical/surgical benefits in the outpatient classification or outpatient sub-classifications. (Applies to at least 2/3rds of expected payments in the outpatient classification or outpatient sub-classifications.) [42 CFR 457.1201(l); 42 CFR 457.496(d)(3)(i)(A)] [Existing standard]

I.M.13.02.04 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a quantitative treatment limitation to MH/SUD benefits, the state's documentation must describe the methodology to determine that the quantitative treatment limitation level is the predominant quantitative treatment limitation level applied to medical/surgical benefits in the outpatient classification or outpatient sub-classifications. (The least restrictive level that applies to at least half of the expected payments for the benefits subject to the type of quantitative treatment limitation.) This methodology should use the same reasonable methodology that was applied to identify

the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation. [42 CFR 457.1201(l); 42 CFR 457.496(d)(3)(i)(B); 42 CFR 457.496(d)(3)(i)(E)] [Existing standard]

I.M.13.02.05 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a quantitative treatment limitation to MH/SUD benefits, the state's documentation must describe the data used and the steps and assumptions to calculate the projected payments in the outpatient classification or outpatient sub-classifications. [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.14 Quantitative Treatment Limitation for the Emergency Classification

I.M.14.01 [Applies to MCO, PIHP, PAHP]

The state's documentation indicates that an MCP may not apply any quantitative treatment limitations to mental health or substance use disorder benefits in the emergency classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.14.02 [Applies to MCO, PIHP, PAHP]

The state's documentation indicates that an MCP may apply any quantitative treatment limitations to mental health or substance use disorder benefits in the emergency classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.14.02.01 [Applies to MCO, PIHP, PAHP]

If the state's documentation indicates that an MCP may apply a quantitative treatment limitation to MH/SUD benefits, the state's documentation must show the type and level of quantitative treatment limitation that applies to each specific MH/SUD benefit in the emergency classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(1)(ii) - (iii)] [Existing standard]

I.M.14.02.02 [Applies to MCO, PIHP, PAHP]

If the state's documentation indicates that an MCP may apply a quantitative treatment limitation to MH/SUD benefits, the state's documentation must show all the medical/surgical benefits in the emergency classification and the applicable type and level of quantitative treatment limitation. [42 CFR 457.1201(l); 42 CFR 457.496(d)(1)(ii) - (iii)] [Existing standard]

I.M.14.02.03 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a quantitative treatment limitation to MH/SUD benefits, the state's documentation must describe the methodology to determine that the quantitative treatment limitation applies to substantially all medical/surgical benefits in the emergency classification. (Applies to at least 2/3rds of expected payments in the emergency classification.) [42 CFR 457.1201(l); 42 CFR 457.496(d)(3)(i)(A)] [Existing standard]

I.M.14.02.04 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a quantitative treatment limitation to MH/SUD benefits, the state's documentation must describe the methodology to determine that the quantitative treatment limitation level is the predominant quantitative

treatment limitation level applied to medical/surgical benefits in the emergency classification. (The least restrictive level that applies to at least half of the expected payments for the benefits subject to the type of quantitative treatment limitation.) This methodology should use the same reasonable methodology that was applied to identify the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation. [42 CFR 457.1201(l); 42 CFR 457.496(d)(3)(i)(B); 42 CFR 457.496(d)(3)(i)(E)] [Existing standard]

I.M.14.02.05 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a quantitative treatment limitation to MH/SUD benefits, the state's documentation must describe the data used and the steps and assumptions to calculate the projected payments in the emergency classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.15 Quantitative Treatment Limitations for the Prescription Drug Classification

I.M.15.01 [Applies to MCO, PIHP, PAHP]

The state's documentation indicates that an MCP may not apply any quantitative treatment limitations to mental health or substance use disorder benefits in the prescription drug classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.15.02 [Applies to MCO, PIHP, PAHP]

The state's documentation indicates that an MCP may apply any quantitative treatment limitations to mental health or substance use disorder benefits in the prescription drug classification (if multi-tiered pharmacy benefits are used as described below). [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.15.02.01 [Applies to MCO, PIHP, PAHP]

If the state's documentation indicates that an MCP may apply a quantitative treatment limitation to MH/SUD benefits, the state's documentation must show the type and level of quantitative treatment limitation that applies to each specific MH/SUD benefit in the prescription drug classification or drug tier (if multi-tiered pharmacy benefits are used as described below). [42 CFR 457.1201(l); 42 CFR 457.496(d)(1)(ii) - (iii)] [Existing standard]

I.M.15.02.02 [Applies to MCO, PIHP, PAHP]

If the state's documentation indicates that an MCP may apply a quantitative treatment limitation to MH/SUD benefits, the state's documentation must show all the medical/surgical benefits in the prescription drug classification or drug tier (if multi-tiered pharmacy benefits are used as described below) and the applicable type and level of quantitative treatment limitation. Existing standard. [42 CFR 457.1201(l); 42 CFR 457.496(d)(1)(ii) - (iii)]

I.M.15.02.03 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a quantitative treatment limitation to MH/SUD benefits, the state's documentation must describe the methodology to determine that the quantitative treatment limitation applies to substantially all medical/surgical benefits in the prescription drug classification or drug tier (if multi-tiered pharmacy benefits

are used as described below). (Applies to at least 2/3rds of expected payments in the prescription drug classification.). [42 CFR 457.1201(l); 42 CFR 457.496(d)(3)(i)(A)] [Existing standard]

I.M.15.02.04 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a quantitative treatment limitation to MH/SUD benefits, the state's documentation must describe the methodology to determine that the quantitative treatment limitation level is the predominant quantitative treatment limitation level applied to medical/surgical benefits in the prescription drug classification or drug tier (if multi-tiered pharmacy benefits are used as described below). (The least restrictive level that applies to at least half of the expected payments for the benefits subject to the type of quantitative treatment limitation.). This methodology should use the same reasonable methodology that was applied to identify the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation. [42 CFR 457.1201(l); 42 CFR 457.496(d)(3)(i)(B); 42 CFR 457.496(d)(3)(i)(E)] [Existing standard]

I.M.15.02.05 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may apply a quantitative treatment limitation to MH/SUD benefits, the state's documentation must describe the data used and the steps and assumptions to calculate the projected payments in the pharmacy classification or pharmacy tier (if multi-tiered pharmacy benefits are used as described below). [42 CFR 457.1201(l); 42 CFR 457.496(d)] [Existing standard]

I.M.16 Special Rules for Multi-Tiered Prescription Drug Benefits

I.M.16.01 [Applies to MCO, PIHP, PAHP]

The state's documentation indicates that an MCP may not establish different tiers of prescription drug benefits. [42 CFR 457.1201(l); 42 CFR 457.496(d)(3)(ii)(A)] [Existing standard]

I.M.16.02 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may establish different tiers of prescription drug benefits, the state's documentation must include a description of how drugs were assigned to each tier without regard as to whether a drug is generally prescribed for medical/surgical or MH/SUD conditions. [42 CFR 457.1201(l); 42 CFR 457.496(d)(3)(ii)(A)] [Existing standard]

I.M.17 Non-Quantitative Treatment Limitations (NQTLs)

I.M.17.01 [Applies to MCO, PIHP, PAHP]*

The state's documentation indicates that an MCP may not impose an NQTL on mental health or substance use disorder benefits in the inpatient classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(4)] [Existing standard]

I.M.17.02 [Applies to MCO, PIHP, PAHP]*

The state's documentation indicates that an MCP may impose an NQTL on mental health or substance use disorder benefits in the inpatient classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(4)] [Existing standard]

I.M.17.02.01 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may impose an NQTL on a MH/SUD benefit in the inpatient classification, the state's documentation must list every NQTL applied to each MH/SUD benefit and medical/surgical benefit in the inpatient classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(4)] [Existing standard]

I.M.17.02.02 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may impose an NQTL to a MH/SUD benefit in the inpatient classification, the state's documentation must describe how the state determined that the processes, strategies, evidentiary standards and other factors used to determine whether and how to apply each NQTL to a MH/SUD service are comparable to, and applied no more stringently than the processes, strategies, evidentiary standards and other factors used to determine whether and how to apply that NQTL on the medical/surgical benefits in the inpatient classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(4)] [Existing standard]

