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State Guide to CMS Criteria for Medicaid 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 Medicaid managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), non-emergency medical transportation prepaid ambulatory health plans (NEMT PAHPs), primary care case management entities (PCCM entities), and health insuring organizations (HIO).[1, 2, 3] 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 contracts with Medicaid managed care entities meet all CMS requirements.[3] This guide is an update to the 2017 State Guide to CMS Criteria for Managed Care Contract Review and Approval and applies to contract actions with an effective start date on or after December 14, 2020.

The guide is organized into three sections. **Section I** outlines the contract requirements based on existing federal requirements in Title XIX of the Social Security Act (referred to as "the Act"), 42 CFR Part 438 and other applicable laws, 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.[4] 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 438 contained in 42 CFR Parts 430 to 481, 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

[1] In accordance with 42 CFR 438.3(p), contracts with HIOs that began operating on or after January 1, 1986 and that the statute does not explicitly exempt from the requirements in section 1903(m) of the Social Security Act are subject to all Federal requirements outlined in 42 CFR Part 438 that apply to MCOs.

[2] CMS utilizes the term "managed care plan" to encompass all types of managed care delivery (i.e. MCO, HIO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity) to which a federal requirement applies.

[3] This guide is not intended as a substitute for 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.

[4] 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-medicaid-and-childrens-health-insurance-program-chip-managed-care.

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:

Enforcement Date	Guide Section	Item Number(s)
Contract actions with an effective start date on or after 12/14/2020	I.A. Contract Completeness, State Directed Payments and Risk-Sharing Mechanisms	I.A.1.10, I.A.1.11
	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.5.20
	I.G.4 Practice Guidelines	I.G.4.03
	I.H.6. Process for Filing an Appeal or Expedited Appeal Request	I.H.6.03
	I.J.4. Third Party Liability (TPL) Activities	I.J.4.02
	I.K. Health Information Systems and Enrollee Data	I.K.1.11 – I.K.1.14
Contract Actions with an effective start date on or after 12/31/2020	I.I.7 Program or Activity No Longer Authorized by Law	I.I.7.01
Contract Actions with an effective start date on or after 07/01/2021	I.K. Health Information Systems and Enrollee Data	I.K.1.09 – I.K.1.10
Contract Actions effective with the rating period beginning on or after 07/01/2021	I.A. Contract Completeness	I.A.1.06
	I.D.7. Pass-Through Payments	I.D.7.04 – I.D.7.06
Contract Actions effective with the rating period beginning on or after 10/01/2021	I.I.2 Program Integrity Requirements, Procedures, and Reporting	I.I.2.41

Each requirement in Section I contains: 1) an item number; 2) the contract requirement(s)[5]; 3) the entity types (i.e., MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity, HIO) 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 (*)

[5] 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.

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 this guide contains a glossary that describes commonly used terms and the applicable federal regulatory citations for each definition.

This guide is designed specifically for review of managed care plan (MCP) contracts serving the Medicaid population. The State Guide to CMS Criteria for Children's Health Insurance Program (CHIP) Managed Care Contract Review and Approval provides separate guidance specific to the review of CHIP managed care provisions. CMS review of MCP contracts serving the separate CHIP (whether included in a single contract covering both the Medicaid and CHIP populations or in a separate contract covering only the CHIP population) became effective with the state fiscal year beginning on or after July 1, 2018.

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 HIOs, 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.

Contents

Section I: Contract Requirements in Effect with the Final Rule

I.A. Contract Completeness

I.A.1.01 [Applies to all entity types]

The contract submission is signed and dated by all parties. [Existing standard]

I.A.1.02 [Applies to all entity types]

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 all entity types]

If the contract submission is an amendment, CMS has received and approved all previous amendments to the base contract. [Existing standard]

I.A.1.04 [Applies to HIO, MCO, PIHP, PAHP]*

If the contract submission implements capitation rates or a change in the contract may impact 42 CFR 438.4, CMS has received a rate certification concurrently with the state's submission of the contract action. [42 CFR 438.7(a)] [Existing standard]

I.A.1.05 [Applies to HIO, MCO, PIHP, PAHP]*

If the state is increasing or decreasing previously certified rates without submitting a rate certification, the rate change must be within 1.5 percent per rate cell of the rates previously certified for the applicable rating period. [42 CFR 438.7(c)(3)] [Existing standard]

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

If the state is increasing or decreasing rates within a previously certified rate range without submitting a rate certification, the rate change must be within 1 percent per rate cell within the rate range previously certified for the applicable rating period. [42 CFR 438.4(c)(2)(iii)] [Effective: No earlier than the rating period for contracts starting on or after 07/01/2021]

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

If the contract submission implements capitation rates for the state’s annual rating period, the Division of Managed Care Operations (DMCO) received the state's summary description of Medical Loss Ratio (MLR) reports received from the HIO(s), MCO(s), PIHP(s) and PAHP(s) under contract with the state. [42 CFR 438.74(a)] [Existing standard]

I.A.1.08 [Applies to all entity types]

The contract submission complies with the federal authority(ies) approved by CMS. For example, if the contractor delivers services for a program authorized under section 1915(b)/1915(c) concurrent authority, the contract is in compliance with the approved section 1915(b)/1915(c) waivers. Another example: if the contract action includes a new benefit,

assure that CMS has approved an appropriate Medicaid authority for this service. [Existing standard]

I.A.1.09 [Applies to HIO, MCO]*

If the state is providing any services to MCO enrollees using a delivery system other than the MCO delivery system and (1) a change in benefits provided by the HIO, MCO, PIHP, PAHP or fee-for-service is occurring or (2) the state is contracting with a new MCO(s), the state has provided documentation of how the requirements of 42 CFR Part 438, subpart K regarding parity in mental health and substance use disorder benefits are met with the submission of the MCO contract. [42 CFR 438.3(n)(2)] [Existing standard]

I.A.1.10 [Applies to HIO, MCO, PIHP, PAHP]*

If the contract submission includes state directed payment initiatives other than the adoption of a minimum fee schedule using State Plan approved rates under 42 CFR 438.6(c), CMS has approved a Section 438.6(c) Preprint prior to the arrangement being implemented. Each state-directed payment arrangement must be described in the Managed Care Plan (MCP) contract and the description must be consistent with the CMS-approved Section 438.6(c) Preprint. [42 CFR 438.6(c)(1); 42 CFR 438.6(c)(2)] [Existing standard. However, the 2020 Final Rule removed the requirement for CMS to approve a Section 438.6(c) preprint when the state adopts a minimum fee schedule using State Plan approved rates under 42 CFR 438.6(c) effective 12/14/2020.]

I.A.1.11 [Applies to HIO, MCO, PIHP, PAHP]*

If the contract submission implements risk-sharing mechanisms (such as reinsurance, risk corridors, or stop-loss limits), the mechanism(s) must be documented in the contract and rate certification documents for the rating period prior to the start of the rating period. Risk-sharing mechanisms may not be added or modified after the start of the rating period. See the applicable tips section for more information as states adjust to this new policy. [42 CFR 438.6(b)(1)] [Revision to the applicable standard made by the 2020 Final Rule; prior to the 2020 Final Rule, submission and documentation prior to the start of the rating period was not required.]

I.A.1.12 [Applies to HIO, MCO, PIHP, PAHP, PCCM entity]

If the state is implementing a managed care program, whether the program is voluntary or mandatory, the state has submitted a readiness review in accordance with 42 CFR 438.66(d)(2), (d)(3), and (d)(4). [42 CFR 438.66(d)(1)(i)] [Existing standard]

I.A.1.13 [Applies to HIO, MCO, PIHP, PAHP, PCCM entity]

If the MCP has not previously contracted with the state, the state has submitted a readiness review in accordance with 42 CFR 438.66(d)(2), (d)(3), and (d)(4). [42 CFR 438.66(d)(1)(ii)] [Existing standard]

I.A.1.14 [Applies to HIO, MCO, PIHP, PAHP, PCCM entity]

If the MCP currently contracting with the state will provide or arrange for the provision of covered benefits to new eligibility groups, the state has submitted a readiness review in accordance with 42 CFR 438.66(d)(2), (d)(3), and (d)(4). [42 CFR 438.66(d)(1)(iii)] [Existing standard]

I.B. Enrollment and Disenrollment

I.B.1 No Discrimination

I.B.1.01 [Applies to HIO, 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 438.3(d)(1)] [Existing standard]

I.B.1.02 [Applies to HIO, 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 438.3(d)(3)] [Existing standard]

I.B.1.03 [Applies to HIO, 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 438.3(d)(4)] [Existing standard]

I.B.1.04 [Applies to HIO, 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 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 438.3(q)(4), 42 CFR 438.3(r)] [Existing standard]

I.B.2 Choice of Doctor

I.B.2.01 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires that for enrollees who qualify under the rural resident exception (under which a state may limit a rural area resident to a single MCP), the limitation on the enrollee's freedom to change between primary care providers (PCP) can only be as restrictive as the limitations on disenrollment from the MCP as requested by the enrollee in accordance with 42 CFR 438.56(c). [42 CFR 438.52(b) - (d); 42 CFR 438.56(c)] [Existing standard]

I.B.2.02 [Applies to HIO, 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 438.3(l)] [Existing standard]

I.B.3 Opt Out

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

The contract provides that MCP enrollment is voluntary, except when CMS has approved federal authority allowing the state to mandate enrollment. [42 CFR 438.3(d)(2)] [Existing standard]

I.B.4 Reenrollment

I.B.4.01 [Applies to HIO, 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 Medicaid eligibility for a period of 2 months or less. [42 CFR 438.56(g)] [Existing standard]

I.B.5 Disenrollment

I.B.5.01 [Applies to HIO, 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 438.56(b)(1)] [Existing standard]

I.B.5.02 – I.B.5.05 [Applies to HIO, 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 MCPs ability to furnish services to the enrollee or other enrollees).

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

I.B.5.06 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]

The contract specifies the methods by which the MCP assures the state that it does not request disenrollment for reasons other than those permitted under the contract. [42 CFR 438.56(b)(3)] [Existing standard]

I.B.5.07 – I.B.5.10 [Applies to HIO, 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 438.3(q)(5); 42 CFR 438.56(c)(1); 42 CFR 438.56(c)(2)(i) - (iii)] [Existing standard]

I.B.5.11 [Applies to HIO, MCO, PCCM, PCCM entity]

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. [42 CFR 438.3(q)(5); 42 CFR 438.56(c)(2)(iv)] [Existing standard]

I.B.5.12 – I.B.5.13 [Applies to HIO, 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 438.56(d)(2)(i) - (ii)] [Existing standard]

I.B.5.14 [Applies to HIO, 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 PCP or another provider must determine that receiving the services separately would subject the enrollee to unnecessary risk. [42 CFR 438.56(d)(2)(iii)] [Existing standard]

I.B.5.15 [Applies to HIO, 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 438.56(d)(2)(iv)] [Existing standard]

I.B.5.16 [Applies to HIO, 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 438.56(d)(2)(v)] [Existing standard]

I.B.6 Disenrollment Request Process

I.B.6.01 [Applies to HIO, 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 438.56(d)(1)(i)-(ii)] [Existing standard]

I.B.6.02 [Applies to HIO, 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 438.56(d)(3)(i)] [Existing standard]

I.B.6.03 [Applies to HIO, 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 438.56(e)(1) - (2); 42 CFR 438.56(d)(3)(ii); 42 CFR 438.3(q); 42 CFR 438.56(c)] [Existing standard]

I.B.6.04 [Applies to HIO, 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 438.56(e)(1) - (2); 42 CFR 438.56(d)(3)(ii); 42 CFR 438.3(q); 42 CFR 438.56(c)] [Existing standard]

I.B.7 Special Rules for American Indians

I.B.7.01 [Applies to HIO, 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; State Medicaid Director Letter (SMDL) 10-001; 42 CFR 438.14(d)] [Existing standard]

I.B.7.02 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]

The contract requires that any Indian enrolled in an MCP, that is not an 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); SMDL 10-001; 42 CFR 438.14(b)(3)] [Existing standard]

I.C. Beneficiary Notification

I.C.1 Language and Format

I.C.1.01 [Applies to HIO, 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 438.10(c)(1)] [Existing standard]

I.C.1.02 [Applies to HIO, 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 438.10(c)(7)] [Existing standard]

I.C.1.03 [Applies to HIO, 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 438.10(d)(3)] [Existing standard]

I.C.1.04 – I.C.1.07 [Applies to HIO, 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 438.10(d)(3)] [Effective: 12/14/2020]

I.C.1.08 [Applies to HIO, 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 438.10(d)(3)] [Existing standard]

I.C.1.09 [Applies to HIO, 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 438.10(d)(4)] [Existing standard]

I.C.1.10 – I.C.1.12 [Applies to HIO, 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 438.10(d)(5)(i) - (iii)] [Existing standard]

I.C.1.13 [Applies to HIO, 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 438.10(d)(6)(i)] [Existing standard]

I.C.1.14 – I.C.1.16 [Applies to HIO, 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 438.10(d)(6)(ii) - (iii)] [Existing standard]

I.C.2 Enrollee Handbook

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

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

I.C.2.02 [Applies to HIO, 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 438.10(g)(1); 45 CFR 147.200(a)] [Existing standard]

I.C.2.03 [Applies to HIO, 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 438.10(g)(2)] [Existing standard]

I.C.2.04 – I.C.2.07 [Applies to HIO, 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 438.10(g)(2)(i) - (ii)] [Existing standard]

I.C.2.08 – I.C.2.09 [Applies to HIO, 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 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 HIO, 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 438.10(g)(2)(iii) - (iv)] [Existing standard]

I.C.2.12 [Applies to HIO, 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 438.10(g)(2)(v)] [Existing standard]

I.C.2.13 – I.C.2.17 [Applies to HIO, 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 438.10(g)(2)(v)] [Existing standard]

I.C.2.18 – I.C.2.19 [Applies to HIO, 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 438.10(g)(2)(vi) - (vii)] [Existing standard]

I.C.2.20 [Applies to HIO, 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 438.10(g)(2)(vii)] [Existing standard]

I.C.2.21 [Applies to HIO, 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 438.10(g)(2)(viii)] [Existing standard]

I.C.2.22 – I.C.2.27 [Applies to HIO, 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 438.10(g)(2)(ix); 42 CFR 438.100(b)(2)(i) - (vi)] [Existing standard]

I.C.2.28 [Applies to HIO, 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 438.10(g)(2)(ix); 42 CFR 438.100(b)(3)] [Existing standard]

I.C.2.29 [Applies to HIO, 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 438.10(g)(2)(x)] [Existing standard]

I.C.2.30 [Applies to HIO, 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 fair hearing procedures and timeframes in a state-developed or state-approved description. [42 CFR 438.10(g)(2)(xi)] [Existing standard]

I.C.2.31 – I.C.2.36 [Applies to HIO, 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 fair hearing 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 fair hearing 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 fair hearing is pending if the final decision is adverse to the enrollee.*

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

I.C.2.37 [Applies to HIO, 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 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 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 HIO, 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 438.10(g)(2)(xiii) - (xvi)] [Existing standard]

I.C.2.45 [Applies to HIO, 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 438.10(g)(4)] [Existing standard]

I.C.2.46 [Applies to HIO, 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 438.62(b)(3)] [Existing standard]

I.C.3 Enrollee Handbook Dissemination

I.C.3.01 [Applies to HIO, 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 438.10(g)(3)(i) - (iv)] [Existing standard]

I.C.4 Network Provider Directory

I.C.4.01 – I.C.4.08 [Applies to HIO, 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 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 HIO, 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 438.10(h)(3)(i)(A) – (B), 42 CFR 438.10(h)(3)(ii)] [Effective: 12/14/2020]

I.C.4.11 [Applies to HIO, 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 438.10(h)(4)] [Existing standard]

I.C.5 Formulary

I.C.5.01 – I.C.5.03 [Applies to HIO, 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 438.10(i)(1) - (3)] [Existing standard]

I.C.6 Provider Terminations and Incentives

I.C.6.01 [Applies to HIO, 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 438.10(f)(1)] [Effective: 12/14/2020]

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

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

I.C.7 Marketing

I.C.7.01 – I.C.7.04 [Applies to HIO, 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.

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

I.C.7.05 – I.C.7.07 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]

The contract:

- 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 438.104(b)(2)(i) - (ii)] [Existing standard]

I.C.8 General Information Requirements

I.C.8.01 – I.C.8.06 [Applies to HIO, 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 438.10(c)(6)(i) - (v)] [Existing standard]

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

The contract requires the MCP to provide adult enrollees with written information on advance directives policies, and include a description of applicable state law. [42 CFR 438.3(j)(3)] [Existing standard]

I.C.8.08 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires the MCP to reflect changes in state law in its written advance directives information as soon as possible, but no later than 90 days after the effective date of the change. [42 CFR 438.3(j)(4)] [Existing standard]

I.C.8.09 [Applies to HIO, 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 438.102(b)(1)(i)(B), 42 CFR 438.10(g)(4)] [Existing standard]

I.C.8.10 – I.C.8.29 [Applies to HIO, 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 438.10(c)(4)(i)] [Existing standard]

I.C.8.30 – I.C.8.41 [Applies to HIO, 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 438.10(c)(4)(i)] [Existing standard]

I.C.8.42 [Applies to HIO, MCO, PIHP, PAHP]*

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

I.C.8.43 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]

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

I.C.8.44 [Applies to HIO, MCO, PIHP, PAHP]*

If the state delegates this function, the MCP contract specifies any state fair hearing notice requirements that are the responsibility of the MCP. [42 CFR 438.228(b)] [Existing standard]

I.C.9 Sales and Transactions

I.C.9.01 [Applies to HIO, MCO]

The contract requires the MCP to make any reports of transactions between the MCP and parties in interest that are provided to the state, or other agencies available to MCP enrollees upon reasonable request. [Section 1903(m)(4)(B) of the Act] [Existing standard]

I.D. Payment

I.D.1 General

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

The contract specifies the final capitation rates for each MCP. [42 CFR 438.3(c)(1)(i)] [Existing standard]

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

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

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

The contract specifies that, if used in the payment arrangement between the state and the MCP, all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, are described in the contract. [42 CFR 438.6(b)(1)] [Existing standard]

I.D.1.04 [Applies to HIO, MCO, PIHP]

The contract specifies the state will only make a monthly capitation payment to the MCP for an enrollee aged 21–64 receiving inpatient treatment in an Institution for Mental Diseases (IMD), as defined in 42 CFR 435.1010, so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services, and length of stay in the IMD

is for a short term stay of no more than 15 days during the period of the monthly capitation payment. [42 CFR 438.6(e)] [Existing standard]

I.D.2 Incentive Arrangements

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

The contract specifies that all incentive arrangements are for a fixed period of time. [42 CFR 438.6(b)(2)(i)] [Existing standard]

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

The contract specifies that performance for all incentive arrangements is measured during the rating period under the contract in which the incentive arrangement is applied. [42 CFR 438.6(b)(2)(i)] [Existing standard]

I.D.2.03 – I.D.2.05 [Applies to HIO, MCO, PIHP, PAHP]*

The contract specifies that incentive arrangements:

- Are not renewed automatically.*
- Are made available to both public and private contractors under the same terms of performance.*
- Do not condition MCP participation in the incentive arrangement on the MCP entering into or adhering to intergovernmental transfer agreements.*

[42 CFR 438.6(b)(2)(ii) - (iv)] [Existing standard]

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

The contract specifies that all incentive arrangements are necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the state's quality strategy. [42 CFR 438.6(b)(2)(v); 42 CFR 438.340] [Existing standard]

I.D.3 Withhold Arrangements

I.D.3.01 – I.D.3.06 [Applies to HIO, MCO, PIHP, PAHP]*

For all withhold arrangements, the contract must provide that:

- The arrangement is for a fixed period of time.*
- That performance is measured during the rating period under the contract in which the withhold arrangement is applied.*
- The arrangement is not to be renewed automatically.*
- The arrangement is made available to both public and private contractors under the same terms of performance.*
- The arrangement does not condition MCP participation in the withhold arrangement on the MCP entering into or adhering to intergovernmental transfer agreements.*

- The arrangement is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the state's quality strategy.*

[42 CFR 438.6(b)(3)(i) - (v); 42 CFR 438.340] [Existing standard]

I.D.4 Medical Loss Ratio (MLR)

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

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

I.D.4.02 [Applies to HIO, 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 438.8(c)] [Existing standard]

I.D.4.03 [Applies to HIO, 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)). [42 CFR 438.8(d) - (f)] [Existing standard]

I.D.4.04 – I.D.4.05 [Applies to HIO, 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 438.8(g)(1)(i) - (ii)] [Existing standard]

I.D.4.06 – I.D.4.08 [Applies to HIO, 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 438.8(g)(2)(i) - (iii)] [Existing standard]

I.D.4.09 – I.D.4.12 [Applies to HIO, 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 438.8(h)(1) - (3)] [Existing standard]

I.D.4.13 [Applies to HIO, MCO, PIHP, PAHP]*

The contract specifies that the MCP will aggregate data for all Medicaid 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 438.8(i)] [Existing standard]

I.D.4.14 [Applies to HIO, MCO, PIHP, PAHP]*

The contract specifies that, if required by the state, the MCP must provide a remittance for an 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 438.8(j); 42 CFR 438.8(c)] [Existing standard]

I.D.4.15 – I.D.4.29 [Applies to HIO, 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 improvement 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 438.8(k)(1)(i) - (xiii); 42 CFR 438.3(m); 42 CFR 438.8(i); 45 CFR Part 158] [Existing standard]

I.D.4.30 [Applies to HIO, 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 438.8(k)(2); 42 CFR 438.8(k)(1)] [Existing standard]

I.D.4.31 [Applies to HIO, 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 438.8(k)(3)] [Existing standard]

I.D.4.32 – D.4.33 [Applies to HIO, MCO, PIHP, PAHP]*

The contract specifies that, in any instance where a state makes a retroactive change to the capitation payments for an 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 438.8(m); 42 CFR 438.8(k)] [Existing standard]

I.D.4.34 Applies to HIO, 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 438.8(n); 42 CFR 438.8(k)] [Existing standard]

I.D.5 Payment for Indian Health Care Providers (IHCP)

I.D.5.01 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP, PCCM entity]

For contracts involving IHCPs, the contract requires that the MCP will meet the requirements of 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. [42 CFR 438.14(b)(2)(iii); ARRA 5006(d); 42 CFR 447.45; 42 CFR 447.46; SMDL 10-001)] [Existing standard]

I.D.5.02 [Applies to HIO, 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 Fee For Service (FFS). [42 CFR 438.14(c)(1)] [Existing standard]

I.D.5.03 [Applies to HIO, 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 438.14(c)(2)] [Existing standard]

I.D.6 Timely Payment

I.D.6.01 [Applies to HIO and MCO]*

The contract requires that the MCP will meet the requirements of FFS timely payment, 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% 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. [42 CFR 447.45(d)(2) - (3); 42 CFR 447.46; sections 1902(a)(37)(A) and 1932(f) of the Act)] [Existing standard]

I.D.6.02 [Applies to HIO and MCO]*

The contract requires that the MCP ensure that the date of receipt is the date the MCP receives the claim, as indicated by its date stamp on the claim; and that the date of payment is the date of the check or other form of payment. [42 CFR 447.45(d)(5) - (6); 42 CFR 447.46; sections 1932(f) and 1902(a)(37)(A) of the Act] [Existing standard]

I.D.7 Pass-through Payments

I.D.7.01 [Applies to MCO, HIO, PIHP, PAHP]*

The contract requires that the MCP must make pass-through payments as defined at 42 CFR 438.6(a) to network providers which can only include hospitals, physicians, or nursing facilities. The contract must include the following:

- The amount of the pass-through payments included in the rates and the schedule of payments to the network providers.
- The amount of the pass-through payments noted in the contract must be consistent with the amount calculated in the rate certification and comply with requirements outlined in 42 CFR 438.6(d).

[42 CFR 438.6(d)] [Existing standard]

I.D.7.02 [Applies to MCO, HIO, PIHP, PAHP]*

Pass-through payments for physicians and nursing facilities are allowed for a 5-year transition period (rating periods for contracts beginning on or after July 1, 2017 through rating periods for contracts beginning on or after July 1, 2021). In order for pass-through payments for physicians and nursing facilities to be allowed for this transition period, a state must demonstrate that it had pass-through payments for physicians and/or nursing facilities as outlined in 42 CFR 438.6(d)(1)(i).

For this transition period, the amount of the pass-through payments for physicians and nursing facilities may be no more than the total dollar amount of pass-through payments to physicians and nursing facilities, respectively, identified in the managed care contract(s) and rate certification(s) used to meet the requirement of 42 CFR 438.6(d)(1)(i).

For rating periods for contracts beginning on or after July 1, 2022, the state cannot require pass-through payments for physicians or nursing facilities under the managed care plan contract(s). [42 CFR 438.6(d)(5); 42 CFR 438.6(d)(1)(i)] [Existing standard]

I.D.7.03 [Applies to MCO, HIO, PIHP or PAHP]*

Pass-through payments for hospitals are allowed for a 10-year transition period (rating periods for contracts beginning on or after July 1, 2017 through rating periods for contracts beginning on or after July 1, 2026). In order for pass-through payments for hospitals to be allowed for this transition period, a state must demonstrate that it had pass-through payments for hospitals as outlined in 42 CFR 438.6(d)(1)(i).

For this transition period, the total dollar amount of the pass-through payments to hospitals may not exceed the lesser of: (1) a percentage of the base amount, beginning with 100 percent for the rating period for contracts beginning on or after July 1, 2017, and decreasing by 10 percentage points each successive year; or (2) the total dollar amount of pass-through payments to hospitals identified in managed care contract(s) and rate certification(s) used to meet the requirement of 42 CFR 438.6(d)(1)(i).

For rating periods for contracts beginning on or after July 1, 2027, the state cannot require pass-through payments for hospitals under the managed care plan contract(s). [42 CFR 438.6(d)(3); 42 CFR 438.6(d)(1)(i); 42 CFR 438.6(d)(2); 42 CFR 438.6(d)(4)] [Existing standard]

I.D.7.04 [Applies to MCO, HIO, PIHP or PAHP]*

Pass-through payments to hospitals for inpatient and outpatient services are permitted for up to 3 years if a state is initially transitioning services or populations from a fee-for-service (FFS) delivery system to a managed care delivery system.

In order for pass-through payments for hospitals to be allowed for this transition period, a state must demonstrate that:

(1) The services will be covered for the first time under a managed care contract and were previously provided in a FFS delivery system prior to the first rating period of the transition period,

(2) The state made supplemental payments as defined in 42 CFR 438.6(a) to hospitals during the 12- month period immediately 2 years prior to the first year of the transition period, and

(3) The aggregate amount of the pass-through payments is less than or equal to the product of the actual supplemental payments paid and the ratio achieved by dividing the amount paid through payment rates for hospital services that are being transitioned from payment in a FFS delivery system to the managed care contract by the total amount paid through State Plan approved rates for hospital services made in the state's FFS delivery system. [42 CFR 438.6(d)(1); 42 CFR 438.6(d)(6)] [Effective: No earlier than the rating period for contracts starting on or after 07/01/2021]

I.D.7.05 [Applies to MCO, HIO, PIHP or PAHP]*

Pass-through payments for physician services are permitted for up to 3 years if a state is initially transitioning services or populations from a FFS delivery system to a managed care delivery system.

In order for pass-through payments for physicians to be allowed for this transition period, a state must demonstrate that:

(1) The services will be covered for the first time under a managed care contract and were previously provided in a FFS delivery system prior to the first rating period of the transition period,

(2) The state made supplemental payments as defined in 42 CFR 438.6(a) to physicians during the 12- month period immediately 2 years prior to the first year of the transition period, and

(3) The aggregate amount of the pass-through payments is less than or equal to the product of the actual supplemental payments paid and the ratio achieved by dividing the amount paid through State Plan approved rates for physician services that are being transitioned from payment in a FFS delivery system to the managed care contract by the total amount paid through payment rates for physician services made in the state's FFS delivery system. [42 CFR 438.6(d)(1); 42 CFR 438.6(d)(6)] [Effective: No earlier than the rating period for contracts starting on or after 07/01/2021]

I.D.7.06 [Applies to MCO, HIO, PIHP or PAHP]*

Pass-through payments for nursing facility services are permitted for up to 3 years if a state is initially transitioning services or populations from a FFS delivery system to a managed care delivery system.

In order for pass-through payments for nursing facilities to be allowed for this transition period, a state must demonstrate that:

(1) The services will be covered for the first time under a managed care contract and were previously provided in a FFS delivery system prior to the first rating period of the transition period,

(2) The state made supplemental payments as defined in 42 CFR 438.6(a) to nursing facilities during the 12- month period immediately 2 years prior to the first year of the transition period, and

(3) The aggregate amount of the pass-through payments is less than or equal to the product of the actual supplemental payments paid and the ratio achieved by dividing the amount paid through State Plan approved rates for nursing facility services that are being transitioned from payment in a FFS delivery system to the managed care contract by the total amount paid through payment rates for nursing facility services made in the state's

FFS delivery system. [42 CFR 438.6(d)(1); 42 CFR 438.6(d)(6)] [Effective: No earlier than the rating period for contracts starting on or after 07/01/2021]

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

I.E.1.03 [Applies to HIO, 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 438.206(b)(1)] [Existing standard]

I.E.1.04 [Applies to HIO, 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 438.206(b)(1)] [Existing standard]

I.E.1.05 [Applies to HIO, 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 438.206(b)(7)] [Existing standard]

I.E.1.06 [Applies to HIO, 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 438.207(a); 42 CFR 438.68; 42 CFR 438.206(c)(1)] [Existing standard]

I.E.1.07 [Applies to HIO, 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 438.207(b)(1)] [Existing standard]

I.E.1.08 [Applies to HIO, 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 438.207(b)(2)] [Existing standard]

I.E.1.09 [Applies to HIO, 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 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 438.3(q)(2); 42 CFR 438.3(r)] [Existing standard]

I.E.2 No Discrimination

I.E.2.01 [Applies to HIO, 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 438.12(a)(1)] [Existing standard]

I.E.3 Provider Selection

I.E.3.01 [Applies to HIO, 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 438.12(a)(1)] [Existing standard]

I.E.3.02 [Applies to HIO, 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 438.12(a)(2); 42 CFR 438.214(a)] [Existing standard]

I.E.3.03 [Applies to HIO, 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 438.12(a)(2); 42 CFR 438.214(b)(1)] [Existing standard]

I.E.3.04 [Applies to HIO, 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 438.12(a)(2); 42 CFR 438.214(b)(2)] [Existing standard]

I.E.3.05 [Applies to HIO, 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 438.12(a)(2); 42 CFR 438.214(c)] [Existing standard]

I.E.3.06 [Applies to HIO, 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 438.12(a)(2); 42 CFR 438.214(e)] [Existing standard]

I.E.3.07 [Applies to HIO, 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 438.12(b)(1)] [Existing standard]

I.E.3.08 [Applies to HIO, 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 438.12(b)(2)] [Existing standard]

I.E.3.09 [Applies to HIO, 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 438.12(b)(3)] [Existing standard]

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

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

I.E.4 Anti-gag

I.E.4.01 – I.E.4.04 [Applies to HIO, 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 438.102(a)(1)(i) - (iv)] [Existing standard]

I.E.4.05 [Applies to HIO, 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 438.410(b)] [Existing standard]

I.E.5 Network Adequacy Standards

I.E.5.01 – I.E.5.06 [Applies to HIO, 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 Medicaid 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 438.206(c)(1)(i) - (vi)] [Existing standard]

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

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

I.E.5.08 – I.E.5.19 [Applies to HIO, 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 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 438.68(b)(1) effective 12/14/2020]

I.E.5.20 [Applies to HIO, 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 438.68(b)(2)(i)] [Existing standard, the 2020 Final Rule replaced "time and distance standards" with "quantitative network adequacy standards" at 42 CFR 438.68(b)(2)(i) effective 12/14/2020]

I.E.5.21 [Applies to HIO, 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 438.68(b)(3); 42 CFR 438.68(b)(2)] [Existing standard]

I.E.5.22 [Applies to HIO, 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 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 HIO, 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 438.414; 42 CFR 438.10(g)(2)(xi)(A) - (C)] [Existing standard]

I.E.6.04 [Applies to HIO, 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 fair hearing after the MCP has made a determination on an enrollee's appeal which is adverse to the enrollee. [42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(D)] [Existing standard]

I.E.6.05 [Applies to HIO, 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 fair hearing 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 fair hearing is pending if the final decision is adverse to the enrollee. [42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(E)] [Existing standard]

I.E.7 Balance Billing

I.E.7.01 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP]

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 438.3(k); 42 CFR 438.230(c)(1) - (2)] [Existing standard]

I.E.8 Physician Incentive Plan

I.E.8.01 [Applies to HIO, 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 422.208(c)(1); 42 CFR 438.3(i)] [Existing standard]

I.E.8.02 [Applies to HIO, 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 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 HIO, 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 438.14(b)(1); 42 CFR 438.14(b)(5)] [Existing standard]

I.E.9.02 [Applies to HIO, 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 438.14(b)(2)(i) - (ii)] [Existing standard]

I.E.9.03 [Applies to HIO, 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 438.14(b)(4)] [Existing standard]

I.E.9.04 [Applies to HIO, 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 438.14(b)(6)] [Existing standard]

I.E.10 Practice guidelines

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

The contract requires that the MCP disseminate practice guidelines to all affected providers. [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 HIO, 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 438.114(b); 42 CFR 422.113(c)] [Existing standard]

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

The contract requires the MCP to pay non-contracted providers for emergency services no more than the amount that would have been paid if the service had been provided under the state's FFS Medicaid program. [SMDL 06-010; section 1932(b)(2)(D) of the Act] [Existing standard]

I.F.1.04 – I.F.1.06 [Applies to HIO, 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 438.114(c)(1)(i); 42 CFR 438.114(c)(1)(ii)(A) - (B)] [Existing standard]

I.F.1.07 – I.F.1.08 [Applies to HIO, 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 438.114(d)(1)(i) - (ii)] [Existing standard]

I.F.1.09 [Applies to HIO, 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 438.114(d)(2)] [Existing standard]