I.M.17.03 [Applies to MCO, PIHP, PAHP]*

The state's documentation indicates that an MCP may not impose an NQTL on MH/SUD benefits in the outpatient classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(4)] [Existing standard]

I.M.17.04 [Applies to MCO, PIHP, PAHP]*

The state's documentation indicates that an MCP may impose an NQTL on MH/SUD benefits in the outpatient classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(4)] [Existing standard]

I.M.17.04.01 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may impose an NQTL on a MH/SUD benefit in the outpatient classification, the state's documentation must list every NQTL applied to each MH/SUD benefit and medical/surgical benefit in the outpatient classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(4)] [Existing standard]

I.M.17.04.02 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may impose an NQTL to a MH/SUD benefit in the outpatient classification, the state's documentation must describe how the state determined that the processes, strategies, evidentiary standards and other factors used to determine whether and how to apply each NQTL to a MH/SUD service are comparable to, and applied no more stringently than the processes, strategies, evidentiary standards and other factors used to determine whether and how to apply that NQTL on the medical/surgical benefits in the outpatient classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(4)] [Existing standard]

I.M.17.05 [Applies to MCO, PIHP, PAHP]*

The state's documentation indicates that an MCP may not impose an NQTL on mental health or substance use disorder benefits in the emergency classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(4)] [Existing standard]

I.M.17.06 [Applies to MCO, PIHP, PAHP]*

The state's documentation indicates that an MCP may impose an NQTL on mental health or substance use disorder benefits in the emergency classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(4)] [Existing standard]

I.M.17.06.01 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may impose an NQTL on a MH/SUD benefit in the emergency classification, the state's documentation must list every NQTL applied to each MH/SUD benefit and medical/surgical benefit in the emergency classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(4)] [Existing standard]

I.M.17.06.02 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may impose an NQTL on a MH/SUD benefit in the emergency classification, the state's documentation must describe how the state determined that the processes, strategies, evidentiary standards and other factors used to determine whether and how to apply each NQTL to a MH/SUD service are comparable to, and applied no more stringently than the processes, strategies, evidentiary standards and other factors used to determine whether and how to apply that NQTL on the medical/surgical benefits in the emergency classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(4)] [Existing standard]

I.M.17.07 [Applies to MCO, PIHP, PAHP]*

The state's documentation indicates that an MCP may not impose an NQTL on mental health or substance use disorder benefits in the prescription drug classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(4)] [Existing standard]

I.M.17.08 [Applies to MCO, PIHP, PAHP]*

The state's documentation indicates that an MCP may impose an NQTL on mental health or substance use disorder benefits in the prescription drug classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(4)] [Existing standard]

I.M.17.08.01 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may impose an NQTL on a MH/SUD benefit in the prescription drug classification, the state's documentation must list every NQTL applied to each MH/SUD benefit and medical/surgical benefit in the prescription drug classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(4)] [Existing standard]

I.M.17.08.02 [Applies to MCO, PIHP, PAHP]*

If the state's documentation indicates that an MCP may impose an NQTL to a MH/SUD benefit in the prescription drug classification, the state's documentation must describe how the state determined that the processes, strategies, evidentiary standards and other factors used to determine whether and how to apply each NQTL to a MH/SUD service are comparable to, and applied no more stringently than the processes, strategies, evidentiary standards and other factors used to determine whether and how to apply that NQTL on the medical/surgical benefits in the prescription drug classification. [42 CFR 457.1201(l); 42 CFR 457.496(d)(4)] [Existing standard]

Section II: Tips Applicable to Contract Requirements

Requirement Numbers	Applicable Tips
I.A. Contract Completeness	
I.A.1.04	<p>Effective with the rating period beginning on or after 07/01/17, 42 CFR 457.1203(f) (cross-referencing 42 CFR 438.8(k)), requires the MCO, PIHP or PAHP to submit a MLR report in a timeframe and manner determined by the state, which must be within 12 months of the end of the MLR reporting year. The state is then responsible for submitting a summary description of the report(s) to CMS.</p> <p>Note that 42 CFR 457.1203(f) (cross-referencing 42 CFR 438.8(l)) provides a MLR reporting exception applicable to the first year of operations for a MCO, PIHP or PAHP newly contracted with the state.</p>
I.B. Enrollment and Disenrollment	
I.B.4.14	Under 42 CFR 457.1212 (cross-referencing 42 CFR 438.56(d)(2)(iii)), an example of “related services” is a cesarean section and a tubal ligation.
I.C. Beneficiary Notification	
I.C.1.01	Pursuant to 42 CFR 457.1207 (cross-referencing 42 CFR 438.10(c)(1)), the MCP must provide all required information to enrollees and potential enrollees in a manner and format that may be understood easily and is readily accessible by such enrollees and potential enrollees.
I.C.1.03	Provider directory, appeal and grievance notice, and denial notice requirements at 42 CFR 457.1207 (cross-referencing 42 CFR 438.10(d)(3)) are not required for NEMT PAHPs.
I.C.1.04 – I.C.1.07	Revisions to 42 CFR 457.1207 (cross-referencing 42 CFR 438.10(d)), in the 2020 Final Rule changed font size requirements for certain materials from "large print" to "conspicuously visible font size."
I.C.1.09 - I.C.1.10	Under 42 CFR 457.1207 (cross-referencing 42 CFR 438.10(d)(4)), oral interpretation requirements apply to all non-English languages, not just those that the state identifies as prevalent.
I.C.2.01 – I.C.2.44	<p>States must develop model handbooks in accordance with 42 CFR 457.1207 (cross-referencing 42 CFR 438.10(c)(4)(ii)). CMS must assure that the model enrollee handbook that the MCP is required to utilize meets all the requirements at 42 CFR 438.10(g) (except 42 CFR 438.10(g)(2)(xi)(E) and 42 CFR 438.10(g)(2)(xii)). How a state chooses to meet these federal requirements may vary. For example, a state may:</p> <ol style="list-style-type: none"> (1) include the model enrollee handbook that outlines these federal requirements as an attachment to the contract; (2) stipulate each requirement of 42 CFR 438.10(g) within the MCP contract in addition to outlining them in the model enrollee handbook; (3) outline in the contract the process by which the state will share the model enrollee handbook; or (4) use another method.

Requirement Numbers	Applicable Tips
I.C.2.12 – I.C.2.15	This requirement at 42 CFR 457.1207 (cross-referencing 42 CFR 438.10(g)(2)(v)), aligns to the scope of the PIHP's or PAHP's contracted services. For example, a dental PAHP or behavioral health PIHP will only describe the after-hours care, emergency care, or stabilization applicable for those services.
I.C.2.28	For PAHPs under 42 CFR 457.1207 (cross-referencing 42 CFR 438.10(g)(2)(ix)), available and accessible health care services are aligned with the scope of the PAHP's contracted services.
I.C.2.30	For NEMT PAHPs under 42 CFR 457.1207 (cross-referencing 42 CFR 438.10(g)(2)(xi)), the handbook must only include fair hearing procedures and timeframes; grievance and appeal requirements do not apply.
I.C.2.45	Pursuant to 42 CFR 457.1230(b) (cross-referencing 42 CFR 438.207(c)(3)), the state defines what constitutes a "significant change."
I.C.4.01 - I.C.4.11	PCCM entities must comply with this provider type requirement under 42 CFR 457.1207 (cross-referencing 42 CFR 438.10(h)) only when appropriate, based on the scope of contracted services.
I.C.5.01 - I.C.5.03	PCCM entities must comply with this requirement under 42 CFR 457.1207 (cross-referencing 42 CFR 438.10(i)) only when appropriate, based on the scope of contracted services.
I.C.5.01 - I.C.5.03	Formulary requirements under 42 CFR 457.1207 (cross-referencing 42 CFR 438.10(i)), only apply when prescription drugs are included in the MCP contract as a covered benefit.
I.C.7.03	Pursuant to 42 CFR 457.1224 (cross-referencing 42 CFR 438.104(a)), private insurance does not include a qualified health plan, as defined in 45 CFR 155.20.
I.C.8.01 - I.C.8.06	All requirements in 42 CFR 457.1207 (cross-referencing 42 CFR 438.10(c)(6)), must be met in order for the MCP to provide information electronically.
I.C.8.40	MCOs, PIHPs, and PAHPs operating in compliance with 42 CFR 438.236(c) will be deemed compliant with the requirement in 42 CFR 457.496(e)(1) (that the MCP make available the criteria for medical necessity determinations made by the MCP for mental health or substance abuse disorder benefits to any enrollee, potential enrollee, or contracting provider upon request. Compliance with the requirement in 42 CFR 457.496(e)(1) is not determinative of compliance with any other provision of applicable Federal or state law.

I.D. Payment

I.D.1.01 – I.D.1.03; I.D.2.01 – I.D.2.34	This provision only applies to risk-bearing entities. MCOs are always risk bearing in accordance with 42 CFR 457.10, however PIHPs or PAHPs may be risk-based or non-risk. The MCP contract should clearly indicate if a contract is risk-based or non-risk.
I.D.1.01	CMS currently requires submission of CHIP contracts. Final capitation rates should be specified in the contract, per 42 CFR 457.1201(c) (cross-referencing 42 CFR 438.3(c)).

Requirement Numbers	Applicable Tips
I.D.1.01 – I.D.1.03; I.D.2.01 – I.D.2.34	This provision only applies to risk-bearing entities. MCOs are always risk bearing in accordance with 42 CFR 457.10, however PIHPs or PAHPs may be risk-based or non-risk. The MCP contract should clearly indicate if a contract is risk-based or non-risk.
I.D.2.09 – I.D.2.11	Given the complexity of the MLR calculation as required by 42 CFR 457.1203(f) (cross-referencing 42 CFR 438.8), states may choose to reference the CFR rather than outline all relevant provisions within the MCP contracts.
I.D.2.15 – I.D.2.34	As described at 42 CFR 457.1203(f) (cross-referencing 42 CFR 438.8(l)), a state, in its discretion, may exclude a MCO, PIHP or PAHP that is newly contracted with the state from the MLR requirements for the first year of the MCO's, PIHP's or PAHP's operation. Such MCOs, PIHPs or PAHPs must be required to comply with these requirements during the next MLR reporting year in which the MCO, PIHP or PAHP is in business with the state, even if the first year was not a full 12 months.
I.E. Providers and Provider Network	
I.E.1.06	See the 'Network Adequacy Standards' subsection for more information on 42 CFR 457.1230(a) (cross-referencing 42 CFR 438.206(c)(1)) and 42 CFR 457.1218 (cross-referencing 42 CFR 438.68) requirements.
I.E.1.07	In accordance with 42 CFR 457.1230(b) (cross-referencing 42 CFR 438.207(b)(1)), the documentation to demonstrate an appropriate range of services must address only the set of services covered under the contract.
I.E.8.02	Refer to 42 CFR 457.1201(h) (cross-referencing 42 CFR 438.438(i) and 42 CFR 422.208) for more information on substantial financial risk and stop-loss protection.
I.E.9.01	As described at 42 CFR 457.1209 (cross-referencing 42 CFR 438.14(b)(5)), in a state where timely access to covered services cannot be ensured due to few or no IHCPs, the MCP will be considered to have met this requirement if Indian enrollees are permitted by the MCP to access out-of-state IHCPs; or if this circumstance is deemed to be good cause for disenrollment from both the MCP and the state's managed care program.
I.E.10.01	MCOs, PIHPs, and PAHPs operating in compliance with 42 CFR 438.236(c) will be deemed compliant with the requirement in 42 CFR 457.496(e)(1) that the MCP make available the criteria for medical necessity determinations made by the MCP for mental health or substance abuse disorder benefits to any enrollee, potential enrollee, or contracting provider upon request. Compliance with the requirement in 42 CFR 457.496(e)(1) is not determinative of compliance with any other provision of applicable Federal or state law.
I.F. Coverage	
I.F.1.01 – I.F.1.21	In accordance with 42 CFR 457.1228 (cross-referencing 42 CFR 438.114), this provision applies to the extent that services required to treat an emergency medical condition, such as dental and behavioral health services, fall within the scope of the services for which the PIHP or PAHP is responsible.
I.F.2.01	Pursuant to 42 CFR 457.1230(a) (cross-referencing 42 CFR 438.206(b)(2)), this requirement applies in addition to the enrollee's designated source of primary care if that source is not the women's health specialist.

Requirement Numbers	Applicable Tips
I.F.2.05	This requirement at 42 CFR 457.496(d)(5) applies to any MCO, PIHP, or PAHP providing access to out-of-network providers for medical/surgical benefits, in states covering medical/surgical and mental health or substance use disorder services under the state plan.
I.F.5.02 - I.F.5.04	The contract would also meet this requirement if, instead of including the regulatory text, the contract specifies that the MCP must comply with parity requirements for aggregate lifetime and annual dollar limits in 42 CFR 457.496(c) or specifies that the MCP cannot impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits.
I.F.5.02 - I.F.5.04	42 CFR 457.496 neither sanctions nor prohibits aggregate lifetime and annual dollar limits; the rule merely provides the standards for applying parity requirements to such limits if the limits are otherwise authorized.
I.F.5.02 – I.F.5.05	Applies where the full scope of medical/surgical and mental health and substance use disorder services are provided through the MCO.
I.F.5.08	<p data-bbox="586 749 1357 779">Per 42 CFR 457.496(d)(4), NQTLs include, but are not limited to:</p> <ul data-bbox="634 785 1511 1400" style="list-style-type: none"> <li data-bbox="634 785 1511 882">• Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; <li data-bbox="634 888 1154 917">• Formulary design for prescription drugs; <li data-bbox="634 924 1479 982">• For MCOs, PIHPs, or PAHPs with multiple network tiers (such as preferred providers and participating providers), network tier design; <li data-bbox="634 989 1511 1050">• Standards for provider admission to participate in a network, including reimbursement rates; <li data-bbox="634 1056 1495 1115">• MCO, PIHP, or PAHP methods for determining usual, customary, and reasonable charges; <li data-bbox="634 1121 1495 1218">• Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); <li data-bbox="634 1224 1406 1253">• Exclusions based on failure to complete a course of treatment; <li data-bbox="634 1260 1495 1356">• Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the MCO, PIHP, or PAHP; and <li data-bbox="634 1362 1373 1400">• Standards for providing access to out-of-network providers.
I.F.6.06	<p data-bbox="586 1436 1511 1533">According to 42 CFR 457.1220 (cross-referencing 42 CFR 438.100(a)(1)), the state must ensure that each MCO, PIHP, PAHP, PCCM, and PCCM entity has written policies regarding the enrollee rights specified in 42 CFR 438.100.</p> <p data-bbox="586 1539 1511 1728">According to 438.100(b)(2)(vi), cross-referenced at 42 CFR 457.1220, the state must ensure that each enrollee of an MCO, PIHP, PAHP, PCCM or PCCM entity has the the right to, if the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.</p>