I.F.1.10 – I.F.1.11 [Applies to HIO, 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 438.114(d)(3)] [Existing standard]

I.F.1.12 – I.F.1.16 [Applies to HIO, 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 a MCP plan provider or representative.*

- Not pre-approved by a 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 a MCP physician was not available for consultation.*

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

I.F.1.17 [Applies to HIO, 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 438.114(e); 42 CFR 422.113(c)(2)(iv)] [Existing standard]

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

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

- A MCP physician with privileges at the treating hospital assumes responsibility for the enrollee's care.*
- A MCP physician assumes responsibility for the enrollee's care through transfer.
- A MCP representative and the treating physician reach an agreement concerning the enrollee's care.*
- The enrollee is discharged.*

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

I.F.2 Family Planning

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

The contract prohibits the MCP from restricting the enrollee's free choice of family planning services and supplies providers. [Section 1902(a)(23) of the Act; 42 CFR 431.51(b)(2)] [Existing standard]

I.F.3 Abortions

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

The MCP's contract stipulates that abortions in the following situations are covered Medicaid benefits:

- If the pregnancy is the result of an act of rape or incest.
- In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

[42 CFR 441.202; Consolidated Appropriations Act of 2008] [Existing standard]

I.F.4 Delivery Network

I.F.4.01 [Applies to HIO, 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 438.206(b)(2)] [Existing standard]

I.F.4.02 [Applies to HIO, 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 438.206(b)(3)] [Existing standard]

I.F.4.03 [Applies to HIO, 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 438.206(b)(4)] [Existing standard]

I.F.4.04 [Applies to HIO, 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 438.206(b)(5)] [Existing standard]

I.F.4.05 [Applies to HIO, 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 438.910(d)(3)] [Existing standard]

I.F.5 Services Not Covered Based on Moral Objections

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

The contract requires a 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 438.102(b)(1)(i)(A)(1)] [Existing standard]

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

The contract requires a 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 438.102(b)(1)(i)(A)(2)] [Existing standard]

I.F.6 Amount, Duration and Scope

I.F.6.01 [Applies to HIO, 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 438.210(a)(1)] [Existing standard]

I.F.6.02 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP]*

The contract requires that each service the MCP is required to provide to adults 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 438.210(a)(2)] [Existing standard]

I.F.6.03 [Applies to HIO, 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 Medicaid. [42 CFR 438.210(a)(2)] [Existing standard]

I.F.6.04 [Applies to HIO, 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 438.210(a)(3)(i)] [Existing standard]

I.F.6.05 [Applies to HIO, 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 438.210(a)(3)(ii)] [Existing standard]

I.F.6.06 [Applies to HIO, 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 Medicaid State Plan (MSP), such as medical necessity. [42 CFR 438.210(a)(4)(i)] [Existing standard]

I.F.6.07 [Applies to HIO, 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 438.210(a)(4)(ii)(A)] [Existing standard]

I.F.6.08 [Applies to HIO, 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 438.210(a)(4)(ii)(B)] [Existing standard]

I.F.6.09 [Applies to HIO, 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 438.210(a)(4)(ii)(C)] [Existing standard]

I.F.6.10 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP]*

The contract must specify what constitutes "medically necessary services" in a manner that is no more restrictive than the state Medicaid program, including Quantitative and Non-Quantitative Treatment Limits (QTL) (NQTL), as indicated in state statutes and regulations, the MSP, and other state policies and procedures. [42 CFR 438.210(a)(5)(i)] [Existing standard]

I.F.6.11 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP]*

The contract must specify what constitutes "medically necessary services" in a manner that addresses the extent to which the MCP is responsible for covering services that address the prevention, diagnosis, and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability. [42 CFR 438.210(a)(5)(ii)(A)] [Existing standard]

I.F.6.12 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP]*

The contract must specify what constitutes "medically necessary services" in a manner that addresses the extent to which the MCP is responsible for covering services related to the ability for an enrollee to achieve age-appropriate growth and development. [42 CFR 438.210(a)(5)(ii)(B)] [Existing standard]

I.F.6.13 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP]*

The contract must specify what constitutes "medically necessary services" in a manner that addresses the extent to which the MCP is responsible for covering services related to the ability for an enrollee to attain, maintain, or regain functional capacity. [42 CFR 438.210(a)(5)(ii)(C)] [Existing standard]

I.F.6.14 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP]*

The contract must specify what constitutes "medically necessary services" in a manner that addresses the extent to which the MCP is responsible for covering services related to the opportunity for an enrollee receiving LTSS to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice. [42 CFR 438.210(a)(5)(ii)(D)] [Existing standard]

I.F.6.15 [Applies to HIO, MCO, PIHP, 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 mental health and substance use disorder benefits in 42 CFR Part 438, subpart K, 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 438.3(e)(1)(ii)] [Existing standard]

I.F.6.16 – I.F.6.20 [Applies to HIO, 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 438.3(e)(2)(i) - (iii)] [Existing standard]

I.F.7 Provider Preventable Conditions

I.F.7.01 [Applies to HIO, MCO, PIHP, PAHP]*

The contract prohibits the MCP from making payment to a provider for provider-preventable conditions that meet the following criteria:

- Is identified in the state plan.
- Has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
- Has a negative consequence for the beneficiary.
- Is auditable.
- Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

[42 CFR 438.3(g); 42 CFR 434.6(a)(12)(i); 42 CFR 447.26(b)] [Existing standard]

I.F.7.02 [Applies to HIO, MCO, PIHP, PAHP]

The contract specifies that the MCP must require all providers to report provider-preventable conditions associated with claims for payment or enrollee treatments for which payment would otherwise be made. [42 CFR 438.3(g); 42 CFR 434.6(a)(12)(ii); 42 CFR 447.26(d)] [Existing standard]

I.F.7.03 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires the MCP to report all identified provider-preventable conditions in a form or frequency, which may be specified by the state. [42 CFR 438.3(g)] [Existing standard]

I.F.8 Cost Sharing

I.F.8.01 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP]

The contract requires that any cost sharing imposed on Medicaid enrollees is in accordance with Medicaid FFS requirements at 42 CFR 447.50 through 42 CFR 447.82. [Sections 1916(a)(2)(D) and 1916(b)(2)(D) of the Act; 42 CFR 438.108; 42 CFR 447.50 - 82; SMD letter 6/16/06] [Existing standard]

I.F.8.02 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP]

The contract requires the MCP to exempt from premiums any Indian who is eligible to receive or has received an item or service furnished by an IHCP or through referral under contract health services. [42 CFR 447.52(h); 42 CFR 447.56(a)(1)(x); ARRA 5006(a); 42 CFR 447.51(a)(2); SMDL 10-001] [Existing standard]

I.F.8.03 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP]

The contract requires the MCP to exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an IHCP or through referral under contract health services. [42 CFR 447.52(h); 42 CFR 447.56(a)(1)(x); ARRA 5006(a); 42 CFR 447.51(a)(2); SMDL 10-001] [Existing standard]

I.F.9 Nonpayment

I.F.9.01 [Applies to MCO, PCCM]*

The contract prohibits the MCP from paying for organ transplants unless the state plan provides, and the MCP follows, written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to enrollees. [Section 1903(i) of the Act, final sentence; section 1903(i)(1) of the Act] [Existing standard]

I.F.9.02 – I.F.9.06 [Applies to MCO, PCCM]

The contract prohibits the MCP from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

- Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Act.
- Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) or the Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

- Furnished by an individual or entity to whom the state has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments.
- With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.
- With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the MSP.

[Section 1903(i) of the Act, final sentence; section 1903(i)(2)(A) - (C) of the Act; section 1903(i)(16) - (17) of the Act] [Existing standard]

I.F.10 Federally Qualified Health Center (FQHC) Payments

I.F.10.01 [Applies to MCO]

The contract provides that if a MCP enters into a contract for the provision of services with a FQHC or a Rural Health Clinic (RHC), the MCP shall provide payment that is not less than the level and amount of payment which the MCP would make for the services if the services were furnished by a provider which is not a FQHC or RHC. [Section 1903(m)(2)(A)(ix) of the Act] [Existing standard]

I.F.11 Outpatient/Prescription Drugs

I.F.11.01 [Applies to HIO, MCO, PIHP, PAHP]

If outpatient drugs are included in the contract, the contract requires the MCP to provide coverage of outpatient drugs as defined in section 1927(k)(2) of the Act, in alignment with standards for such coverage imposed by section 1927 of the Act. [42 CFR 438.3(s)(1)] [Existing standard]

I.F.11.02 – I.F.11.03 [Applies to HIO, MCO, PIHP, PAHP]

If outpatient drugs are included in the contract, the contract requires the MCP to report:

- Drug utilization data that is necessary for the state to bill manufacturers for rebates no later than 45 calendar days after the end of each quarterly rebate period.
- Drug utilization information that includes, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code (NDC) of each covered outpatient drug dispensed or covered by MCP.

[42 CFR 438.3(s)(2); section 1927(b)(1)(A) of the Act] [Existing standard]

I.F.11.04 [Applies to HIO, MCO, PIHP, PAHP]

If outpatient drugs are included in the contract, the contract requires the MCP to establish procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program from drug utilization data reports when states do not require submission of managed care drug claims data from covered entities directly. [42 CFR 438.3(s)(3)] [Existing standard]

I.F.11.05 [Applies to HIO, MCO, PIHP, PAHP]

If outpatient drugs are included in the contract, the contract requires the MCP to operate a drug utilization review program that includes prospective drug review, retrospective drug use review, and an educational program as required at 42 CFR Part 456, subpart K. [42 CFR 438.3(s)(4)] [Existing standard]

I.F.11.06 [Applies to HIO, MCO, PIHP, PAHP]

If outpatient drugs are included in the contract, the contract requires the MCP to provide a detailed description of its drug utilization review program activities to the state on an annual basis. [42 CFR 438.3(s)(5)] [Existing standard]

I.F.11.07 [Applies to HIO, MCO, PIHP, PAHP]

If outpatient drugs are included in the contract, the contract requires the MCP to conduct a prior authorization program that complies with the requirements of section 1927(d)(5) of the Act. [42 CFR 438.3(s)(6); section 1927(d)(5) of the Act] [Existing standard]

I.F.11.08 – I.F.11.11 [Applies to MCO, PCCM entity]*

If covered outpatient drugs are included in the contract, the contract requires

- The MCP to implement prospective safety edits on subsequent fills of opioid prescriptions, as specified by the state, which may include edits to address days' supply, early refills, duplicate fills and quantity limitations for clinical appropriateness.
- The MCP to implement prospective safety edits on maximum daily morphine milligram equivalents (MME) on opioids prescriptions to limit the daily morphine milligram equivalent.
- The implementation of retrospective reviews on opioid prescriptions exceeding above limitations on an ongoing basis.
- The MCP to implement retrospective reviews on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing basis.

[Section 1902(a)(85) of the Act; Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act); 08/05/2019 CIB] [Existing standard]

I.F.11.12 [Applies to MCO, PCCM entity]*

If covered outpatient drugs are included in the contract and children are enrolled in the contract, the contract requires review of antipsychotic agents for appropriateness for all children 18 and under including foster children based on approved indications and clinical guidelines. [Section 1902(a)(85) of the Act; Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act); 08/05/2019 CIB] [Existing standard]

I.F.11.13 [Applies to MCO, PCCM entity]*

If outpatient drugs are included in the contract, the contract requires the DUR program to have an established process that identifies potential fraud or abuse of controlled substances by

enrolled individuals, health care providers and pharmacies. [Section 1902(a)(85) of the Act; Section 1004 of the SUPPORT Act; 08/05/2019 CIB] [Existing standard]

I.F.12 Parity in Mental Health and Substance Use Disorder (MH/SUD) Benefits[6]

I.F.12.01 [Applies to HIO, 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 438.905(b)] [Existing standard]

I.F.12.02 [Applies to HIO, 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 438.905(c)] [Existing standard]

I.F.12.03 [Applies to HIO, 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 438.905(e)(ii). [42 CFR 438.905(e)] [Existing standard]

I.F.12.04 [Applies to HIO, 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 438.910(b)(1)] [Existing standard]

I.F.12.05 [Applies to HIO, 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

[6] In accordance with 42 CFR 438.905(a), each MCO, PIHP, and PAHP providing services to MCO enrollees must comply with 42 CFR Subpart K—Parity in Mental Health and Substance Use Disorder Benefits requirements for all enrollees of an MCO in states that cover both

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 438.910(b)(2)] [Existing standard]

I.F.12.06 [Applies to HIO, 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 438.910(c)(3)] [Existing standard]

I.F.12.07 [Applies to HIO, MCO, PIHP, PAHP]*

The contract specifies that the MCP may not impose 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 438.910(d)] [Existing standard]

I.F.12.08 [Applies to HIO, 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 Part 438, subpart K regarding parity in mental health and substance use disorder benefits. [61 Fed. Reg. 18413, 18414 and 18417 (March 30, 2016)] [Existing standard]

I.F.13 Long-Term Services and Supports (LTSS)

I.F.13.01 [Applies to HIO, MCO, PIHP, PAHP]

If LTSS are covered under a risk contract between the state and the MCP, the contract must provide that the MCP establish and maintain a member advisory committee. [42 CFR 438.110(a)] [Existing standard]

I.F.13.02 [Applies to HIO, MCO, PIHP, PAHP]

If LTSS are covered under a risk contract between the state and the MCP, the contract requires that the member advisory committee include at least a reasonably representative sample of the LTSS populations, or other individuals representing those enrollees, covered under the contract with the MCP [42 CFR 438.110(b)] [Existing standard]

I.F.13.03 [Applies to HIO, MCO, PIHP, PAHP]*

If the MCP is required to provide LTSS in a community-based setting that could be authorized through a section 1915(c) waiver, a section 1915(i) SPA, or a section 1915(k) SPA, the contract specifies that the long term services and supports must be provided in a setting which complies with the 42 CFR 441.301(c)(4) requirements for home and community-based settings. [42 CFR 438.3(o); sections 1915(c), 1915(i), and 1915(k) of the Act; 42 CFR 441.301(c)(4)] [Existing standard]

I.F.14 Advance Directives[7]

I.F.14.01 [Applies to HIO, MCO, PIHP, PAHP]*

The contract requires that each MCP maintain written policies and procedures on advance directives for all adults receiving medical care by or through the MCP. [42 CFR 438.3(j)(1) and (2); 42 CFR 422.128(a); 42 CFR 422.128(b); 42 CFR 489.102(a)] [Existing standard]

I.F.14.02 [Applies to HIO, MCO, PIHP, PAHP]*

The contract prohibits the MCP from conditioning the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive. [42 CFR 438.3(j)(1) and (2); 42 CFR 422.128(b)(1)(ii)(F); 42 CFR 489.102(a)(3)] [Existing standard]

I.F.14.03 [Applies to HIO, MCO, PIHP, PAHP]*

The contract requires the MCP to educate staff concerning their policies and procedures on advance directives. [42 CFR 438.3(j)(1) and (2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5)] Existing standard]

I.F.15 Moral Objections

I.F.15.01 [Applies to HIO, 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 438.102(a)(2)] [Existing standard]

I.F.16 Enrollee Rights

I.F.16.01 [Applies to HIO, 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 438.100(a)(1); 42 CFR 438.100(b)(2)(i)] [Existing standard]

I.F.16.02 [Applies to HIO, 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 438.100(a)(1); 42 CFR 438.100(b)(2)(ii)] [Existing standard]

I.F.16.03 [Applies to HIO, 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

[7] In accordance with 42 CFR 438.3(j)(2), these requirements only applies to PAHP contracts if the PAHP's provider network includes: hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), hospices, and religious nonmedical health care institutions

appropriate to the enrollee's condition and ability to understand. [42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(iii)] [Existing standard]

I.F.16.04 [Applies to HIO, 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 438.100(a)(1); 42 CFR 438.100(b)(2)(iv)] [Existing standard]

I.F.16.05 [Applies to HIO, 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 438.100(a)(1); 42 CFR 438.100(b)(2)(v)] [Existing standard]

I.F.16.06 [Applies to HIO, 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 438.100(a)(1); 42 CFR 438.100(b)(2)(vi)] [Existing standard]

I.F.16.07 [Applies to HIO, 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 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 HIO, 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 438.350] [Existing standard]

I.G.2 Care Coordination

I.G.2.01 – I.G.2.02 [Applies to HIO, 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 438.208(b)(1)] [Existing standard]

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

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

I.G.2.04 [Applies to HIO, 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 438.208(b)(2)(i)] [Existing standard]

I.G.2.05 [Applies to HIO, 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 438.208(b)(2)(ii)] [Existing standard]

I.G.2.06 [Applies to HIO, 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 438.208(b)(2)(iii)] [Existing standard]

I.G.2.07 [Applies to HIO, 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 438.208(b)(2)(iv)] [Existing standard]

I.G.2.08 – I.G.2.09 [Applies to HIO, 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 438.208(b)(3)] [Existing standard]

I.G.2.10 [Applies to HIO, 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 438.208(b)(4)] [Existing standard]

I.G.2.11 [Applies to HIO, 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 438.208(b)(5)] [Existing standard]

I.G.2.12 [Applies to HIO, 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 438.208(b)(6); 42 CFR 438.224; 45 CFR 160; 45 CFR 164] [Existing standard]