Requirement Numbers	Applicable Tips
I.G. Quality and Utilization Management	
I.G.1.01, I.G.5.04, I.G.5.06, I.G.5.13	This requirement per 42 CFR 457.1240(f) applies to PCCM entities whose contracts with the state provide for shared savings, incentive payments or other financial reward for the PCCM entity for improved quality outcomes.
I.G.2.05	Related to 42 CFR 457.496, Parity in Mental Health and Substance Use Disorder Benefits, parity applies to CHIP benefits regardless of delivery system. Therefore, the contract should specify (1) a mechanism for the MCP to work with other MCPs (managed care plans) and/or the State, to ensure that any MCO enrollee is provided access to a set of benefits that meets the requirements of 42 CFR 457.496 regarding parity in mental health and substance use disorder benefits, regardless of what mental health or substance use disorder benefits are provided by the MCO; and (2) specify that the MCP coordinate with other MCPs and/or the State and providers to deliver an integrated set of benefits to MCO enrollees.
I.G.2.13	States must have in effect a transition of care policy consistent with 42 CFR 457.1216 (cross-referencing 42 CFR 438.62), and must require the MCPs to implement the transition to care policy. How a state chooses to meet these federal requirements may vary. For example, a state may: <ul style="list-style-type: none"> (1) Include its transition to care policy within the MCP contract or as an attachment to the contract; (2) Outline in the contract the process by which the state will share the model enrollee handbook; or (3) Use another method.
I.G.3.05	This requirement under 42 CFR 457.496(d)(4) applies to MCOs or a PIHP or PAHP providing services to an MCO enrollee, in states covering medical/surgical and mental health or substance use disorder services under the state plan.
I.G.5.01- I.G.5.06, I.G.5.13	The requirement only applies to PCCM-Es meeting the 42 CFR 457.1240(f) definition, meaning a PCCM entity whose contract with the state provides for shared savings, incentive payments, or other financial reward for improved quality outcomes.
I.G.7.07	For the requirement at 42 CFR 457.1230(c) (cross-referencing 42 CFR 438.208(c)(3)(ii)), see the person-centered planning process and person-centered service plan requirements at 42 CFR 441.301(c)(1) and (2), as the treatment or service plan must meet these requirements.
I.H. Grievance and Appeals	
I.H.1.11	Pursuant to 42 CFR 457.1212 (cross-referencing 42 CFR 438.56(d)(5)(iii)), the contract provides that if, as a result of the grievance process, the MCP approves a disenrollment request, the state agency is not required to make a determination.
I.H.2.01 - I.H.2.06	If the contract clearly specifies that the enrollee will receive a notice of adverse benefit determination when payment for a service has been denied, then the contract also meets the requirement in 42 CFR 457.496(e)(2), which requires the MCP to make available to the enrollee the reason for any denial by the MCP of reimbursement or payment for services for mental health or substance use disorder benefits to the enrollee.

Requirement Numbers	Applicable Tips
I.H.3.08 - I.H.3.09	Pursuant to 42 CFR 457.1230(d) (cross-referencing 42 CFR 438.210(d)), the MCP may extend the 14 calendar day service authorization notice timeframe by up to 14 additional calendar days if the enrollee or provider requests extension, or if the MCP justifies (to the state agency upon request) a need for additional information and how the extension is in the enrollee's interest.
I.H.4.01	An enrollee may request a State external review in accordance with the terms of subpart K of 42 CFR 457 after receiving notice that the adverse benefit determination is upheld by the MCP.
I.H.6.04	Pursuant to 42 CFR 457.1260(d) (cross-referencing 42 CFR 438.406(b)(3)), oral inquiries seeking to appeal an adverse benefit determination are treated as appeals in order to establish the earliest possible filing date for the appeal.
I.H.6.10	Pursuant to 42 CFR 457.1260(e)(1) (cross-referencing 42 CFR 438.408(b)(2)), for standard resolution of an appeal and notice to the affected parties, the state must establish a timeframe that is no longer than 30 calendar days from the day the MCP receives the appeal. Pursuant to 438.408(b)(3), for expedited resolution of an appeal and notice to affected parties, the state must establish a timeframe that is no longer than 72 hours after the MCP receives the appeal.
I.H.8.01	Refer to the Beneficiary Notification section of this State Guide for further detail regarding the notification requirements at 42 CFR 457.1260(e)(1) (cross-referencing 42 CFR 438.408(d)(2)(i)).
I.H.10.09	Refer to the Beneficiary Notification section of this State Guide for further detail regarding the notification requirements at 42 CFR 457.1260(e)(1) (cross-referencing 42 CFR 438.408(d)(1)).
I.I. Program Integrity	
I.I.1.01	Pursuant to 42 CFR 457.1233(a) (cross-referencing 42 CFR 438.214(d)(1)), CMS encourages states to require the MCP to check their employees and contractors every month against the OIG's list of Excluded Individuals/Entities (LEIE) and the GSA Excluded Parties List System (EPLS) to ensure that no employee or contractor has been excluded.
I.I.1.01	Pursuant to 42 CFR 457.1233(a) (cross-referencing 42 CFR 438.214(d)(1)), CMS encourages the state to require MCPs to notify the state agency promptly of any action it takes to limit the ability of an individual or entity to participate in its network. This includes, but is not limited to, suspension actions, settlement agreements and situations where an individual or entity voluntarily withdraws from the network to avoid a formal sanction.

Requirement Numbers	Applicable Tips
I.I.2.01	Under 42 CFR 457.1285 (cross-referencing 42 CFR 438.818), enrollee encounter data reports must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy standards, and reports must be submitted in the format required by the Medicaid Statistical Information System or format required by any successor system to the Medicaid Statistical Information System. Additionally, states must ensure that enrollee encounter data is validated for accuracy and completeness as required under 42 CFR 438.242 before submitting to CMS, and must validate that the data submitted to CMS is a complete and accurate representation of the information submitted to the state by the MCP.
I.I.2.13 - I.I.2.15	The data, documentation and information that must be certified under 42 CFR 457.1285 (cross-referencing 42 CFR 438.604 and 42 CFR 438.606) is described in I.I.2.01 - I.I.2.12 and I.I.5.05.
I.I.2.37	Under 42 CFR 457.1285 (cross-referencing 42 CFR 438.608(b)), this provision does not require the network provider to render services to FFS beneficiaries.
I.I.2.37	Pursuant to 42 CFR 457.1285 cross-referencing 42 CFR 438.608(b)), the disclosure and screening functions can be delegated. The enrollment functions, however, cannot.
I.J. General Terms and Conditions	
I.J.1.06	NEMT PAHPs are only subject to the data, information, and documentation provisions specified in 42 CFR 457.1201(q) (cross-referencing 42 CFR 438.3(u)).
I.J.3.01 - I.J.3.16	This subcontractor requirement under 42 CFR 457.1233(b) (cross-referencing 42 CFR 438.230) only applies to contracts where the MCP has a subcontractor(s).
I.J.4.03	Pursuant to 42 CFR 457.1270(a) (cross-referencing 42 CFR 438.700(b)(3)), this includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under CHIP, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.
I.J.4.06	PIP requirements are described in the “Providers and Provider Networks” and “Beneficiary Notification” sections of this guide.
I.J.4.12	Pursuant to 42 CFR 457.1270(a) (cross-referencing 42 CFR 438.700(b)(3)), discrimination among enrollees on the basis of their health status or need for health care services includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under CHIP, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.

Requirement Numbers	Applicable Tips
I.L. State Obligations	
I.L.1.01 – I.L.5.08	Federal requirements in accordance with 42 CFR 457 Subpart L and 42 CFR 438 do not specifically require the MCP contract to articulate the obligations of the state that are screened for in this section; however, the Centers for Medicare & Medicaid Services (CMS) believes that these obligations directly relate to functions the MCP is required to perform or actions the state may take against the MCP. Therefore, CMS will seek assurance of compliance with these federal requirements as part of contract review. Inclusion in a contract is just one way that a state can assure compliance. A state may also assure compliance with these federal requirements through other supporting documentation.
I.L.1.01	For additional information on contract language requirements at 42 CFR 457.1207 (cross-referencing 42 CFR 438.10(d)(1)), see related items in I.C.1 'Language and Format' in the "Beneficiary Notification" Section.
I.L.2.01	Pursuant to 42 CFR 457.1270(a) (cross-referencing 42 CFR 438.704(c)), the maximum amount of the penalty is \$25,000 or double the amount of the excess charges, whichever is greater.
I.L.4.01	If the state or enrollment broker is responsible for this identification under 42 CFR 457.1230(c) (cross-referencing 42 CFR 438.208(c)(1)), the contract should indicate the mechanism through which the MCP is notified of persons identified as having special health care needs. It is necessary for the MCP to be notified of enrollees with special health care needs in order for the MCP to meet the requirement at 42 CFR 438.208(c)(2), described in the Quality and UM section of this tool, to assess those individuals.
I.L.4.01	Related to the identification of persons as having special health care needs under 42 CFR 457.1230(c) (cross-referencing 42 CFR 438.208(c)(1)), see the related "Special Health Care Needs: Assessment and Treatment Plans" Subsection in the Quality and Utilization Management Section.
I.L.4.01- I.L.4.02	42 CFR 457.1230(c) (cross-referencing 42 CFR 438.208) regulates coordination and continuity of care for enrollees. Under 42 CFR 438.208(a)(2), For PIHPs and PAHPs, the state determines, based on the scope of the entity's services, and on the way the state has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs. Under 42 CFR 438.208(a)(3), for each MCO that serves enrollees who are also enrolled in and receive Medicare benefits from a Medicare Advantage Organization (MAO), the state determines to what extent the MCO must meet identification, assessment, and treatment planning requirements for dually eligible individuals.
I.L.4.02	Related to the identification of persons as having LTSS needs under 42 CFR 457.1230(c) (cross-referencing 42 CFR 438.208(c)(1)), see the related "Special Health Care Needs: Assessment and Treatment Plans" Subsection in the Quality and Utilization Management Section.

Requirement Numbers	Applicable Tips
I.L.5.05	This requirement at 42 CFR 457.1285 (cross-referencing 42 CFR 438.602(b)(1)) extends to PCCMs and PCCM entities to the extent the primary care case manager is not otherwise enrolled with the state to provide services to FFS beneficiaries. This provision does not require the network provider to render services to FFS beneficiaries.
I.M. Parity Documentation	
I.M.1	For CHIP, the state does not need to submit documentation with every amendment or contract effective after October 2, 2017 if the state can show that the MCP or state did not change their operations in a way that would affect compliance with 42 CFR 457.496. As part of the contract review process, the state may attest that there are no changes in benefit design or requirements that affect compliance with 42 CFR 457.496.
I.M.1; I.M.2.01 – I.M.2.03; I.M.3; I.M.4.01 – I.M.4.02; I.M.5; I.M.6.01 – I.M.6.06; I.M.7.01 – I.M.7.06; I.M.8.01 – I.M.8.02.05; I.M.9.01 – I.M.9.02.05; I.M.10.01 – I.M.10.02.05; I.M.11.01 – I.M.11.02.05; I.M.12.01 – I.M.12.02.05; I.M.13.01 – I.M.13.02.05; I.M.14.01 – I.M.14.02.05; I.M.15.01 – I.M.15.02.05; I.M.16.01 – I.M.16.02; I.M.17.01 – I.M.17.08.02	Although CMS began reviewing CHIP parity requirements 7/1/2018, contracts were required to be in compliance with these regulations starting 10/2/2017.
I.M.2.01 - I.M.2.03	For CHIP, as specified in 42 CFR 457.496(a), the state must define benefits in accordance with applicable Federal and state law and consistent with generally recognized independent standards of current medical practice, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD). If the state does not use DSM or ICD, section 6.2.1.1- MHPAEA of the CHIP state plan must provide the standards used.
I.M.2.01 – I.M.2.03	Per 42 CFR 457.496(f)(1)(i), the state must indicate the standard used to define medical/surgical benefits, mental health benefits, and substance use disorder benefits in the state plan.
I.M.2.01 – I.M.2.03	This requirement applies to all states with a separate CHIP program.
I.M.3	This requirement is applicable to EPSDT-only states. It is applicable to the portion(s) of the contract where EPSDT is provided in CHIP.
I.M.3	EPSDT services for separate CHIP populations is an optional benefit that states may elect to cover under the CHIP state plan. States may be deemed compliant with parity requirements if they provide EPSDT in CHIP consistent with Medicaid statutory requirements cross-referenced at 42 CFR 457.496(b). If the state provides EPSDT in CHIP, this requirement applies.

Requirement Numbers	Applicable Tips
I.M.4.01 – I.M.4.02	For CHIP, 42 CFR 457.496(d)(2)(ii) provides that if an MCO enrollee is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits must be provided to the MCO enrollee in every classification in which medical/surgical benefits are provided. The state’s documentation should indicate whether the state added a mental health or substance use disorder benefit to the MCP benefit package.
I.M.4.01 – I.M.4.02	If the state child health plan does not provide EPSDT to separate CHIP populations consistent with Medicaid statutory requirements, the state must conduct a parity analysis of the benefit packages provided to separate CHIP populations. For states conducting the full parity analysis, this requirement applies.
I.M.4.01 – I.M.4.02; I.M.5; I.M.6.01 – I.M.6.06; I.M.7.01 – I.M.7.06; I.M.8.01 – I.M.8.02.05; I.M.9.01 – I.M.9.02.05; I.M.10.01 – I.M.10.02.05; I.M.11.01 – I.M.11.02.05; I.M.12.01 – I.M.12.02.05; I.M.13.01 – I.M.13.02.05; I.M.14.01 – I.M.14.02.05; I.M.15.01 – I.M.15.02.05; I.M.16.01 – I.M.16.02; I.M.17.01 – I.M.17.08.02	Requirements described in subsection III.M.4 through III.M.17 apply depending on the state’s benefit limitations and financial requirements.
I.M.5	For CHIP, as required by 42 CFR 457.496(d)(2)(ii) and 42 CFR 457.496(d)(3)(ii)(B), in determining the classification in which a benefit belongs, state defined standards must be applied to medical/surgical benefits and to MH/SUD benefits. Only the following four classifications may be used: inpatient; outpatient (with a sub classification for office visits); emergency care; and prescription drugs. If a sub classification is used for outpatient office visits, documentation should list the benefits mapped to the office visit sub-classification versus those for “other outpatient,” and the method used for the placement in each sub-classification.
I.M.5	If EPSDT is not provided to all separate CHIP populations consistent with Medicaid statutory requirements and the state is not deemed compliant with parity requirements for those populations, this requirement applies.

Requirement Numbers	Applicable Tips
I.M.6.01 – I.M.6.06; I.M.7.01 – I.M.7.06; I.M.8.01 – I.M.8.02.05; I.M.9.01 – I.M.9.02.05; I.M.10.01 – I.M.10.02.05; I.M.11.01 – I.M.11.02.05; I.M.12.01 – I.M.12.02.05; I.M.13.01 – I.M.13.02.05; I.M.14.01 – I.M.14.02.05; I.M.15.01 – I.M.15.02.05; I.M.16.01 – I.M.16.02; I.M.17.01 – I.M.17.08.02	If EPSDT is not provided to all separate CHIP populations consistent with Medicaid statutory requirements, the state must conduct a full parity analysis of the benefit packages provided to separate CHIP populations that do not receive EPSDT. For states conducting the full parity analysis, this requirement applies. This rule applies to subsections III.M.6 – III.M.17.
I.M.6.02.1 – I.M.6.05	Any reasonable method may be used to determine the percentage of total medical/surgical benefits to which an aggregate lifetime dollar limit applies.
I.M.6.06	<p>Documentation for this may include:</p> <ul style="list-style-type: none"> • The categories of medical/surgical benefits and the determined average aggregate lifetime dollar limits applicable to each. • The calculation of the average aggregate lifetime dollar limit, which takes into account a weighted average of the aggregate lifetime dollar limits applicable to categories of medical/surgical benefits. • The documentation should describe the reasonable method used to determine the weighted average of the aggregate lifetime dollar limits applicable to categories of medical/surgical benefits. • The methodology used to calculate the average aggregate lifetime dollar limit for each category, including: <ul style="list-style-type: none"> ○ The aggregate lifetime dollar limit and the total expected payments for medical/surgical benefits for the applicable contract year for the categories of benefits, including the estimated aggregate lifetime limit for benefits not subject to an aggregate lifetime dollar limit. ○ For benefits that are not within a category that is subject to an aggregate lifetime dollar limit, the calculation of the aggregate lifetime dollar limit based on the upper limit on the reasonably expected dollar amount. <p>Any reasonable method may be used to determine the weighted average of the aggregate lifetime dollar limits applicable to categories of medical/surgical benefits. When determining the weighted average: 1) limits based on delivery mechanisms, such as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories of medical/surgical benefits and 2) any benefits that are not within a category that is subject to a separately-designated dollar limit under the contract are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that an MCP may reasonably be expected to incur for such benefits, taking into account any other applicable restrictions.</p>