I.G.2.13 [Applies to HIO, 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 438.62(b)(1) - (2)] [Existing standard]

I.G.3 Authorization and Utilization Management

I.G.3.01 [Applies to HIO, 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 438.210(b)(1)] [Existing standard]

I.G.3.02 [Applies to HIO, 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 438.210(b)(2)(i)] [Existing standard]

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

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

I.G.3.04 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires the MCP to authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan. [42 CFR 438.210(b)(2)(iii)] [Existing standard]

I.G.3.05 [Applies to HIO, 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 438.210(b)(3)] [Existing standard]

I.G.3.06 [Applies to HIO, MCO, PIHP, PAHP]*

The contract requires that the MCP's prior authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910(d). [42 CFR 438.910(d)] [Existing standard]

I.G.3.07 [Applies to HIO, 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 438.210(d)(1)] [Existing standard]

I.G.3.08 [Applies to HIO, 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 438.210(d)(2)] [Existing standard]

I.G.3.09 [Applies to HIO, 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 438.210(d)(3)] [Existing standard]

I.G.3.10 [Applies to HIO, 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 438.210(e)] [Existing standard]

I.G.4 Practice Guidelines

I.G.4.01 [Applies to HIO, 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 438.236(b)(1)] [Existing standard]

I.G.4.02 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires the MCP to adopt practice guidelines that consider the needs of the enrollees. [42 CFR 438.236(b)(2)] [Existing standard]

I.G.4.03 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires the MCP to adopt practice guidelines in consultation with network providers. [42 CFR 438.236(b)(3)] [Effective: 12/14/2020]

I.G.4.04 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires the MCP to review and update practice guidelines periodically as appropriate. [42 CFR 438.236(b)(4)] [Existing standard]

I.G.4.05 [Applies to HIO, 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 438.236(d)] [Existing standard]

I.G.5 Quality

I.G.5.01 [Applies to HIO, 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 438.330(a)(1); 42 CFR 438.330(a)(3)] [Existing standard]

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

The contract requires that the comprehensive QAPI program must include Performance Improvement Projects (PIPs), including any required by the state or CMS, that focus on clinical and non-clinical areas. [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 HIO, 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 438.330(b)(2); 42 CFR 438.330(c); 42 CFR 438.330(a)(2)] [Existing standard]

I.G.5.04 [Applies to HIO, 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 438.330(b)(3)] [Existing standard]

I.G.5.05 [Applies to HIO, 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 438.330(b)(4); 42 CFR 438.340] [Existing standard]

I.G.5.06 – G.5.07 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires that for MCPs providing LTSS, the comprehensive QAPI program must include mechanisms to assess the quality and appropriateness of care furnished to enrollees using LTSS, including:

- An assessment of care between care settings; and
- A comparison of services and supports received with those set forth in the enrollee's treatment/service plan.

[42 CFR 438.330(b)(5)(i)] [Existing standard]

I.G.5.08 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires that for MCPs providing LTSS, the comprehensive QAPI program must include participation in efforts by the state to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare that are based, at a minimum, on the requirements on the state for home and community-based waiver programs. [42 CFR 438.330(b)(5)(ii); 42 CFR 441.302; 42 CFR 441.730(a); 42 CFR 441.302(h)] [Existing standard]

I.G.5.09 [Applies to HIO, 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 438.330(c)(1) and (2)] [Existing standard]

I.G.5.10 [Applies to HIO, 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 438.330(d)(2)] [Existing standard]

I.G.5.11 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires that each PIP include measurement of performance using objective quality indicators. [42 CFR 438.330(d)(2)(i)] [Existing standard]

I.G.5.12 [Applies to HIO, 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 438.330(d)(2)(ii)] [Existing standard]

I.G.5.13 [Applies to HIO, 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 438.330(d)(2)(iii)] [Existing standard]

I.G.5.14 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires that each PIP include planning and initiation of activities for increasing or sustaining improvement. [42 CFR 438.330(d)(2)(iv)] [Existing standard]

I.G.5.15 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires that the MCP report the status and results of each performance improvement project to the state as requested, but not less than once per year. [42 CFR 438.330(d)(1) and (3)] [Existing standard]

I.G.5.16 [Applies to HIO, MCO, PIHP, PAHP]

At the state's option, the contract specifies that the state may permit an MCP exclusively serving dual eligibles to substitute a Medicare Advantage Organization (MAO) quality

improvement project for one of more of the PIPs otherwise required. [42 CFR 438.330(d)(4); 42 CFR 422.152(d)] [Existing standard]

I.G.5.17 [Applies to HIO, 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 438.330(e)(2); 42 CFR 438.310(c)(2)] [Existing standard]

I.G.6 Cultural Competence

I.G.6.01 [Applies to HIO, 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 438.206(c)(2)] [Existing standard]

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

I.G.7.01 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires that the MCP implement mechanisms to comprehensively assess

each Medicaid 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 438.208(c)(2)] [Existing standard]

I.G.7.02 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires that the MCP implement mechanisms to comprehensively assess each Medicaid 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 438.208(c)(2)] [Existing standard]

I.G.7.03 [Applies to HIO, 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 438.208(c)(2)] [Existing standard]

I.G.7.04 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires that MCPs produce a treatment or service plan for enrollees who require LTSS. [42 CFR 438.208(c)(3)] [Existing standard]

I.G.7.05 [Applies to HIO, 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 438.208(c)(3)] [Existing standard]

I.G.7.06 – I.G.7.10 [Applies to HIO, 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 care 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 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 HIO, 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 438.208(c)(3)(iii) - (v); 42 CFR 441.301(c)(3)] [Existing standard]

I.G.7.14 [HIO, 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 438.208(c)(4)] [Existing standard]

I.G.8 Accreditation

I.G.8.01 [Applies to HIO, 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 438.332(a)] [Existing standard]

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

The contract requires that the MCP have a grievance and appeal system in place for enrollees.* [42 CFR 438.402(a); 42 CFR 438.228(a)] [Existing standard]

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

The contract requires that the MCP has only one level of appeal for enrollees. [42 CFR 438.402(b); 42 CFR 438.228(a)] [Existing standard]

I.H.1.03 [Applies to HIO, 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 438.406(a); 42 CFR 438.228(a)] [Existing standard]

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

The contract requires the MCP to acknowledge receipt of each grievance and appeal of adverse benefit determinations. [42 CFR 438.406(b)(1); 42 CFR 438.228(a)] [Existing standard]

I.H.1.05 – I.H.1.06 [Applies to HIO, 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 438.406(b)(2)(i); 42 CFR 438.228(a)] [Existing standard]

I.H.1.07 – I.H.1.09 [Applies to HIO, 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 438.406(b)(2)(ii)(A) - (C); 42 CFR 438.228(a)] [Existing standard]

I.H.1.10 [Applies to HIO, 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 438.406(b)(2)(iii); 42 CFR 438.228(a)] [Existing standard]

I.H.1.11 [Applies to HIO, 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 438.56(d)(5)(ii); 42 CFR 438.56(e)(1); 42 CFR 438.228(a)] [Existing standard]

I.H.2 Notice of Adverse Benefit Determination Requirements

I.H.2.01 [Applies to HIO, 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 438.404(b)(1)] [Existing standard]

I.H.2.02 [Applies to HIO, 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 438.404(b)(2)] [Existing standard]

I.H.2.03 [Applies to HIO, 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 fair hearing after receiving notice that the adverse benefit determination is upheld. [42 CFR 438.404(b)(3); 42 CFR 438.402(b) - (c)] [Existing standard]

I.H.2.04 [Applies to HIO, 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 438.404(b)(4)] [Existing standard]

I.H.2.05 [Applies to HIO, 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 438.404(b)(5)] [Existing standard]

I.H.2.06 [Applies to HIO, MCO, PIHP, PAHP]*

The contract requires that the MCP's notice of adverse benefit determination explain the enrollee's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of continued services. [42 CFR 438.404(b)(6)] [Existing standard]

I.H.3 Notice of Adverse Benefit Determination Timing

I.H.3.01 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires the MCP to mail the notice of adverse benefit determination at least 10 days before the date of action, when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services. [42 CFR 438.404(c)(1); 42 CFR 431.211] [Existing standard]

I.H.3.02 [Applies to HIO, MCO, PIHP, PAHP]

The contract allows the MCP to mail the notice of adverse benefit determination as few as 5 days prior to the date of action if the agency has facts indicating that action should be taken because of probable fraud by the beneficiary, and the facts have been verified, if possible, through secondary sources [42 CFR 438.404(c)(1); 42 CFR 431.214] [Existing standard]

I.H.3.03 [Applies to HIO, MCO, PIHP, PAHP]*

The contract requires the MCP to mail the notice of adverse benefit determination by the date of the action when any of the following occur:

- The recipient has died.
- The enrollee submits a signed written statement requesting service termination.
- The enrollee submits a signed written statement including information that requires service termination or reduction and indicates that he understands that service termination or reduction will result.
- The enrollee has been admitted to an institution where he or she is ineligible under the plan for further services.
- The enrollee's address is determined unknown based on returned mail with no forwarding address.

- The enrollee is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
- A change in the level of medical care is prescribed by the enrollee's physician.
- The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act.
- The transfer or discharge from a facility will occur in an expedited fashion.

[42 CFR 438.404(c)(1); 42 CFR 431.213; 42 CFR 431.231(d); section 1919(e)(7) of the Act; 42 CFR 483.12(a)(5)(i); 42 CFR 483.12(a)(5)(ii)] [Existing standard]

I.H.3.04 [Applies to HIO, 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 438.404(c)(2)] [Existing standard]

I.H.3.05 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires the MCP to give notice of adverse benefit determination as expeditiously as the enrollee's condition requires within state-established timeframes that may not exceed 14 calendar days following receipt of the request for service, for standard authorization decisions that deny or limit services. [42 CFR 438.210(d)(1); 42 CFR 438.404(c)(3)] [Existing standard]

I.H.3.06 [Applies to HIO, MCO, PIHP, PAHP]

The contract allows the MCP to extend the 14 calendar day notice of adverse benefit determination timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the enrollee or the provider requests extension. [42 CFR 438.404(c)(4); 42 CFR 438.210(d)(1)(i)] [Existing standard]

I.H.3.07 [Applies to HIO, MCO, PIHP, PAHP]

The contract allows the MCP to extend the 14 calendar day notice of adverse benefit determination timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the MCP justifies a need (to the state agency, upon request) for additional information and shows how the extension is in the enrollee's best interest. [42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)] [Existing standard]

I.H.3.08 [Applies to HIO, MCO, PIHP, PAHP]*

The contract requires that if the MCP extends the 14 calendar day notice of adverse benefit determination timeframe for standard authorization decisions that deny or limit services, it must give the enrollee written notice of the reason for the extension and inform the enrollee of the right to file a grievance if he/she disagrees with the decision. [42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(i)] [Existing standard]

I.H.3.09 [Applies to HIO, MCO, PIHP, PAHP]*

The contract requires that if the MCP extends the 14 calendar day notice of adverse benefit determination timeframe for standard authorization decisions that deny or limit services, it must issue and carry out its determination as expeditiously as the enrollee's health condition

requires and no later than the date the extension expires. [42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(ii)] [Existing standard]

I.H.3.10 [Applies to HIO, MCO, PIHP, PAHP]

The MCP 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 438.210(d)(2)(i); 42 CFR 438.404(c)(6)] [Existing standard]

I.H.3.11 [Applies to HIO, 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 438.210(d)(2)(ii); 42 CFR 438.404(c)(6)] [Existing standard]

I.H.3.12 [Applies to HIO, MCO, PIHP, PAHP]*

The contract requires that the MCP give notice on the date that the timeframes expire, when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations. [42 CFR 438.404(c)(5)] [Existing standard]

I.H.4 Who May File Appeals and Grievances

I.H.4.01 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires the MCP to allow enrollees to file appeals, grievances, and state fair hearing requests (after receiving notice that an adverse benefit determination is upheld). [42 CFR 438.402(c)(1); 42 CFR 438.408] [Existing standard]

I.H.4.02 [Applies to HIO, MCO, PIHP, PAHP]

If the state chooses to offer and arrange for an external medical review, that complies with 42 CFR 402(c)(1)(i)(B), the process for such review and the MCP's obligation to comply with such review is outlined in the contract. [42 CFR 438.402(c)(1)(i)(B)] [Existing standard]

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

If state law permits, the contract requires the MCP to allow providers, or authorized representatives, acting on behalf of the enrollee and with the enrollee's written consent, to request an appeal, file a grievance, or request a state fair hearing request. [42 CFR 438.402(c)(1)(i) - (ii); 42 CFR 438.408] [Existing standard]

I.H.5 Timeframes for Filing Appeals

I.H.5.01 [Applies to HIO, 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 fair hearing. [42 CFR 438.408; 42 CFR 438.402(c)(1)(i)(A)] [Existing standard]

I.H.5.02 [Applies to HIO, 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 438.402(c)(2)(ii)] [Existing standard]

I.H.5.03 [Applies to HIO, 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 438.402(c)(2)(ii)] [Existing standard]

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

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

The contract requires that the MCP allow the enrollee to request an appeal either orally or in writing. [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 HIO, 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 438.402(c)(3)(ii); 42 CFR 438.402(c)(1)(ii)] [Existing standard]

I.H.6.03 [Applies to HIO, 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 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 HIO, 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 438.406(b)(4)] [Existing standard]

I.H.6.05 [Applies to HIO, 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 438.406(b)(5)] [Existing standard]

I.H.6.06 [Applies to HIO, 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 438.406(b)(5); 438.408(b) - (c)] [Existing standard]

I.H.6.07 [Applies to HIO, 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 438.406(b)(6)] [Existing standard]

I.H.6.08 [Applies to HIO, 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 438.410(a)] [Existing standard]

I.H.6.09 [Applies to HIO, 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 438.406(b)(4); 42 CFR 438.408(b); 42 CFR 438.408(c) [Existing standard]

I.H.6.10 [Applies to HIO, 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 438.410(c); 42 CFR 438.408(b)(2); 42 CFR 438.408(c)(2)] [Existing standard]

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

I.H.7.01 [Applies to HIO, 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 438.408(a); 42 CFR 438.408(b)(2)] [Existing standard]

I.H.7.02 – I.H.7.03 [Applies to HIO, 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 that the delay is in the enrollee's interest (upon state request). [42 CFR 438.408(c)(1); 42 CFR 438.408(b)(2)] [Existing standard]

I.H.7.04 – I.H.7.06 [Applies to HIO, 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 438.408(c)(2)(i) - (iii); 42 CFR 438.408(b)(2)] [Existing standard]

I.H.7.07 [Applies to HIO, 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 438.408(a); 42 CFR 438.408(b)(3)] [Existing standard]

I.H.7.08 – I.H.7.09 [Applies to HIO, 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 438.408(c)(1)(i) - (ii); 42 CFR 438.408(b)(3)] [Existing standard]

I.H.7.10 – I.H.7.12 [Applies to HIO, 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 438.408(c)(2)(i) - (iii); 42 CFR 438.408(b)(3)] [Existing standard]

I.H.8 Notice of Resolution for Appeals

I.H.8.01 – I.H.8.04 [Applies to HIO, 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 fair hearing.
- How to request a state fair hearing.
- The right to request and receive benefits pending a hearing.
- How to request the continuation of benefits.
- Notice that the enrollee may, consistent with state policy, be liable for the cost of any continued benefits if the MCP's adverse benefit determination is upheld in the hearing.

[42 CFR 438.408(d)(2)(i); 42 CFR 438.10; 42 CFR 438.408(e)(1) - (2)] [Existing standard]

I.H.8.05 [Applies to HIO, 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 438.408(d)(2)(ii)] [Existing standard]

I.H.9 Continuation of Benefits

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

The contract requires that the MCP continue the enrollee's benefits while an appeal is in process if all of the following occur:

- The enrollee files the request for an appeal within 60 calendar days following the date on the adverse benefit determination notice.
- The appeal involves the termination, suspension, or reduction of a previously authorized service.
- The enrollee's services were ordered by an authorized provider.
- The period covered by the original authorization has not expired.
- The request for continuation of benefits is filed on or before the later of the following:
  - Within 10 calendar days of the MCP sending the notice of adverse benefit determination, or
  - The intended effective date of the MCP's proposed adverse benefit determination.

[42 CFR 438.420(a); 42 CFR 438.420(b)(1) - (5); 42 CFR 438.402(c)(2)(ii)] [Existing standard]

I.H.9.02 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires that if, at the enrollee's request, the MCP continues or reinstates the enrollee's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one of the following occurs:

- The enrollee withdraws the appeal or request for state fair hearing.
- The enrollee does not request a state fair hearing and continuation of benefits within 10 calendar days from the date the MCP sends the notice of an adverse appeal resolution.
- A state fair hearing decision adverse to the enrollee is issued.

[42 CFR 438.420(c)(1)-(3); 42 CFR 438.408(d)(2)] [Existing standard]

I.H.9.03 [Applies to HIO, MCO, PIHP, PAHP]

The contract provides that the MCP may, consistent with the state's usual policy on recoveries and as specified in the MCP's contract, recover the cost of continued services furnished to the enrollee while the appeal or state fair hearing was pending if the final resolution of the appeal or state fair hearing upholds the MCP's adverse benefit determination. [42 CFR 438.420(d); 42 CFR 431.230(b)] [Existing standard]

I.H.9.04 [Applies to HIO, 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 it receives notice reversing the determination) if the services were not furnished while the appeal was pending and if the MCP or state fair hearing officer reverses a decision to deny, limit, or delay services. [42 CFR 438.424(a)] [Existing standard]

I.H.9.05 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires the MCP to pay for disputed services received by the enrollee while the appeal was pending, unless state policy and regulations provide for the state to cover the cost of such services, when the MCP or state fair hearing officer reverses a decision to deny authorization of the services, [42 CFR 438.424(b)] [Existing standard]

I.H.9.06 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP]*

The contract requires that the MCP notify the requesting provider and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. [42 CFR 438.10(c); 42 CFR 438.404] [Existing standard]

I.H.10 Grievances

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

The contract specifies that an enrollee may file a grievance with an MCP at any time. [42 CFR 438.402(c)(2)(i)] [Existing standard]

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

The MCP contract specifies that an enrollee may file a grievance either orally or in writing. [42 CFR 438.402(c)(3)(i)] [Existing standard]

I.H.10.03 [Applies to HIO, 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 438.402(c)(3)(i)] [Existing standard]

I.H.10.04 [Applies to HIO, 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 438.408(a); 42 CFR 438.408(b)(1)] [Existing standard]

I.H.10.06 [Applies to HIO, 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 438.408(c)(1)(i) - (ii); 438.408(b)(1)] [Existing standard]

I.H.10.07 – I.H.10.08 [Applies to HIO, 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 438.408(c)(2)(i) - (ii); 42 CFR 438.408(b)(1)] [Existing standard]

I.H.10.09 [Applies to HIO, 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 438.408(d)(1); 42 CFR 438.10] [Existing standard]

I.H.11 Grievance and Appeal Recordkeeping Requirements

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

The contract requires that the MCP maintain records of grievances and appeals. [42 CFR 438.416(a)] [Existing standard]

I.H.11.02 – I.H.11.07 [Applies to HIO, 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 438.416(b)(1) - (6)] [Existing standard]

I.H.11.08 [Applies to HIO, 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 438.416(c)] [Existing standard]

I.I. Program Integrity

I.I.1 Exclusions

I.I.1.01 [Applies to HIO, 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 438.214(d)(1)] [Existing standard]

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

The contract prohibits the MCP from being controlled by a sanctioned individual under section 1128(b)(8) of the Act. [42 CFR 438.808(a); 42 CFR 438.808(b)(1); 42 CFR 431.55(h); section 1903(i)(2) of the Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09] [Existing standard]

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

The contract prohibits the MCP from having a contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with an individual convicted of crimes described in section 1128(b)(8)(B) of the Act. [42 CFR 438.808(a); 42 CFR 438.808(b)(2); 42 CFR 431.55(h); section 1903(i)(2) of the Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09] [Existing standard]

I.I.1.04 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*

The contract prohibits the MCP from having a contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. [42 CFR 438.808(a); 42 CFR 438.808(b)(2); 42 CFR 438.610(a); 42 CFR 431.55(h); section 1903(i)(2) of the Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549] [Existing standard]

I.I.1.05 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*

The contract prohibits the MCP from having a contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with any individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act. [42 CFR 438.808(a); 42 CFR 438.808(b)(2); 42 CFR 438.610(b); 42 CFR 431.55(h); section 1903(i)(2) of the Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09] [Existing standard]

I.I.1.06 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*

The contract prohibits the MCP from employing or contracting, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. [42 CFR 438.808(a); 42 CFR 438.808(b)(3)(i); 42 CFR 438.610(a); 1903(i)(2); 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549] [Existing standard]

I.I.1.07 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]*

The contract prohibits the MCP from employing or contracting, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with any individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act. [42 CFR 438.808(a); 42 CFR 438.808(b)(3)(i); 42 CFR 438.610(b); section 1903(i)(2) of the Act; 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09] [Existing standard]

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

The contract prohibits the MCP from employing or contracting, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with any individual or entity that would (or is affiliated with a person/entity that would) provide those services through an individual or entity debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. [42 CFR 438.808(a); 42 CFR 438.808(b)(3)(ii); 42 CFR 438.610(a); section 1903(i)(2) of the Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549] [Existing standard]

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

The contract prohibits the MCP from employing or contracting, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with any individual or entity that would provide those services through an individual or entity excluded from participation in any Federal health care program under section 1128 or 1128A of the Act. [42 CFR 438.808(a); 42 CFR 438.808(b)(3)(ii); 42 CFR 438.610(b); section 1903(i)(2) of the Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09] [Existing standard]

I.I.2 Requirements, Procedures, and Reporting

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

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

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

The contract requires the MCP to submit data on the basis of which the state certifies the actuarial soundness of capitation rates to an MCP, including base data that is generated by the MCP. [42 CFR 438.604(a)(2); 42 CFR 438.606; 42 CFR 438.3; 42 CFR 438.5(c)] [Existing standard]

I.I.2.03 [Applies to HIO, 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 438.604(a)(3); 42 CFR 438.606; 42 CFR 438.8] [Existing standard]

I.I.2.04 [Applies to HIO, 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 438.604(a)(4); 42 CFR 438.606; 42 CFR 438.116] [Existing standard]

I.I.2.05 [Applies to HIO, 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 438.604(a)(5); 42 CFR 438.606; 42 CFR 438.207(b); 42 CFR 438.206] [Existing standard]

I.I.2.06 – I.I.2.12 [Applies to HIO, 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 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.2.13 [Applies to HIO, 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 438.604(b); 42 CFR 438.606] [Existing standard]

I.I.2.14 [Applies to HIO, 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 438.604; 42 CFR 438.606(b)] [Existing standard]

I.I.2.15 [Applies to HIO, 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 438.604; 42 CFR 438.606(a)] [Existing standard]

I.I.2.16 [Applies to HIO, 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 438.606(c); 42 CFR 438.604(a) - (b)] [Existing standard]

I.I.2.17 – I.I.2.24 [Applies to HIO, 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 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 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.2.25 – I.I.2.26 [Applies to HIO, 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 438.610(a)(1) - (2); 42 CFR 438.610(c)(2); Exec. Order No. 12549] [Existing standard]

I.I.2.27 – I.I.2.37 [Applies to HIO, 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 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.2.38 [Applies to HIO, 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 438.608(b); 42 CFR 455.100-106; 42 CFR 455.400 - 470] [Existing standard]

I.I.2.39 [Applies to HIO, 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 438.608(c)(3)] [Existing standard]

I.I.2.40 [Applies to HIO, 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 438.3(m)] [Existing standard]

I.I.2.41 [Applies to HIO, MCO, PCCM entity]*

The contract requires that the MCP not contract with providers that the state has determined have been terminated from the Medicare, Medicaid or CHIP programs pursuant to 42 CFR 455.101. [Section 1932(d)(5) of the Act] [Effective: No later than the rating period for contracts starting on or after 10/01/2021]

I.I.3 Disclosure

I.I.3.01 [Applies to HIO, 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 438.608(c)(2); 42 CFR 455.100 - 104] [Existing standard]

I.I.3.02 [Applies to HIO, 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 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 438.608(c)(2); 42 CFR 455.100 - 103; 42 CFR 455.104(c)(1) and (4)] [Existing standard]

I.I.4 Reporting Transactions

I.I.4.01 [Applies to MCO]

The contract requires the MCP to report to the state and, upon request, to the Secretary of the Department of Health & Human Services (DHHS), the Inspector General of the DHHS, and the Comptroller General a description of transactions between the MCP and a party in interest (as defined in section 1318(b) of such Act), including the following transactions: (i) Any sale or exchange, or leasing of any property between the MCP and such a party; (ii) Any furnishing for consideration of goods, services (including management services), or facilities between the MCP and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; (iii) Any lending of money or other extension of credit

between the MCP and such a party. [Section 1903(m)(4)(A) of the Act; section 1318(b) of the Act] [Existing standard]

I.I.5 Compliance Program

I.I.5.01 – I.I.5.07 [Applies to HIO, 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 438.608(a); 42 CFR 438.608(a)(1)(i) - (vii)] [Existing standard]

I.I.5.08 [Applies to HIO, 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 438.608(a)(2)] [Existing standard]

I.I.5.09 – I.I.5.10 [Applies to HIO, 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 438.608(a)(3)] [Existing standard]

I.I.5.11 [Applies to HIO, 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 438.608(a)(4)] [Existing standard]

I.I.5.12 [Applies to HIO, 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 438.608(a)(5)] [Existing standard]

I.I.5.13 [Applies to HIO, 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 438.608(a)(6)] [Existing standard]

I.I.5.14 [Applies to HIO, 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. [42 CFR 438.608(a)(7)] [Existing standard]

I.I.5.15 [Applies to HIO, 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 438.608(a)(8); 42 CFR 455.23] [Existing standard]

I.I.6 Treatment of Recoveries

I.I.6.01 [Applies to HIO, 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 438.608(d)(1)(i)] [Existing standard]

I.I.6.02 [Applies to HIO, 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 438.608(d)(1)(ii)] [Existing standard]

I.I.6.03 [Applies to HIO, 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 438.608(d)(1)(iii)] [Existing standard]

I.I.6.04 [Applies to HIO, 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 438.608(d)(2)] [Existing standard]

I.I.6.05 [Applies to HIO, MCO, PIHP, PAHP, PCCM, PCCM entity]

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

I.I.7 Program/Activity No Longer Authorized by Law

I.I.7.01 [Applies to HIO, 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 [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 HIO, 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 438.3(h)] [Existing standard]

I.J.1.02 [Applies to HIO, 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 438.3(h)] [Existing standard]

I.J.1.03 [Applies to HIO, 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 438.3(h)] [Existing standard]

I.J.1.04 – I.J.1.05 [Applies to HIO, 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 438.3(h)] [Existing standard]

I.J.1.06 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP]*

The risk contract requires that the Secretary, DHHS, and the state (or any person or organization designated by either) have the right to audit and inspect any books or records of the MCP or its subcontractors pertaining to:

- The ability of the MCP to bear the risk of financial losses.*
- Services performed or payable amounts under the contract. [Section 1903(m)(2)(A)(iv) of the Act] [Existing standard]

I.J.1.07 [Applies to HIO, 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, 438.606, 438.608, and 438.610 for a period of no less than 10 years. [42 CFR 438.3(u)] [Existing standard]

I.J.2 Compliance with State and Federal Laws

I.J.2.01 [Applies to HIO, 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 438.3(f)(1); 42 CFR 438.100(d)] [Existing standard]

I.J.2.02 [Applies to HIO, 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 438.100(a)(2)] [Existing standard]

I.J.3 Subcontracts

I.J.3.01 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP, 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 438.230(b)(1); 42 CFR 438.3(k)] [Existing standard]

I.J.3.02 – I.J.3.03 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP, 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 438.230(c)(1)(i) - (iii); 42 CFR 438.3(k)] [Existing standard]

I.J.3.04 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP, 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 438.230(c)(2); 42 CFR 438.3(k)] [Existing standard]

I.J.3.05 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP, 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 438.230(c)(3)(i); 42 I.J.3.06; CFR 438.3(k)] [Existing standard]

I.J.3.06 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP, 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 Medicaid enrollees. [42 CFR 438.230(c)(3)(ii); 42 CFR 438.3(k)] [Existing standard]

I.J.3.07 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP, 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 438.230(c)(3)(iii); 42 CFR 438.3(k)] [Existing standard]

I.J.3.08 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP, 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 438.230(c)(3)(iv); 42 CFR 438.3(k)] [Existing standard]

I.J.4 Third Partly Liability (TPL) Activities

I.J.4.01 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]

The contract specifies any activities the MCP is to perform related to Third Party Liability (TPL), including:

- The activities and obligations, and related reporting responsibilities, are specified in the contract or written agreement between the MCP and the subcontractor.
- How the MCP will reduce payments based on payments by a third party for any part of a service.
- Whether the state or the MCP retains the TPL collections.
- How the state monitors to confirm that the MCP is upholding contractual requirements for TPL activities.

[42 CFR 433 Sub D; 42 CFR 447.20] [Existing standard]

I.J.4.02 [Applies to HIO, MCO, PIHP, PAHP]

If the state enters into a Coordination of Benefits Agreement (COBA) with Medicare for FFS, the contract specifies the methodology by which the state ensures that the appropriate MCO, PIHP, or PAHP receives all applicable crossover claims for which the MCO, PIHP, or PAHP is responsible [42 CFR 438.3(t)] [Effective: 12/14/2020]

I.J.5 Sanctions

I.J.5.01 [Applies to HIO, MCO, PCCM, PCCM entity]*

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.

[42 CFR 438.700(b)(1); 42 CFR 438.702(a); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(i); 1903(m)(5)(B); 1932(e)(1)(A)(i); 1932(e)(2)(A)(i) of the Act] [Existing standard]

I.J.5.02 [Applies to HIO, MCO, PCCM, PCCM entity]*

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 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.

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

I.J.5.03 [Applies to HIO, MCO, PCCM, PCCM entity]*

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.

[42 CFR 438.700(b)(3); 42 CFR 438.702(a); 42 CFR 438.704(b)(2) and (3); sections 1903(m)(5)(A)(iii); 1903(m)(5)(B); 1932(e)(1)(A)(iii); 1932(e)(2)(A)(ii) & (iv) of the Act] [Existing standard]

I.J.5.04 [Applies to HIO, MCO, PCCM, PCCM entity]*

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.

[42 CFR 438.700(b)(4); 42 CFR 438.702(a); 42 CFR 438.704(b)(2); sections 1932(e)(1)(iv); 1903(m)(5)(A)(iv)(l); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(I); 1932(e)(2)(A)(ii) of the Act] [Existing standard]

I.J.5.05 [Applies to HIO, MCO, PCCM, PCCM entity]*

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.

[42 CFR 438.702(a); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1); 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] [Existing standard]

I.J.5.06 [Applies to HIO, MCO, PCCM, PCCM entity]*

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.

[42 CFR 438.700(b)(6); 42 CFR 438.702(a); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(v); 1903(m)(5)(B); 1932(e)(1)(A)(v); 1932(e)(2)(A)(i) of the Act] [Existing standard]

I.J.5.07 [Applies to HIO, MCO, PCCM, PCCM entity]*

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. [42 CFR 438.700(c); 42 CFR 438.704(b)(1); sections 1932(e)(1)(A); 1932(e)(2)(A)(i) of the Act] [Existing standard]

I.J.5.08 [Applies to HIO and 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.

[42 CFR 438.700(d)(1); 42 CFR 438.702(a)(3) - (5); sections 1932(e)(2)(C); 1932(e)(2)(D); 1932(e)(2)(E) of the Act] [Existing standard]

I.J.5.09 [Applies to PCCM and PCCM entity]*

The contract provides that if the MCP violates any other applicable requirements in sections 1932 or 1905(t) of the Act, 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.

[42 CFR 438.700(d)(2); 42 CFR 438.702(a)(3) - (5); sections 1932(e)(2)(C); 1932(e)(2)(D); 1932(e)(2)(E) of the Act] [Existing standard]

I.J.5.10 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP, PCCM, PCCM entity]

The contract provides that the state may impose additional sanctions provided for under state statutes or regulations to address noncompliance. [42 CFR 438.702(b)] [Existing standard]

I.J.5.11 – I.J.5.16 [Applies to HIO and 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.

[42 CFR 438.700(b)(1) - (6) 42 CFR 438.726(b); 42 CFR 438.730(e)(1)(i); section 1903(m)(5)(B)(ii) of the Act] [Existing standard]

I.J.5.17 [Applies to HIO, 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 438.726(b); 42 CFR 438.730(e)(1)(ii)] [Existing standard]

I.J.5.18 [Applies to HIO, 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;
- 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.