Requirement Numbers	Applicable Tips
I.M.7.02.1 – I.M.7.05	Any reasonable method may be used to determine the percentage of total medical/surgical benefits to which an annual dollar limit applies.
I.M.7.06	<p>Documentation for this may include:</p> <ul style="list-style-type: none"> • The categories of medical/surgical benefits and the determined average annual dollar limits applicable to each. • The calculation of the average annual dollar limit, which takes into account a weighted average of the annual dollar limits applicable to categories of medical/surgical benefits. • The documentation should describe the reasonable method used to determine the weighted average of the annual dollar limits applicable to categories of medical/surgical benefits. • The methodology used to calculate the average annual dollar limit for each category, including: <ul style="list-style-type: none"> ○ The annual dollar limit and the total expected payments for medical/surgical benefits for the applicable contract year for the categories of benefits, including the estimated annual limit for benefits not subject to an annual dollar limit. ○ For benefits that are not within a category that is subject to an annual dollar limit, the calculation of the annual dollar limit based on the upper limit on the reasonably expected dollar amount. <p>Any reasonable method may be used to determine the weighted average of the annual dollar limits applicable to categories of medical/surgical benefits. When determining the weighted average: 1) limits based on delivery mechanisms, such as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories of medical/surgical benefits and 2) any benefits that are not within a category that is subject to a separately-designated dollar limit under the contract are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that an MCP may reasonably be expected to incur for such benefits, taking into account any other applicable restrictions.</p>
I.M.8.01 – I.M.8.02.05; I.M.9.01 – I.M.02.05; I.M.10.01 – I.M.10.02.05; I.M.11.01 – I.M.11.02.05	In the context of parity, for subsections III.M.8 through III.M.11, financial requirements refer to copayments, deductibles, coinsurance out-of-pocket maximums and other forms of cost-sharing. Parity requirements do not apply to premiums.
I.M.8.02.03 – I.M.8.02.05, I.M.9.02.03 – I.M.9.02.05, I.M.10.02.03 – I.M.10.02.05, I.M.11.02.03 – I.M.11.02.05, I.M.12.02.03 – I.M.12.02.05, I.M.13.02.03 – I.M.13.02.05, I.M.14.02.03 – I.M.14.02.05, I.M.15.02.03 – I.M.15.02.05	The determination of the portion of medical/surgical benefits in a classification of benefits subject to a financial requirement or quantitative treatment limitation is based on the total dollar amount of all combinations of MCP payments for medical/surgical benefits in the classification expected to be paid under the MCPs for a contract year. Any reasonable method may be used to determine the dollar amount expected to be paid under an MCP for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation.

Requirement Numbers	Applicable Tips
I.M.8.02.04, I.M.9.02.04, I.M.10.02.04, I.M.11.02.04, I.M.12.02.04, I.M.13.02.04, I.M.15.02.04	For CHIP contracts, see 61 Fed. Reg. 18397, March 30, 2016 for an example. If, for a type of financial requirement or quantitative treatment limit that applies to substantially all medical/surgical benefits in a classification, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, levels may be combined. See 42 CFR 457.496(d)(3)(i)(B)(2). Per 42 CFR 457.496(d)(3)(i)(D), except as otherwise specified for certain threshold requirements, any reasonable method may be used to determine the dollar amount expected to be paid for medical/surgical benefits.
I.M.9.01 – I.M.9.02, I.M.9.02.03-I.M.9.02.05, I.M.13.01 – I.M.13.02, I.M.13.02.01 – I.M.13.02.05	For purposes of applying the financial requirement and treatment limitation rules of this section, a MCO, PIHP, or PAHP may divide its benefits furnished on an outpatient basis into the two sub-classifications: <ul style="list-style-type: none"> • Office visits (such as physician visits); or • All other outpatient items and services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).
I.M.16.02	Examples of reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up/delivery.
I.M.17.01 – I.M.17.02, I.M.17.02.01, I.M.17.03 – I.M.17.04, I.M.17.04.01 – I.M.17.04.02, I.M.17.05 – I.M.17.06, I.M.17.06.01 – I.M.17.06.02, I.M.17.07 – I.M.17.08, I.M.17.08.01 – I.M.17.08.02	Per 42 CFR 457.496(d)(4), NQTLs include, but are not limited to: <ul style="list-style-type: none"> • Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; • Formulary design for prescription drugs; • For MCOs, PIHPs, or PAHPs with multiple network tiers (such as preferred providers and participating providers), network tier design; • Standards for provider admission to participate in a network, including reimbursement rates; • MCO, PIHP, or PAHP methods for determining usual, customary, and reasonable charges; • Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); • Exclusions based on failure to complete a course of treatment; • Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the MCO, PIHP, or PAHP; and • Standards for providing access to out-of-network providers.
I.M.17.02.02, I.M.17.02.02, I.M.17.04.02, I.M.17.08.02	As specified in 42 CFR 457.496(d)(4), an NQTL may not be imposed for MH/SUD benefits in any classification unless, under the applicable policies and procedures as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

Section III: Glossary of Terms

Actuarially sound principles:	Generally accepted actuarial principles and practices that are applied to determine aggregate utilization patterns, are appropriate for the population and services to be covered, and have been certified by actuaries who meet the qualification standards established by the Actuarial Standards Board. [42 CFR 457.10]
Adverse benefit determination:	In the case of an MCO, PIHP, or PAHP, any of the following: <ol style="list-style-type: none">(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.(2) The reduction, suspension, or termination of a previously authorized service.(3) The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” at 42 CFR 447.45(b) of this chapter is not an adverse benefit determination.(4) The failure to provide services in a timely manner, as defined by the state.(5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in 42 CFR 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.(6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network.(7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities. [42 CFR 457.1260; 42 CFR 438.400(b)]
Aggregate lifetime dollar limit:	A dollar limitation on the total amount of specified benefits that may be paid under a state plan or a managed care entity that contracts with the state plan [42 CFR 457.496]
American Indian/Alaska Native:	<ol style="list-style-type: none">(1) A member of a Federally recognized Indian tribe, band, or group;(2) An Eskimo or Aleut or other Alaska Native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601 et. seq.; or(3) A person who is considered by the Secretary of the Interior to be an Indian for any purpose. [42 CFR 457.10]
Annual dollar limit:	A dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a state plan or an MCP that contracts with a state plan. [42 CFR 457.496(a)]
Appeal:	A review by an MCO, PIHP, or PAHP of an adverse benefit determination. [42 CFR 457.1260; 42 CFR 438.400(b)]
Child:	An individual under the age of 19 including the period from conception to birth. [42 CFR 457.10]
Child health assistance:	Payment for part or all of the cost of health benefits coverage provided to targeted low-income children for the services listed at 42 CFR 457.402. [42 CFR 457.10]

Children's Health Insurance Program:	A program established and administered by a state, jointly funded with the Federal government, to provide child health assistance to uninsured, low-income children through a separate child health program, a Medicaid expansion program, or a combination program. [42 CFR 457.10]
Cold-call marketing:	Any unsolicited personal contact by the MCO, PIHP, PAHP, PCCM or PCCM entity with a potential enrollee for the purpose of marketing. [42 CFR 457.1224; 42 CFR 438.104(a)]
Combination program:	A program under which a state implements both a Medicaid expansion program and a separate child health program. [42 CFR 457.10]
Comprehensive risk contract:	A risk contract between the state and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services: <ol style="list-style-type: none"> (1) Outpatient hospital services (2) Rural health clinic (RHC) services (3) FQHC services (4) Other laboratory and X-ray services (5) Nursing facility services (6) EPSDT services (7) Family planning services (8) Physician services (9) Home health services. [42 CFR 457.10]
Cost sharing:	Premium charges, enrollment fees, deductibles, coinsurance, copayments, or other similar fees that the enrollee has responsibility for paying. [42 CFR 457.10]
Credibility adjustment:	An adjustment to the MLR for a partially credible MCO, PIHP, or PAHP to account for a difference between the actual and target MLRs that may be due to random statistical variation. [42 CFR 457.1203(f); 42 CFR 438.8(b)]
Cumulative financial requirements	Financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums. (However, cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.) [42 CFR 457.496]
Discrimination:	Termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates a probable need for substantial future medical services. [42 CFR 457.1270; 42 CFR 438.700(b)(3)]