[42 CFR 438.706(a); section 1932(e)(2)(B)(i) of the Act] [Existing standard]

I.J.5.19 [Applies to HIO, MCO]

The contract specifies that the state must impose mandatory temporary management when an MCP repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Act or 42 CFR 438. 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. [42 CFR 438.706(b) - (d); section 1932(e)(2)(B)(ii) of the Act] [Existing standard]

I.J.5.20 [Applies to HIO, 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 sections 1903(m) or 1932 of the Act or 42 CFR 438. [42 CFR 438.706(b) - (d); section 1932(e)(2)(B)(ii) of the Act] [Existing standard]

I.J.6 Termination

I.J.6.01 [Applies to HIO, MCO, PCCM, PCCM entity]

The contract specifies that the state may terminate an MCP contract, and place enrollees into a different MCP or provide Medicaid 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. [42 CFR 438.708(a); 42 CFR 438.708(b); sections 1903(m); 1905(t); 1932 of the Act] [Existing standard]

I.J.7 Insolvency

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

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

I.J.7.02 – I.J.7.03 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP]

The contract specifies that Medicaid enrollees are not held liable for covered services provided to the enrollee, for which the state does not pay the MCP, or for which the state or MCP does not pay the provider that furnished the service under a contractual, referral, or other arrangement. [42 CFR 438.106(b)(1) - (2); 42 CFR 438.3(k); 42 CFR 438.230; section 1932(b)(6) of the Act] [Existing standard]

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

The contract specifies that Medicaid 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. [42 CFR 438.106(c); 42 CFR 438.3(k); 42 CFR 438.230; section 1932(b)(6) of the Act] [Existing standard]

I.J.7.05 [Applies to HIO, MCO, PIHP, PAHP]

The contract requires the MCP to provide assurances satisfactory to the state that its provision against the risk of insolvency is adequate to ensure that Medicaid enrollees will not be liable for the MCP's debt if the MCP becomes insolvent. [42 CFR 438.116(a)] [Existing standard]

I.J.7.06 [Applies to HIO, MCO, PIHP]*

The contract requires the MCP to meet the state's solvency standards for private health maintenance organizations, or be licensed or certified by the state as a risk-bearing entity. [Section 1903(m)(1) of the Act; 42 CFR 438.116(b)] [Existing standard]

I.K. Health Information Systems and Enrollee Data

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

The contract requires that the MCP maintain a health information system that collects, analyzes, integrates, and reports data. [42 CFR 438.242(a)] [Existing standard]

I.K.1.02 [Applies to HIO, 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 Medicaid eligibility. [42 CFR 438.242(a)] [Existing standard]

I.K.1.03 [Applies to HIO, 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 [42 CFR 438.242(b)(1); Section 6504(a) of the ACA; section 1903(r)(1)(F) of the Act] [Existing standard]

I.K.1.04 [Applies to HIO, 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 438.242(b)(2)] [Existing standard]

I.K.1.05 [Applies to HIO, 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 438.242(b)(3)(i)] [Existing standard]

I.K.1.06 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP]

The contract requires that the MCP screen the data received from providers for completeness, logic, and consistency. [42 CFR 438.242(b)(3)(ii)] [Existing standard]

I.K.1.07 [Applies to HIO, 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 438.242(b)(3)(iii)] [Existing standard]

I.K.1.08 [Applies to HIO, 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 438.242(b)(4)] [Existing standard]

I.K.1.09 [Applies to HIO, 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.1.10 [Applies to HIO, MCO, PIHP, PAHP, NEMT PAHP]*

The contract requires that the MCP implement and maintain a publicly accessible standards-based API as described in 42 CFR 431.70, which must include all of the provider directory information specified in 42 CFR 438.10(h)(1) and (2). [42 CFR 438.242(b)(6); 42 CFR 457.1233(d)(3)] [Effective: No later than 7/1/2021]

I.K.1.11 – I.K.14 [Applies to HIO, 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.
- 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 438.242(c)(1) - (4); 42 CFR 438.818] [Existing standard] [The 2020 Final Rule clarified the submission of enrollee encounter data requirement at 42 CFR 438.242(c)(3), effective 12/14/2020]

I.L. State Obligations

I.L.1 Enrollee and Potential Enrollee Information

I.L.1.01 [Applies to HIO, 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 438.10(d)(1)] [Existing standard]

I.L.1.02 [Applies to HIO, 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 438.10(e)(2)(v)(C)] [Existing standard]

I.L.2 Contract Sanctions and Terminations

I.L.2.01 [Applies to HIO, MCO, PCCM, PCCM entity]*

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 438.704(c)] [Existing standard]

I.L.2.02 [Applies to HIO, 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 438.706(b)] [Existing standard]

I.L.2.03 [Applies to HIO, MCO, PCCM, PCCM entity]*

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 438.710(a)(1)] [Existing standard]

I.L.2.04 [Applies to HIO, MCO, PCCM, PCCM entity]*

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 438.710(a)(2)] [Existing standard]

I.L.2.05 – I.L.2.11 [Applies to HIO, MCO, PCCM, PCCM entity]*

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 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 HIO, MCO, PCCM, PCCM entity]*

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 438.722(a) - (b)] [Existing standard]

I.L.3 Payment

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

The contract provides that the state agency must ensure that no payment is made to a network provider other than by the MCP for services covered under the contract between the state and the MCP, except when these payments are specifically required to be made by the state in Title XIX of the Act, in 42 CFR, or when the state agency makes direct payments to network

providers for graduate medical education costs approved under the state plan. [42 CFR 438.60] [Existing standard]

I.L.3.02 [Applies to HIO, 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 438.14(c)(3)] [Existing standard]

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

I.L.4.01 [Applies to HIO, 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 438.208(c)(1)] [Existing standard]

I.L.4.02 [Applies to HIO, 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 438.208(c)(1)] [Existing standard]

I.L.5 Program Integrity

I.L.5.01 [Applies to HIO, 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 438.610(d)(2); 42 CFR 438.610(a); Exec. Order No. 12549] [Existing standard]

I.L.5.02 [Applies to HIO, 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 438.610(d)(2); 42 CFR 438.610(b)] [Existing standard]

I.L.5.03 [Applies to HIO, 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 438.610(d)(3); 42 CFR 438.610(a); Exec. Order No. 12549] [Existing standard]

I.L.5.04 [Applies to HIO, 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 438.610(d)(3); 42 CFR 438.610(b)] [Existing standard]

I.L.5.05 [Applies to HIO, 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 438.602(b)(1)] [Existing standard]

I.L.5.06 [Applies to HIO, 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 438.602(b)(2)] [Existing standard]

I.L.5.07 [Applies to HIO, 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 438.602(c); 42 CFR 438.608(c)] [Existing standard]

I.L.5.08 [Applies to HIO, 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 438.602(i)] [Existing standard]

Section II: Tips Applicable to Contract Requirements

Requirement Numbers	Applicable Tips
I.A. Completeness	
I.A.1.04, I.A.1.05	CMS uses the term "rate certification" in 42 CFR 438.7(a) to refer to the actuary's certification of the rates or rate ranges, along with the report from the actuary describing the development of the rates or rate ranges.
I.A.1.04	If the contract action revises the covered populations, services furnished under the contract or other changes that could reasonably change the rate development, and the state does not submit a new actuarial certification for capitation rates, the state and its actuary must provide actuarial documentation indicating the rationale as to why the rates continue to be actuarially sound in accordance with 42 CFR 438.4.
I.A.1.04	Pursuant to 42 CFR 438.4(b)(4), for rating periods beginning on or after July 1, 2018, a rate certification must be specific to payments for each rate cell under the MCP contract. For rating periods beginning before July 1, 2018, state actuaries can certify actuarially sound rate ranges. If a state's actuary does certify rate ranges for rating periods beginning before July 1, 2018, and the state is choosing to increase or decrease the capitation rate per rate cell within this actuarially certified rate range, the state is not required to submit a revised rate certification. The state also does not need to complete the CMS rate-setting review tool.
I.A.1.04, I.A.1.05	For rating periods beginning on or after July 1, 2018, if the state is choosing to increase or decrease the capitation rate per rate cell up to 1.5 percent, as allowed in 42 CFR 438.7(c)(3), the state is not required to submit a revised rate certification.
I.A.1.06	Any modification to the capitation rates within the rate range greater than the permissible 1 percent requires the state to provide a revised rate certification for CMS approval.
I.A.1.06	When a state develops and certifies a range of capitation rates per rate cell as actuarially sound, the state must post on the website required in 42 CFR 438.10(c)(3) the following information prior to executing a managed care contract or contract amendment that includes or modifies a rate range: (a) The upper and lower bounds of each rate cell; (b) A description of all assumptions that vary between the upper and lower bounds of each rate cell, including for the assumptions that vary, the specific assumptions used for the upper and lower bounds of each rate cell; and (c) A description of the data and methodologies that vary between the upper and lower bounds of each rate cell, including for the data and methodologies that vary, the specific data and methodologies used for the upper and lower bounds of each rate cell.
I.A.1.06	When a state develops and certifies a range of capitation rates per rate cell as actuarially sound, the state may not utilize the 42 CFR 438.7(c)(3) option to modify capitation rates up to 1.5% without submitting a revised rate certification.
I.A.1.07	Effective with the rating period beginning on or after 07/01/17, 438.8(k) requires the MCO, PIHP or PAHP to submit an 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

Requirement Numbers	Applicable Tips
	responsible for submitting a summary description of the report(s) to CMS. Note that 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.
I.A.1.09	This requirement at 42 CFR 438.3(n)(2) applies to MCOs in states covering medical/surgical and mental health or substance use disorder services under the state plan. This item is not applicable when all medical/surgical and mental health or substance use disorder services to MCO enrollees are provided through the MCO delivery system.
I.A.1.10	Contractual requirements for state directed payments should be sufficiently detailed for plans to operationalize each payment arrangement in alignment with the approved preprint(s). Examples of details from the approved preprint to consider including in such contract requirements would be, but are not limited to: the provider class(es) for the state directed payment, how the state will operationalize the payment with the plans (e.g. whether plans will use a separate payment term or not and if so how much is each separate payment term), how the plan is to operationalize the payment to the provider (e.g. uniform increase of $x to be paid per claim) and any reporting the state may require to ensure compliance with the state directed payment. In order to ensure clarity, the state may wish to include the control name of the CMS-approved Section 438.6(c) preprint for each contract arrangement that directs the MCP's expenditures under 42 CFR 438.6(c).
I.A.1.10	In accordance with 42 CFR 438.6(c), the state may require the HIO, MCO, PIHP or PAHP to implement value-based purchasing models for provider reimbursement, such as pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services. The state may also require the MCP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative, adopt a minimum fee schedule, provide a uniform dollar or percentage increase, or adopt a maximum fee schedule.
I.A.1.10	Contract arrangements that adopt a minimum fee schedule using approved State Plan rates under 42 CFR 438.6(c)(1(iii)(A) do not require written approval prior to implementation but are required to meet the criteria under 42 CFR 438.6(c)(2)(ii)(A) through (F). State plan approved rates does not include supplemental payments, which the regulation defines as “amounts paid by the state in its FFS Medicaid delivery system to providers that are described and approved in the State Plan or under a demonstration authority or waiver thereof and are in addition to State Plan approved rates. DSH and GME payments are not, and do not constitute, supplemental payments.
I.A.1.11	States planning to implement one or more risk mitigation strategy(ies) for a future rating period must submit documentation to CMS prior to the start of the rating period. This documentation must include contract and rate certification documents that incorporate the risk mitigation strategy into the contract between the state and the managed care plan. States must supply this information even if the state implemented the risk corridor (or other risk mitigation provision) in a prior rating period. Examples of risk

Requirement Numbers	Applicable Tips
	mitigation include: reinsurance, stop loss limits, risk corridors, and a minimum MLR with a remittance. For rating periods starting on or after January 1, 2021, submission of documentation of the final risk mitigation arrangement(s) prior to the start of the rating period is required to meet the regulatory standard of documenting those arrangement(s) to CMS in the contract and rate certification documents for the rating period prior to the start of the rating period. CMS will accept states' submissions of draft managed care contract actions that are not officially executed and documentation from a state's actuary that may not reflect final full rate development or is limited to a description of the risk sharing arrangement(s). States must submit both contract and rate certification documentation prior to the start of the rating period. The risk mitigation arrangement(s) in the final, executed contract and rate certification documents must be unchanged from the submission to CMS prior to the start of the rating period for the risk mitigation arrangement(s) to be approvable under 42 CFR 438.6(b)(1).
I.B. Enrollment and Disenrollment	
I.B.5.14	Under 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 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 438.10(d)(3) are not required for NEMT PAHPs.
I.C.1.09, I.C.1.10	Under 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.1.05, I.C.1.06, I.C.1.07	Revisions to 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.2.01 - I.C.2.44	States must develop model handbooks in accordance with 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). How a state chooses to meet these federal requirements may vary. For example, a state may: (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.
I.C.2.12 - I.C.2.15	This requirement at 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.

Requirement Numbers	Applicable Tips
I.C.2.28	For PAHPs under 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 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 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 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 438.10(i) only when appropriate, based on the scope of contracted services. Formulary requirements under 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 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 438.10(c)(6) must be met in order for the MCP to provide information electronically.
I.C.8.42	MCOs, PIHPs, and PAHPs operating in compliance with 42 CFR 438.236(c) will be deemed compliant with the requirement in 42 CFR 438.915(a) (part of 42 CFR Part 438, subpart K, Parity in Mental Health and Substance Use Disorder Benefits) 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 438.915(a) is not determinative of compliance with any other provision of applicable Federal or state law.
I.C.8.44	Pursuant to 42 CFR 431.205, the Medicaid agency is responsible for maintaining a fair hearing system. The hearing system works in conjunction with the MCP grievance and appeals processes. [42 CFR 431.205]
I.D. Payment	
I.D.1.01 – I.D.4.34	This provision only applies to risk-bearing entities. MCOs are always risk bearing in accordance with 42 CFR 438.2, 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 – I.D.1.03	The requirement that the final capitation rate be specified in the contract is not a new requirement; see 42 CFR 438.6(c)(2)(ii) of the 2002 final rule. The amount of payment for performance—in this context, the final capitation rate—is a primary component of any contract and must be included for purposes of verifying claims for FFP on the CMS-64. The state must submit a formal contract amendment when the final capitation rates differ from the payment terms in an approved contract.
I.D.1.03	Pursuant to 42 CFR 438.6(b)(1), the state may not add or modify risk sharing mechanisms after the start of the rating period.
I.D.2.01 - I.D.2.06	The incentive arrangement(s) outlined in the MCP contract pursuant to 42 CFR 438.6(b) should be consistent with those described in a rate

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	certification.
I.D.2.06	The incentive arrangement(s) described in the MCP contract should be consistent with those in the state's quality strategy, currently required at 42 CFR 438.340, to confirm that the incentive arrangements described in the contract relate to specified activities, targets, performance measures, or quality- based outcomes that support program initiatives as specified in the state's current quality strategy. 42 CFR 438.340(c)(3) requires the state to submit the initial quality strategy, and a copy of the revised strategy whenever significant changes are made, to CMS.
I.D.3.01 - I.D.3.06	The withhold arrangement(s) outlined in the MCP contract under 42 CFR 438.6(b)(3) should be consistent with those described in a rate certification.
I.D.3.06	The withhold arrangement(s) described in the MCP contract should be consistent with those in the state's quality strategy, currently required at 42 CFR 438.340, to confirm that the withhold arrangements described in the contract relate to specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the state's current quality strategy. 42 CFR 438.340(c)(3) requires the state to submit the initial quality strategy, and a copy of the revised strategy whenever significant changes are made, to CMS.
I.D.4.01 – I.D.4.34	In accordance with 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.D.4.03, I.D.4.30	Given the complexity of the MLR calculation as required by 42 CFR 438.8(d), states may choose to reference the CFR rather than outline all relevant provisions within the MCP contracts.
I.D.4.09 – I.D.4.11, I.D.4.24	Pursuant to 42 CFR 438.8(h), CMS will annually publish guidance for MCOs, PIHPs and PAHPs to help assess if MCOs, PIHPs and PAHPs are determined to be fully credible or partially credible.
I.D.4.17	Fraud prevention activities are defined at 42 CFR 438.8(e)(4) as those that are consistent with regulations adopted for the private market at 45 CFR Part 158.
I.D.6.01, I.D.6.02	Per 42 CFR 447.46(c)(2) and 42 CFR 447.46(c)(3), as an exception, the contract may allow the MCO and its providers, by mutual agreement, to establish an alternative payment schedule. Any alternative schedule must be stipulated in the contract.
I.D.7.01 - I.D.7.06	Under 42 CFR 438.6(d), this requirement is only applicable if the state has included a pass-through payment. The definition of pass-through payments as outlined in 42 CFR 438.6(a) is: any amount required by the State to be added to the contracted payment rate, and considered in calculating the actuarially sound capitation rate, between the MCO, PIHP, or PAHP and hospitals, physicians, or nursing facilities that is not for the following purposes: A specific service or benefit provided to a specific enrollee covered under the contract; a provider payment methodology permitted under 42 CFR

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	438.6(c)(1)(i) through (iii) for services and enrollees covered under the contract; a subcapitated payment arrangement for a specific set of services and enrollees covered under the contract; GME payments; or FQHC or RHC wrap around payments. Pass-through payments are most easily identified as required payments that are not directly tied to utilization or outcomes based on utilization during the rating period of the contract.
I.D.7.01 – I.D.7.03	Pass-through payments are allowed for transition periods as outlined in 42 CFR 438.6(d). In accordance with 42 CFR 438.6(d)(1)(i), in order to use a transition period, a state must demonstrate that it had pass-through payments for hospitals, physicians, or nursing facilities in: (1) Managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016, and were submitted for CMS review and approval on or before July 5, 2016; or (2) if the managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016 had not been submitted to CMS on or before July 5, 2016, the managed care contract(s) and rate certification(s) for a rating period before July 5, 2016 that had been most recently submitted for CMS review and approval as of July 5, 2016.
I.D.7.03	Calculation of the base amount of pass-through payments to hospitals is defined at 42 CFR 438.6(d)(2).
I.E. Providers and Provider Network	
I.E.1.06	See the 'Network Adequacy Standards' subsection for more information on 42 CFR 438.68 and 42 CFR 438.206(c)(1) requirements.
I.E.1.07	In accordance with 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.5.08 – I.E.5.20	The state must develop and enforce with its MCPs quantitative network adequacy standards in accordance with 42 CFR 438.68. CMS must assure that its standards meets all federal requirements. How a state chooses to enforce of these requirements with the MCP may vary. For example, a state may: (1) include the network adequacy standards as an attachment to the contract; (2) stipulate each standard in accordance with 42 CFR 438.68 within the MCP contract in additional to federal requirements to publish them on the state's website; (3) require within the contract that the MCP adhere to the state's network adequacy standards and describe the process by which MCPs will be notified of these standards (such as through the state's website, quality strategy, provider notices, etc.); or (4) use another method
I.E.8.02	Refer to 42 CFR 422.208 for more information on substantial financial risk and stop-loss protection.
I.E.9.01	In accordance with 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