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit:	Benefits defined in section 1905(r) of the Act including: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan, provided in accordance with section 1902(a)(43) of the Act. [42 CFR 457.496(b); Section 1905(r) of the Act]
Emergency medical condition:	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: <ul style="list-style-type: none"> (1) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of a woman or her unborn child; (2) Serious impairment of bodily function; or (3) Serious dysfunction of any bodily organ or part. [42 CFR 457.10]
Emergency services:	Health care services that are: <ul style="list-style-type: none"> (1) Furnished by any provider qualified to furnish such services; and (2) Needed to evaluate, treat, or stabilize an emergency medical condition. [42 CFR 457.10]
Enrollee:	A child who receives health benefits coverage through CHIP. [42 CFR 457.10]
External quality review:	The analysis and evaluation by an External Quality Review Organization (EQRO), of aggregated information on quality, timeliness, and access to the health care services that an MCO, PIHP, or PAHP, or their contractors furnish to CHIP beneficiaries. [42 CFR 457.10]
External quality review organization:	An organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and holds a contract with a state to perform external quality review, other EQR-related activities as set forth in 42 CFR 438.358, or both. [42 CFR 457.10]
Federally qualified HMO:	A Health Maintenance Organization (HMO) that CMS has determined is a qualified HMO under section 2791(b)(3) of the Public Health Service Act. [42 CFR 457.10]
Fee-for-service entity:	Any individual or entity that furnishes services under the program on a fee-for-service basis, including health insurance services. [42 CFR 457.10]
Financial requirements	Deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include premiums or aggregate lifetime or annual dollar limits. [42 CFR 457.496]
Full credibility:	A standard for which the experience of an MCO, PIHP, or PAHP is determined to be sufficient for the calculation of a MLR with a minimal chance that the difference between the actual and target MLR is not statistically significant. An MCO, PIHP, or PAHP that is assigned full credibility (or is fully credible) will not receive a credibility adjustment to its MLR. [42 CFR 457.1203(f); 42 CFR 438.8(b)]

Grievance:	An expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision. [42 CFR 457.1260; 42 CFR 438.400(b)]
Grievance and appeal system:	The processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them. [42 CFR 457.1260; 42 CFR 438.400(b)]
Health benefits coverage:	An arrangement under which enrolled individuals are protected from some or all liability for the cost of specified health care services. [42 CFR 457.10]
Health care services:	Any of the services, devices, supplies, therapies, or other items listed in 42 CFR 457.402. [42 CFR 457.10]
Health maintenance organization plan:	A health insurance coverage plan that is offered through an HMO (as defined in section 2791(b)(3) of the Public Health Service Act) and has the largest insured commercial, non-Medicaid enrollment in the state. [42 CFR 457.10; 42 CFR 457.420]
Indian health care provider:	A health care program operated by the IHS or by an I/T/U as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). [42 CFR 457.1209; 42 CFR 438.14(a)]
Indian managed care entity:	A MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Act) by the IHS, an I/T/U, or a consortium, which may be composed of one or more I/T/Us, and which also may include the Service. [42 CFR 457.1209; 42 CFR 438.14(a)]
Limited English Proficient:	Potential enrollees and enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be Limited English Proficient (LEP) and may be eligible to receive language assistance for a particular type of service, benefit, or encounter. [42 CFR 457.1207; 42 CFR 438.10(a)]
Low-income child:	A child whose household income is at or below 200 percent of the poverty line for the size of the family involved. [42 CFR 457.10]
Managed care entity:	An entity that enters into a contract to provide services in a managed care delivery system, including but not limited to managed care organizations, prepaid health plans, and primary care case managers. [42 CFR 457.10]

Managed care organization:	An entity that has, or is seeking to qualify for, a comprehensive risk contract under Part 457, and that is: <ol style="list-style-type: none"> (1) A Federally qualified HMO that meets the advance directives requirements of 42 CFR 489 subpart I; or (2) Makes the services it provides to its CHIP enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other CHIP beneficiaries within the area served by the entity and (3) Meets the solvency standards of 42 CFR 438.116. [42 CFR 457.10]
Marketing:	Any communication, from an MCO, PIHP, PAHP, PCCM or PCCM entity to a CHIP enrollee who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's CHIP product, or either to not enroll in or to disenroll from another MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's CHIP product. Marketing does not include communication to a CHIP enrollee from the issuer of a qualified health plan, as defined in 45 CFR 155.20, about the qualified health plan. [42 CFR 457.1224; 42 CFR 438.104(a)]
Marketing materials:	Materials that— <ol style="list-style-type: none"> (1) Are produced in any medium, by or on behalf of an MCO, PIHP, PAHP, PCCM, or PCCM entity; and (2) Can reasonably be interpreted as intended to market the MCO, PIHP, PAHP, PCCM, or PCCM entity to potential enrollees. [42 CFR 457.1224; 42 CFR 438.104(a)]
MCO, PIHP, PAHP, PCCM, or PCCM entity:	Any of the entity's employees, network providers, agents, or contractors. [42 CFR 457.1224; 42 CFR 438.104(a)]
Medicaid expansion program:	A program under which a state receives Federal funding to expand Medicaid eligibility to optional targeted low-income children. [42 CFR 457.10]
Medical/surgical benefits:	Benefits for items or services for medical conditions or surgical procedures, as defined under the terms of the state plan in accordance with applicable federal and state law, but does not include mental health or substance use disorder benefits. Any condition defined by the state plan as being or not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or generally applicable State guidelines). Medical/surgical benefits include long term care services. [42 CFR 457.496]
Member months:	The number of months an enrollee or a group of enrollees is covered by an MCO, PIHP, or PAHP over a specified time period, such as a year. [42 CFR 457.1203(f); 42 CFR 438.8(b)]

Mental health benefits:	Benefits for items or services that treat or otherwise address mental health conditions, as defined under the terms of the state plan in accordance with applicable federal and state law, and consistent with generally recognized independent standards of current medical practice. Standards of current medical practice can be based on the most current version of the DSM, the most current version of the ICD, or generally applicable state guidelines. The term includes long term care services. [42 CFR 457.496]
Medical Loss Ratio reporting year:	A period of 12 months consistent with the rating period selected by the state. [42 CFR 457.1203(f); 42 CFR 438.8(b)]
No credibility:	A standard for which the experience of an MCO, PIHP, or PAHP is determined to be insufficient for the calculation of a MLR. An MCO, PIHP, or PAHP that is assigned no credibility (or is non-credible) will not be measured against any MLR requirements. [42 CFR 457.1203(f); 42 CFR 438.8(b)]
Non-claims costs:	Those expenses for administrative services that are not: <ul style="list-style-type: none"> (1) Incurred claims; (2) Expenditures on activities that improve health care quality; or (3) Licensing and regulatory fees, or (4) Federal and state taxes. [42 CFR 457.1203(f); 42 CFR 438.8(b)]
Non-emergency medical transportation prepaid ambulatory health plan:	An entity that provides only NEMT services to enrollees under contract with the state, and on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates. [42 CFR 457.1206]
Optional targeted low-income child (for states):	A child under age 19 who meets the financial and categorical standards described below. <ul style="list-style-type: none"> (1) Financial need. An optional targeted low-income child: <ul style="list-style-type: none"> a. Has a household income at or below 200 percent of the Federal poverty line for a family of the size involved; and b. Resides in a state with no Medicaid applicable income level (as defined at 42 CFR 457.10); or c. Resides in a state that has a Medicaid applicable income level (as defined at 42 CFR 457.10) and has household income that either: <ul style="list-style-type: none"> i. Exceeds the Medicaid applicable income level for the age of such child, but not by more than 50 percentage points; or ii. Does not exceed the income level specified for such child to be eligible for medical assistance under the policies of the state plan under title XIX on June 1, 1997. (2) No other coverage and state maintenance of effort. An optional targeted low-

income child is not covered under a group health plan or health insurance coverage, or would not be eligible for Medicaid under the policies of the state plan in effect on March 31, 1997; except that, for purposes of this standard:

- a. A child shall not be considered to be covered by health insurance coverage based on coverage offered by the state under a program in operation prior to July 1, 1997 if that program received no Federal financial participation;
 - b. A child shall not be considered to be covered under a group health plan or health insurance coverage if the child did not have reasonable geographic access to care under that coverage.
- (3) For purposes of this section, policies of the state plan a under title XIX plan include policies under a statewide demonstration project under section 1115(a) of the Act other than a demonstration project that covered an expanded group of eligible children but that either -
- a. Did not provide inpatient hospital coverage; or
 - b. Limited eligibility to children previously enrolled in Medicaid, imposed premiums as a condition of initial or continued enrollment, and did not impose a general time limit on eligibility. [42 CFR 457.10; 42 CFR 435.4]

Optional targeted low-income child (for Territories):

A child under age 19 who meets the financial and categorical standards described below.

- (1) Financial need. An optional targeted low-income child:
 - a. Has a family income at or below 200 percent of the Federal poverty line for a family of the size involved;
 - b. Resides in a state with no Medicaid applicable income level (as defined in 42 CFR 457.10); or,
 - c. Resides in a state that has a Medicaid applicable income level (as defined in 42 CFR 457.10) and has family income that either:
 - i. Exceeds the Medicaid applicable income level for the age of such child, but not by more than 50 percentage points (expressed as a percentage of the Federal poverty line); or
 - ii. Does not exceed the income level specified for such child to be eligible for medical assistance under the policies of the state plan under title XIX on June 1, 1997.
- (2) No other coverage and state maintenance of effort. An optional targeted low-income child is not covered under a group health plan or health insurance coverage, or would not be eligible for Medicaid under the policies of the state plan in effect on March 31, 1997; except that, for purposes of this standard -
 - a. A child shall not be considered to be covered by health insurance coverage based on coverage offered by the state under a program in operation prior to July 1, 1997 if that program received no Federal financial participation;
 - b. A child shall not be considered to be covered under a group health plan

or health insurance coverage if the child did not have reasonable geographic access to care under that coverage.

- (3) For purposes of this section, policies of the state plan under title XIX plan include policies under a statewide demonstration project under section 1115(a) of the Act other than a demonstration project that covered an expanded group of eligible children but that either -
- a. Did not provide inpatient hospital coverage; or
 - b. Limited eligibility to children previously enrolled in Medicaid, imposed premiums as a condition of initial or continued enrollment, and did not impose a general time limit on eligibility. [42 CFR 457.10; 42 CFR 436.3]

Partial credibility:	A standard for which the experience of an MCO, PIHP, or PAHP is determined to be sufficient for the calculation of a MLR but with a non-negligible chance that the difference between the actual and target MLRs is statistically significant. An MCO, PIHP, or PAHP that is assigned partial credibility (or is partially credible) will receive a credibility adjustment to its MLR. [42 CFR 457.1203(f); 42 CFR 438.8(b)]
Poststabilization care services:	Covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e), to improve or resolve the enrollee's condition. [42 CFR 457.1228; 42 CFR 438.114(a)]
Poverty line/Federal poverty level:	The poverty guidelines updated annually in the Federal Register by the U.S. Department of Health and Human Services under authority of 42 U.S.C. 9902(2). [42 CFR 457.10]
Prepaid ambulatory health plan:	An entity that— <ol style="list-style-type: none">(1) Provides services to enrollees under contract with the state, and on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates.(2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees.(3) Does not have a comprehensive risk contract. [42 CFR 457.10]
Prepaid inpatient health plan:	An entity that— <ol style="list-style-type: none">(1) Provides services to enrollees under contract with the state, and on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates.(2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees(3) Does not have a comprehensive risk contract. [42 CFR 457.10]
Prevalent language:	A non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient. [42 CFR 457.1207; 42 CFR 438.10(a)]

Primary care case management:	<p>A system under which:</p> <ol style="list-style-type: none"> (1) A PCCM contracts with the state to furnish case management services (which include the location, coordination and monitoring of primary health care services) to CHIP beneficiaries; or (2) A PCCM entity contracts with the state to provide a defined set of functions to CHIP beneficiaries. [42 CFR 457.10]
Primary care case management entity:	<p>An organization that provides any of the following functions, in addition to primary care case management services, for the state:</p> <ol style="list-style-type: none"> (1) Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line. (2) Development of enrollee care plans. (3) Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program. (4) Provision of payments to FFS providers on behalf of the state. (5) Provision of enrollee outreach and education activities. (6) Operation of a customer service call center. (7) Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement. (8) Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers. (9) Coordination with behavioral health systems/providers. (10) Coordination with LTSS systems/providers. [42 CFR 457.10]
Primary care case manager:	<p>A physician, a physician group practice or, at state option, any of the following in addition to primary care case management services:</p> <ol style="list-style-type: none"> (1) A physician assistant. (2) A nurse practitioner. (3) A certified nurse-midwife [42 CFR 457.10]
Private insurance:	<p>Does not include a qualified health plan, as defined in 45 CFR 155.20. [42 CFR 457.1224; 42 CFR 438.104(a)]</p>
Provider:	<p>Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services. [42 CFR 457.10]</p>
Readily accessible:	<p>Electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions. [42 CFR 457.1207; 42 CFR 438.10(a)]</p>
Risk contract:	<p>A contract under which the contractor -</p> <ol style="list-style-type: none"> (1) Assumes risk for the cost of the services covered under the contract. (2) Incurs loss if the cost of furnishing the services exceeds the payments under the contract. [42 CFR 457.10]

Separate child health program:	A program under which a state receives Federal funding from its title XXI allotment to provide child health assistance through obtaining coverage that meets the requirements of section 2103 of the Act and 42 CFR 457.402. [42 CFR 457.10]
State:	All states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands. The Territories are excluded from this definition for purposes of 42 CFR 457.740. [42 CFR 457.10]
State plan:	The title XXI state child health plan. [42 CFR 457.10]
State review:	The process set forth in subpart K of part 457 chapter IV, title 42. [42 CFR 457.1260; 42 CFR 438.400(b)]
Substance use disorder benefits:	Benefits for items or services for substance use disorder, as defined under the terms of the State plan in accordance with applicable federal and state law, and consistent with generally recognized independent standards of current medical practice. Standards of current medical practice can be based on the most current version of the DSM, the most current version of the ICD, or generally applicable state guidelines. The term includes long term care services. [42 CFR 457.496]
Targeted low-income child:	<p>A targeted low-income child is a child who meets the standards set forth below and the eligibility standards established by the state under 42 CFR 457.320.</p> <p>(1) Financial need standard. A targeted low-income child:</p> <ul style="list-style-type: none"> a. Has a household income, as determined in accordance with 42 CFR 457.315, at or below 200 percent of the Federal poverty level for a family of the size involved; b. Resides in a state with no Medicaid applicable income level; c. Resides in a state that has a Medicaid applicable income level and has a household income that either - <ul style="list-style-type: none"> i. Exceeds the Medicaid applicable income level for the age of such child, but not by more than 50 percentage points; or ii. Does not exceed the income level specified for such child to be eligible for medical assistance under policies of the state plan under title XIX on June 1, 1997. <p>(2) No other coverage standard. A targeted low-income child must not be -</p> <ul style="list-style-type: none"> a. Found eligible or potentially eligible for Medicaid under policies of the state plan (determined through either the Medicaid application process or the screening process described at 42 CFR 457.350), except for eligibility under 42 CFR 435.214 (related to coverage for family planning services); b. Covered under a group health plan or under health insurance coverage, as defined in section 2791 of the Public Health Service Act, unless the plan or health insurance coverage program has been in operation since before July 1, 1997 and is administered by a state that receives no Federal funds for the program's operation. A child is not considered covered under a group health plan or health insurance coverage if the

child does not have reasonable geographic access to care under that plan.

- (3) For purposes of this section, policies of the state plan under title XIX plan include policies under a statewide demonstration project under section 1115(a) of the Act other than a demonstration project that covered an expanded group of eligible children but that either -
- a. Did not provide inpatient hospital coverage; or
 - b. Limited eligibility to children previously enrolled in Medicaid, imposed premiums as a condition of initial or continued enrollment, and did not impose a general time limit on eligibility. [42 CFR 457.10; 42 CFR 457.310]

Treatment limitations:

Include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and NQTLs, which otherwise limit the scope or duration of benefits for treatment under the state plan. (*See* 42 CFR 457.496(d)(4)(ii) for an illustrative list of NQTLs.) A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition. [42 CFR 457.496]