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	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 438.915(a) (part of 42 CFR Part 438, subpart K, Parity in Mental Health and Substance Use Disorder Benefits) 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 438.915(a) 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 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.1.03	Pursuant to state Medicaid Director Letter #06-010, for services provided by non-contracted hospitals, this amount must be less any payments for indirect costs of medical education and direct costs of graduate medical education that would have been included in FFS payments. In states where Medicaid rates paid to hospitals are negotiated and not publicly released, the applicable payment amount would be the average contract rate that would apply for tertiary hospitals.
I.F.2.01	Under Section 1902(a)(23) of the Act and 42 CFR 431.51(b)(2), this provision applies to the extent that family planning services fall within the scope of the services for which the PIHP or PAHP is responsible.
I.F.4.01	Pursuant to 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.
I.F.4.05	This requirement at 42 CFR 438.910(d)(3) 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. This requirement at 42 CFR 438.910(d)(3) 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.F.6.02, I.F.6.03	States have the option to provide Alternative Benefit Plans (ABP) specifically tailored to meet the needs of certain Medicaid population groups. For those populations, this requirement under 42 CFR 438.210(a)(2) is met if the contract requires the MCP to furnish services in an amount, duration and scope that is no less than the amount, duration and scope described in the approved ABP state plan.
I.F.6.10, I.F.12.07	Per 42 CFR 438.910(d), NQTLs include, but are not limited to: • 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;

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	• 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.F.6.10 - I.F.6.14	Pursuant to 42 CFR 438.210(a)(5), the contract should be clear as to whether the MCP is responsible for providing the full range of EPSDT services, including 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 during screening, whether or not such services are covered under the State Plan.
I.F.7.01	Pursuant to 42 CFR 447.26(c), no reduction in payment for a provider preventable condition is imposed when the condition defined as a provider preventable condition for a particular patient existed prior to the initiation of treatment for that patient by that provider. Reductions in provider payment may be limited to the extent that the identified provider-preventable conditions would otherwise result in an increase in payment; and the MCP can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.
I.F.9.01	This prohibition under section 1903(i) of the Act (final sentence) and section 1903(i)(1) of the Act is only applicable when the contract requires the MCP to cover organ transplants.
I.F.11.08 – I.F.11.13	For states where pharmacy benefits are carved out of MCO or PCCM entity benefits, if the MCO or PCCM entity still handles physician administered drugs or hospital dispensed drugs (i.e. partial benefits for covered outpatient drugs), the contract must include this provision.
I.F.12.01 - I.F.12.08	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.F.12.01 – I.F.12.04	Applies where the full scope of medical/surgical and mental health and substance use disorder services are provided through the MCO.
I.F.13.03	If the MCP is required to provide services that could be authorized through sections 1915(c), 1915(i), or 1915(k) of the Act, and the 42 CFR 441.301(c)(4) settings requirements do apply to the MCP contract period under review, the contract must specify that the LTSS are provided in a setting which complies with the 42 CFR 441.301(c)(4) requirements for home and community-based settings. If the MCP contract provides for the delivery of services that could be authorized through 1915(c), 1915(i), or 1915(k) authority and were

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	initially approved by CMS, under any federal authority, on or after 3/17/14, the MCP contract must comply with the settings requirements. If the MCP contract provides for the delivery of services that could be authorized through 1915(c), 1915(i), or 1915(k) authority and were initially approved by CMS, under any federal authority, prior to 3/17/14, the MCP contract must comply with settings requirements based on the timeframe described in the state's settings transition plan approved by CMS. The Home and Community-Based Services (HCBS) settings requirements apply to services that are authorized through a 1915(c) waiver, a 1915(i) SPA, or a 1915(k) SPA. The settings requirements also apply to services authorized under any federal authority that "could be" authorized through a 1915(c) waiver, a 1915(i) SPA, or a 1915(k) SPA. For instance, a service authorized under 1115 waiver or 1915(b)(3) authority must meet the settings requirements when the service is of a nature that "could be" authorized under 1915(c), 1915(i), or 1915(k).
I.F.14.01 - I.F.14.03	This requirement only applies to PAHP contracts if the PAHP's provider network includes provider types outlined at 42 CFR 489.102(a), including: home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), hospices, and religious nonmedical institutions.
I.F.16.06	According to 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. According to 438.100(b)(2)(vi), the state must ensure that each enrollee of an MCO, PIHP, PAHP, PCCM or PCCM entity has 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.
I.G. Quality and Utilization Management	
I.G.1.01, I.G.5.01, I.G.5.03 - I.G.5.04, I.G.5.09, I.G.5.17	This requirement per 42 CFR 438.310(c)(2) 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 subpart K, Parity in Mental Health and Substance Use Disorder Benefits, the contract should specify (1) a mechanism for the MCP to work with other MCPs to ensure that any MCO enrollee is provided access to a set of benefits that meets the requirements of 42 CFR Part 438, subpart K 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 with 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 in accordance with 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: (1) Include its transition to care policy within the MCP contract or as an attachment to the contract;

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	(2) Outline in the contract the process by which the state will share the model enrollee handbook; or (3) Use another method.
I.G.3.06	This requirement under 42 CFR 438.910(d) 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.7.01 – I.G.7.14	For each MCO that serves enrollees who are also enrolled in and receive Medicare benefits from an MCA, the state determines to what extent the MCO must meet the identification, assessment, and treatment planning provisions of 42 CFR 438.208(c) for dually eligible individuals. The state must base its determination on the needs of the populations the MCO is required to serve.
I.G.7.07, I.G.7.14	For the requirement at 42 CFR 438.208(c)(3)(ii), see the person-centered planning process and person-centered service plan requirements at 42 CFR 431.301(c)(1) and (2), as the treatment or service plan must meet these requirements.
I.H. Grievance and Appeals	
I.H.1.01	A subset of FIDE SNPs and HIDE SNPs with exclusively aligned enrollment must implement the unified appeals and grievance procedures described in 42 CFR 422.629 – 634 effective 01/01/2021. Regulations refer to these plans as "applicable integrated plans," defined at 42 CFR 422.561 as FIDE SNPs or HIDE SNPs with exclusively aligned enrollment, where state policy limits the D-SNP's membership to a Medicaid managed care plan offered by the same organization. The Medicaid MCO that covers Medicaid benefits for the dually eligible individuals in the FIDE SNP or HIDE SNP with exclusively aligned enrollment is also an applicable integrated plan subject to the unified appeals and grievance procedures under CFR 438.210 and 438.402. In such plans, one organization is responsible for managing Medicare and Medicaid benefits for all D-SNP enrollees. The contracts with the states for these plans must include a requirement that the D-SNP uses the unified appeals and grievance procedures under 42 CFR 422.629 – 422.634, as well as conforming Medicaid managed care rules at 438.210, 438.400, and 438.402. As specified in the April 2019 final rule, states have the discretion to implement standards different than those established in the final rule if the state standards are more protective for enrollees, such as shorter timelines for a plan to make a decision on an appeal (see 42 CFR 422.629(c)). Where states use this discretion and implement standards different than those in 42 CFR 422.629 – 422.634, the state must specify its requirements in the D-SNP contract.
I.H.1.11	Pursuant to 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

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	438.915(b) (in Subpart K, Parity in Mental Health and Substance Use Disorder Benefits), 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.
I.H.3.08, I.H.3.09	Pursuant to 42 CFR 438.408(c),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.3.12	Pursuant to 42 CFR 438.404(c)(5), untimely service authorizations constitute a denial, and are thus adverse benefit determinations.
I.H.6.03	Pursuant to 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.6.09	Pursuant to 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 – 8.04	Refer to section **I.C. Beneficiary** Notification of this State Guide for further detail regarding the notification requirements at 42 CFR 438.408(d)(2)(i).
I.H.9.06	For service authorizations or denials under 42 CFR 438.210(c), please see the notice and timing requirements in 42 CFR 438.404.
I.H.10.09	Refer to section **I.C. Beneficiary** Notification of this State Guide for further detail regarding the notification requirements at 42 CFR 438.408(d)(1).
I.I. Program Integrity	
I.I.1.01	Pursuant to 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 System of Aware Management (SAM; formerly known as the GSA Excluded Parties List System) to ensure that no employee or contractor has been excluded. Pursuant to 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.
I.I.1.02	In accordance with section 1128(b)(8) of the Act, a sanctioned individual is a person who: 1. Has a direct or indirect ownership or control interest of 5 percent or more in the entity, and: a. Has had a conviction of relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony

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	healthcare fraud; or b. Has been assessed a civil monetary penalty under section 1128A or 1129 of the Act; or c. Has been excluded from participation under a program under title XVIII or under a state health care program 2. Has an ownership or control interest (as defined in section 1124(a)(3) of the Act) in the entity, and: a. Has had a conviction of relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony healthcare fraud; or b. Has been assessed a civil monetary penalty under section 1128A or 1129 of the Act; or c. Has been excluded from participation under a program under title XVIII or under a state health care program 3. Is an officer, director, agent, or managing employee of the MCP, and: a. Has had a conviction of relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony healthcare fraud; or b. Has been assessed a civil monetary penalty under section 1128A or 1129 of the Act; or c. Has been excluded from participation under a program under title XVIII or under a state health care program 4. No longer has direct or indirect ownership or control interest of 5 percent or more in the MCP or no longer has an ownership or control interest defined under section 1124(a)(3) of the Act, because of a transfer of ownership or control interest, in anticipation of or following a conviction, assessment, or exclusion against the person, to an immediate family member or a member of the household of the person who continues to maintain an ownership or control interest who: a. Has had a conviction of relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony healthcare fraud; or b. Has been assessed a civil monetary penalty under section 1128A or 1129 of the Act; or c. Has been excluded from participation under a program under title XVIII or under a state health care program. [Section 1128(b)(8) of the Act] This requirement only applies to PIHPs, PAHPs, PCCMs, and PCCM entities that operate under section 1915(b)(1) authority. This requirement applies to all MCOs and HIOs.
I.1.03	Crimes under section 1128(b)(8)(B) of Act include conviction relating to fraud, conviction relating to obstruction of an investigation or audit, misdemeanor conviction relating to a controlled substance, conviction of program-related crimes, conviction relating to patient abuse, felony conviction relating to health care fraud, and felony conviction relating to

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	a controlled substance. This requirement only applies to PIHPs, PAHPs, PCCMs, and PCCM entities that operate under section 1915(b)(1) authority. This requirement applies to all MCOs and HIOs.
I.I.1.04 - I.I.1.07	This requirement only applies to PIHPs, PAHPs, PCCMs, and PCCM entities that operate under section 1915(b)(1) authority. This requirement applies to all MCOs and HIOs.
I.I.1.08, I.I.1.09	An individual or entity that would provide services through an individual or entity debarred, suspended, or excluded under 42 CFR 438.610(a) or (b) is an individual or entity that intends to meet its contractual obligations by subcontracting or employing an individual or entity debarred, suspended, or excluded under 42 CFR 438.610(a) or (b). For example, a MCO contracts with a Pharmacy Benefits Manager (PBM), which subcontracts to a pharmacy, which employs a debarred pharmacist. Because of the debarred pharmacist, the MCO cannot contract with the PBM (until the pharmacy or pharmacist is terminated). This requirement only applies to PIHPs, PAHPs, PCCMs, and PCCM entities that operate under section 1915(b)(1) authority. This requirement applies to all MCOs and HIOs.
I.I.2.01	Under 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.2.14 - I.I.2.16	The data, documentation and information that must be certified under 42 CFR 438.604 and 42 CFR 438.606 is described in I.I.2.01 - I.I.2.13 and I.I.6.05.
I.I.2.38	Under 42 CFR 438.608(b), this provision does not require the network provider to render services to FFS beneficiaries. Pursuant to 42 CFR 438.608(b), the disclosure and screening functions can be delegated. The enrollment functions, however, cannot.
I.I.2.41	Terminated pursuant to 455.101 is defined as follows: • For a Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. • For a Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired.

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	• In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary and the provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated. • The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to fraud, integrity or quality. The state determines that providers have been terminated from Medicaid, CHIP, or Medicare pursuant to 455.101 through monitoring the CMS Data Exchange System (DEX) during the state's provider screening/enrollment process and on an ongoing basis.
I.I.6.01 - I.I.6.03	This recovery provision under 42 CFR 438.608(d)(1) does not apply to any amount of a recovery to be retained under FCA cases or through other investigations.
I.I.7.01	The letter to State Medicaid Directors (SMDs), date 9/4/2020, provides contract language that should be incorporated into existing managed care plan contracts via amendment, and should be included in any new based contracts the state executes with an MCP.
I.J. General Terms and Conditions	
I.J.1.06	This provision only applies to risk-bearing entities. HIOs and MCOs are always risk bearing in accordance with 42 CFR 438.2, however PIHPs, PAHPs, and NEMT PAHPs may be risk-based or non-risk.
I.J.1.07	NEMT PAHPs are only subject to the data, information, and documentation provisions specified in 42 CFR 438.610 under this requirement at 42 CFR 438.3(u).
I.J.3.01 - I.J.3.08	This subcontractor requirement under 42 CFR 438.230 only applies to contracts where the MCP has a subcontractor(s).
I.J.4.02	If the state elects to use a methodology other than requiring the MCO, PIHP, or PAHP to enter into a Coordination of Benefits Agreement (COBA) with Medicare, that methodology must ensure that the submitting provider is promptly informed on the state's remittance advice that the state has not denied payment and that the claim has been sent to the MCO, PIHP, or PAHP for payment consideration.
I.J.5.01 - I.J.5.07	This requirement applies to PCCMs and PCCM entities at the state's option. Therefore, this requirement is not applicable for PCCMs and PCCM entities if the State does not exercise this option under 42 CFR 438.700(a).
I.J.5.03	Pursuant to 42 CFR 438.700(b)(3), this includes 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 probable need for substantial future medical services.
I.J.5.06	PIP requirements are described in the "Providers and Provider Networks" and "Beneficiary Notification" sections of the tool.
I.J.5.13	Pursuant to 42 CFR 438.700(b)(3), discrimination among enrollees on the basis of their health status or need for health care services includes

Requirement Numbers	Applicable Tips
	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 probable need for substantial future medical services.
I.J.7.06	An exception to the solvency requirement at 42 CFR 438.116(b) applies when the MCP 1) does not provide inpatient hospital and physician services, 2) is a public entity, 3) is, or is controlled by, an FQHC and meets the state's FQHC solvency requirements, or 4) has solvency guaranteed by the state.
I.K. Health Information Systems and Enrollee Data	
I.K.1.09	The criteria for an API is specified at 42 CFR 431.60 and can be located at https://www.ecfr.gov/cgi-bin/text-idx?SID=b51bdca62c0150e27b5a25411e829cd2&mc=true&node=se42.4.431_160&rgn=div8.
I.K.1.10	The criteria for a publicly accessible standards-based API is specified at 42 CFR 431.70 and can be located at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b51bdca62c0150e27b5a25411e829cd2&mc=true&n=sp42.4.431.b&r=SUBPART&ty=HTML#se42.4.431_170. The provider directory information at 42 CFR 431.10(h)(1) and (2) can be located at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b51bdca62c0150e27b5a25411e829cd2&mc=true&n=pt42.4.431&r=PART&ty=HTML#se42.4.431_110.

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I.L. State Obligations	
I.L.1.01 – I.L.5.08	Federal requirements in accordance with 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 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 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.3.01	Pursuant to 42 CFR 438.60, capitation payments are to be inclusive of all service and associated administrative costs under the contract. Ensure, for example, that there are no unallowable payment mechanisms in the contract, such as pass-through payments.
I.L.4.01	If the state or enrollment broker is responsible for this identification under 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. Related to the identification of persons as having special health care needs under 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 – 4.02	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 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 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.

Section III: Glossary of Terms[8]

Abuse:	Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. [42 CFR 438.2; 42 CFR 455.2]
Access:	As used in part 438 subpart E and pertaining to external quality review, the timely use of services to achieve optimal outcomes, as evidenced by MCPs successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 42 CFR 438.68 (Network adequacy standards) and 438.206 (Availability of services). [42 CFR 438.320]
Actuary:	An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In Part 438, Actuary refers to an individual who is acting on behalf of the state when used in reference to the development and certification of capitation rates. [42 CFR 438.2]
Adverse benefit determination:	In the case of an MCO, PIHP, or PAHP, any of the following: (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 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 438.400(b)]

[8] Note that some definitions apply to 42 CFR 438 in its entirety, while other definitions apply to a subpart. Please see the regulatory citation following each definition for further details.

Aggregate lifetime dollar limit:	A dollar limitation on the total amount of specified benefits that may be paid under a MCO, PIHP, or PAHP. [42 CFR 438.900]
Annual dollar limit:	A dollar limitation on the total amount of specified benefits that may be paid in a 12- month period under a MCO, PIHP, or PAHP. [42 CFR 438.900]
Appeal:	A review by an MCO, PIHP, or PAHP of an adverse benefit determination. [42 CFR 438.400(b)]
Capitation payment:	A payment the state makes periodically to a contractor on behalf of each beneficiary enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the state plan. The state makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment. [42 CFR 438.2]
Choice counseling:	The provision of information and services designed to assist beneficiaries in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among MCPs and PCPs. Choice counseling does not include making recommendations for or against enrollment into a specific MCO, PIHP, or PAHP. [42 CFR 438.2]
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 438.104(a)]
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: (1) Outpatient hospital services (2) RHC services (3) FQHC services (4) Other laboratory and X-ray services (5) Nursing facility (NF) services (6) EPSDT services (7) Family planning services (8) Physician services (9) Home health services. [42 CFR 438.2]
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 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 438.900]

Default enrollment:	In its discussion of the final Medicaid managed care rule at 81 FR 27614, CMS described default enrollment (also commonly known as auto-assignment) as a process used by states with mandatory managed care programs to assign beneficiaries into plans when they do not actively select a managed care plan in the timeframe permitted by the state. [81 FR 27614]
Disability status:	For the purposes of the managed care state quality strategy element, whether the individual qualified for Medicaid on the basis of a disability. [42 CFR 438.340(b)(6)]
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 probably need for substantial future medical services. [42 CFR 438.700(b)(3)]
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits:	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. [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, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. (2) Serious impairment to bodily functions. (3) Serious dysfunction of any bodily organ or part. [42 CFR 438.114(a)]
Emergency services:	Covered inpatient and outpatient services that are as follows: (1) Furnished by a provider that is qualified to furnish these services under this Title. (2) Needed to evaluate or stabilize an emergency medical condition. [42 CFR 438.114(a)]
Enrollee:	A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program. [42 CFR 438.2]
Enrollee encounter data:	The information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a state and a MCO, PIHP, or PAHP that is subject to the requirements of 42 CFR 438.242 and 42 CFR 438.818. [42 CFR 438.2]
Enrollment activities:	Activities such as distributing, collecting, and processing enrollment materials and taking enrollments by phone, in person, or through electronic methods of communication. [42 CFR 438.810(a)]

Enrollment broker:	An individual or entity that performs choice counseling or enrollment activities, or both. [42 CFR 438.810(a)]
External quality review:	As used in part 438 subpart E, 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, PAHP, or PCCM entity (described in 42 CFR 438.310(c)(2)), or their contractors furnish to Medicaid beneficiaries. [42 CFR 438.320]
External quality review organization (EQRO):	As used in part 438 subpart E, an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review, other external quality review-related activities as set forth in 42 CFR 438.358, or both. [42 CFR 438.320]
Federally qualified HMO:	A Health Maintenance Organization (HMO) that CMS has determined is a qualified HMO under section 1310(d) of the Public Health Service (PHS) Act. [42 CFR 438.2]
Financial relationship:	As used in part 438 subpart E: • A direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means, and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest; or • A compensation arrangement with an entity. [42 CFR 438.320]
Financial requirements:	Deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits. [42 CFR 438.900]
Fraud:	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or state law. [42 CFR 438.2; 42 CFR 455.2]
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 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

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 438.400(b)]

Health care services: As used in part 438 subpart E, all Medicaid services provided by an MCO, PIHP, or PAHP under contract with the state Medicaid agency in any setting, including but not limited to medical care, behavioral health care, and LTSS. [42 CFR 438.320]

Health insuring organization (HIO): A county operated entity, that in exchange for capitation payments, covers services for beneficiaries

(1) Through payments to, or arrangements with, providers;
(2) Under a comprehensive risk contract with the state; and
(3) Meets the following criteria—
    i. First became operational prior to January 1, 1986; or
    ii. Is described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act (OBRA) of 1985 (as amended by section 4734 of the Omnibus Budget Reconciliation Act of 1990 and section 205 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008). [42 CFR 438.2]

Indian: Any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual:

(1) Is a member of a Federally recognized Indian tribe;
(2) Resides in an urban center and meets one or more of the four criteria:
    i. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member;
    ii. Is an Eskimo or Aleut or other Alaska Native;
    iii. Is considered by the Secretary of the Interior to be an Indian for any purpose; or
    iv. Is determined to be an Indian under regulations issued by the Secretary;
(3) Is considered by the Secretary of the Interior to be an Indian for any purpose; or
(4) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native. [42 CFR 438.14(a)]

Incentive arrangement: Any payment mechanism under which a MCO, PIHP, or PAHP may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract. [42 CFR 438.6]

Indian health care provider (IHCP): 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 438.14(a)]

Indian managed care entity (IMCE):	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 438.14(a)]
Limited English proficient (LEP):	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 438.10(a)]
Long-term services and supports (LTSS):	Services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting. [42 CFR 438.2]
Managed care organization (MCO):	An entity that has, or is seeking to qualify for, a comprehensive risk contract under Part 438, and that is— (1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or (2) Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions: (i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity; (ii) Meets the solvency standards of 42 CFR 438.116. [42 CFR 438.2]
Managed care program (MCP):	A managed care delivery system operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act. [42 CFR 438.2]
Mandatory enrollment:	Enrollment where one or more groups of beneficiaries as enumerated in section 1905(a) of the Act must enroll in an MCO, PIHP, PAHP, PCCM or PCCM entity to receive covered Medicaid benefits. [42 CFR 438.54(b)(2)]
Marketing:	Any communication, from an MCO, PIHP, PAHP, PCCM or PCCM entity to a Medicaid beneficiary 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 Medicaid product, or either to not enroll in or to disenroll from another MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's Medicaid product. Marketing does not include communication to a Medicaid beneficiary from the issuer of a qualified health plan, as defined in 45 CFR 155.20, about the qualified health plan. [42 CFR 438.104(a)]

Marketing materials:	Materials that— (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 438.104(a)]
MCO, PIHP, PAHP, PCCM, or PCCM entity:	Any of the entity's employees, network providers, agents, or contractors. [42 CFR 438.104(a)]
Medical/surgical benefits:	Benefits for items or services for medical conditions or surgical procedures, as defined by the state and in accordance with applicable Federal and state law, but do not include mental health or substance use disorder benefits. Any condition defined by the state as being or as 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 state guidelines). Medical/surgical benefits include long term care services. [42 CFR 438.900]
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 438.8(b)]
Mental health benefits:	Benefits for items or services for mental health conditions, as defined by the state and in accordance with applicable Federal and state law. Any condition defined by the state as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or state guidelines). Mental health benefits include long term care services. [42 CFR 438.900]
Medical Loss Ratio (MLR) reporting year:	A period of 12 months consistent with the rating period selected by the state. [42 CFR 438.8(b)]
Network provider:	Any provider, group of providers, or entity that has a network provider agreement with a MCO, PIHP, or PAHP, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP, or PAHP. A network provider is not a subcontractor by virtue of the network provider agreement. [42 CFR 438.2]
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 438.8(b)]

Non-claims costs:	Those expenses for administrative services that are not: (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 438.8(b)]
Non-Emergency Medical Transportation PAHP (NEMT PAHP):	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 438.9(a)]
Nonrisk contract:	A contract between the state and a PIHP or PAHP under which the contractor— (1) Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR 447.362; and (2) May be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits. [42 CFR 438.2]
Outcomes:	As used in part 438 subpart E, changes in patient health, functional status, satisfaction or goal achievement that result from health care or supportive services. [42 CFR 438.320]
Overpayment:	Any payment made to a network provider by a MCO, PIHP, or PAHP to which the network provider is not entitled to under Title XIX of the Act or any payment to a MCO, PIHP, or PAHP by a state to which the MCO, PIHP, or PAHP is not entitled to under Title XIX of the Act. [42 CFR 438.2]
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 438.8(b)]
Passive enrollment:	In its discussion of the final Medicaid managed care rule at 81 FR 27613, CMS defined a passive enrollment process as one in which the state selects an MCP for a potential enrollee but provides a period of time for the potential enrollee to decline the managed care plan selection before enrollment became effective. [81 FR 27613]

Pass-through payment: Any amount required by the state to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between the MCO, PIHP, or PAHP and hospitals, physicians, or nursing facilities that is not for the following purposes: A specific service or benefit provided to a specific enrollee covered under the contract; a provider payment methodology permitted under paragraphs (c)(1)(i) through (iii) of 42 CFR 438.6 for services and enrollees covered under the contract; a subcapitated payment arrangement for a specific set of services and enrollees covered under the contract; graduate medical education payments; or FQHC or RHC wrap around payments. [42 CFR 438.6]

Person-centered planning process: A process led by the individual, where possible, and includes the individual's representative in a participatory role, as needed and as defined by the individual, unless state law confers decision-making authority to the legal representative. In addition to being led by the individual receiving services and supports, the person-centered planning process:

(1) Includes people chosen by the individual;
(2) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
(3) Is timely and occurs at times and locations of convenience to the individual;
(4) Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b);
(5) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
(6) Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the state demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the state must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process;
(7) Offers informed choices to the individual regarding the services and supports they receive and from whom;
(8) Includes a method for the individual to request updates to the plan as needed;
(9) Records the alternative home and community-based settings that were considered by the individual. [42 CFR 441.301(c)(1)]

Person-centered service plan:

A person-centered plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the state's 1915(c) HCBS waiver, the written plan must:

(1) Reflect that the setting in which the individual resides is chosen by the individual. The state must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS;
(2) Reflect the individual's strengths and preferences;
(3) Reflect clinical and support needs as identified through an assessment of functional need;
(4) Include individually identified goals and desired outcomes;
(5) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports;
(6) Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
(7) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b) of this chapter;
(8) Identify the individual and/or entity responsible for monitoring the plan;
(9) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation;
(10) Be distributed to the individual and other people involved in the plan;
(11) Include those services, the purpose or control of which the individual elects to self-direct;
(12) Prevent the provision of unnecessary or inappropriate services and supports;
(13) Document that any modification of the additional conditions, under paragraph (c)(4)(vi)(A) through (D) of 42 CFR 431.301, must be supported by a specific assessed need and justified in the person-centered service plan. [42 CFR 431.301(c)(2)]

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 438.114(a)]
Potential enrollee:	A Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given MCO, PIHP, PAHP, PCCM or PCCM entity, but is not yet an enrollee of a specific MCO, PIHP, PAHP, PCCM, or PCCM entity. [42 CFR 438.2]
Prepaid ambulatory health plan (PAHP):	An entity that— (1) Provides services to enrollees under contract with the state, and on the basis of 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; and (3) Does not have a comprehensive risk contract. [42 CFR 438.2]
Prepaid inpatient health plan (PIHP):	An entity that— (1) Provides services to enrollees under contract with the state, and on the basis of 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; and (3) Does not have a comprehensive risk contract. [42 CFR 438.2]
Prevalent:	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 438.10(a)]
Primary care:	All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, OB/GYN, pediatrician, or other licensed practitioner as authorized by the state Medicaid program, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them. [42 CFR 438.2]
Primary care case management:	A system under which: (1) A primary care case manager contracts with the state to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries; or (2) A PCCM entity contracts with the state to provide a defined set of functions. [42 CFR 438.2]
Primary care case management entity (PCCM entity):	An organization that provides any of the following functions, in addition to primary care case management services, for the state: (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 438.2]

Primary care case manager (PCCM): A physician, a physician group practice or, at state option, any of the following:
(1) A physician assistant.
(2) A nurse practitioner.
(3) A certified nurse-midwife [42 CFR 438.2]

Private insurance: Does not include a qualified health plan, as defined in 45 CFR 155.20. [42 CFR 438.104(a)]

Provider: 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 438.2]

Other disclosing entity: Any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:
(1) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, RHC, or HMO that participates in Medicare (title XVIII);
(2) Any Medicare intermediary or carrier; and
(3) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act. [42 CFR 455.101]

Quality: As used in part 438 subpart E and pertaining to external quality review, the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR 438.310(c)(2)) increases the likelihood of desired outcomes of its enrollees through:
(1) Its structural and operational characteristics.
(2) The provision of services that are consistent with current professional, evidenced-based-knowledge.
(3) Interventions for performance improvement. [42 CFR 438.320]

Rating period: A period of 12 months selected by the state for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by 42 CFR 438.7(a). [42 CFR 438.2]

Readily accessible:	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 438.10(a)]
Risk contract:	A contract between the state an MCO, PIHP or PAHP under which the contractor— (1) Assumes risk for the cost of the services covered under the contract; and (2) Incurs loss if the cost of furnishing the services exceeds the payments under the contract. [42 CFR 438.2]
Risk corridor:	A risk sharing mechanism in which states and MCOs, PIHPs, or PAHPs may share in profits and losses under the contract outside of a predetermined threshold amount. [42 CFR 438.6]
Rural Area:	Any county designated as “micro,” “rural,” or “County with Extreme Access Considerations (CEAC)” in the Medicare Advantage Health Services Delivery (HSD) Reference file for the applicable calendar year. [42 CFR 438.52(b)(3)]
Sanctioned individual:	In accordance with section 1128(b)(8) of the Act, a sanctioned individual is a person who: 5. Has a direct or indirect ownership or control interest of 5 percent or more in the entity, and: a. Has had a conviction of relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony healthcare fraud; or b. Has been assessed a civil monetary penalty under section 1128A or 1129 of the Act; or c. Has been excluded from participation under a program under title XVIII or under a state health care program 6. Has an ownership or control interest (as defined in section 1124(a)(3) of the Act) in the entity, and: a. Has had a conviction of relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony healthcare fraud; or b. Has been assessed a civil monetary penalty under section 1128A or 1129 of the Act; or c. Has been excluded from participation under a program under title XVIII or under a state health care program 7. Is an officer, director, agent, or managing employee of the MCP, and: a. Has had a conviction of relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony healthcare fraud; or b. Has been assessed a civil monetary penalty under section 1128A or 1129 of the Act; or c. Has been excluded from participation under a program under title XVIII or under a state health care program

8. No longer has direct or indirect ownership or control interest of 5 percent or more in the MCP or no longer has an ownership or control interest defined under section 1124(a)(3) of the Act, because of a transfer of ownership or control interest, in anticipation of or following a conviction, assessment, or exclusion against the person, to an immediate family member or a member of the household of the person who continues to maintain an ownership or control interest who:
    a. Has had a conviction of relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony healthcare fraud; or
    b. Has been assessed a civil monetary penalty under section 1128A or 1129 of the Act; or
    c. Has been excluded from participation under a program under title XVIII or under a state health care program. [Section 1128(b)(8) of the Act]

Service Authorization:	A managed care enrollee's request for the provision of a service. [42 CFR 431.201]
State:	A Medicaid agency is the Single state agency as specified in 431.10. [42 CFR 438.2; 42 CFR 431.10]
State fair hearing:	The process set forth in subpart E of part 431 chapter IV, title 42. [42 CFR 438.400(b)]
State plan approved rates:	Amounts calculated for specific services identifiable as having been provided to an individual beneficiary described under CMS approved rate methodologies in the Medicaid State plan. Supplemental payments contained in a state plan are not, and do not constitute, state plan approved rates. [42 CFR 438.6(a)]
Subcontractor:	An individual or entity that has a contract with an MCO, PIHP, PAHP, or PCCM entity that relates directly or indirectly to the performance of the MCO's, PIHP's, PAHP's, or PCCM entity's obligations under its contract with the state. A network provider is not a subcontractor by virtue of the network provider agreement with the MCO, PIHP, or PAHP. [42 CFR 438.2]
Substance use disorder benefits:	Benefits for items or services for substance use disorders, as defined by the state and in accordance with applicable Federal and state law. Any disorder defined by the state as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or state guidelines). Substance use disorder benefits include long term care services. [42 CFR 438.900]
Supplemental payments:	Amounts paid by the state in its FFS Medicaid delivery system to providers that are described and approved in the state plan or under a demonstration or waiver thereof and are in addition to state plan approved rates. Disproportionate share hospital (DSH) and graduate medical education (GME) payments are not, and do not constitute, supplemental payments. [42 CFR 438.6(a)]

Timely files:	Files for continuation of benefits on or before the later of the following: (i) Within 10 calendar days of the MCO, PIHP, or PAHP sending the notice of adverse benefit determination. (ii) The intended effective date of the MCO's, PIHP's, or PAHP's proposed adverse benefit determination. [42 CFR 438.420(a)]
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 QTLs, 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 a plan or coverage. (See 42 CFR 438.910(d)(2) 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 438.900]
Validation:	As used in part 438 subpart E, the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis. [42 CFR 438.320]
Withhold arrangement:	Any payment mechanism under which a portion of a capitation rate is withheld from an MCO, PIHP, or PAHP and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract. The targets for a withhold arrangement are distinct from general operational requirements under the contract. Arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement. [42 CFR 438.6]
Voluntary enrollment:	Enrollment where one or more groups of beneficiaries as enumerated in section 1905(a) of the Act have the option to either enroll in a MCO, PIHP, PAHP, PCCM, or PCCM entity, or remain enrolled in FFS to receive Medicaid covered benefits. [42 CFR 438.54(b)(1)]