DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Medicaid and CHIP Managed Care Final Rule (CMS 2390-F)
Implementation Dates

April 25, 2016

The table is a reference guide to the implementation dates for provisions in the final rule, this information is also provided at the beginning of the final rule. Some implementation dates are tied to the rating period, which is the twelve month period for which capitation rates are developed under a managed care contract, to address States that have multi-year managed care contracts.

Medicaid Managed Care	
Effective Immediately	
Citation	**Description**
§433.15 §438.370	Federal financial participation for external quality review
60 days after publication	
§431.200	Part 431; Basis and scope
§431.220	When a hearing is required
§431.244	Hearing decisions
§433.138	Identifying liable third parties
§438.1	Basis and scope
§438.2	Definitions (generally applicable to 42 CFR part 438)
§438.3(a)	CMS review and approval of contracts
§438.3(b)	Entities eligible for comprehensive risk contracts
§438.3(c)	Payment
§438.3(d)	Enrollment discrimination prohibited
§438.3(e)	Services that may be covered by an MCO, PIHP, or PAHP
§438.3(f)	Compliance with applicable laws and conflict of interest safeguards
§438.3(g)	Provider-preventable condition requirements

§438.3(i)	Physician incentive plans
§438.3(j)	Advance directives
§438.3(k)	Subcontracts
§438.3(l)	Choice of network provider
§438.3(n)	Parity in mental health and substance use disorder benefits
§438.3(o)	LTSS contract requirements
§438.3(p)	Special rules for certain HIOs
§438.4(a)	Actuarial soundness; Actuarially sound capitation rates defined
§438.4(b)(1)	Actuarial soundness; CMS review and approval of actuarially sound capitation rates – developed in accordance with §438.5 and differences among capitation rates must be based on valid rating factors
§438.4(b)(2)	Actuarial soundness; CMS review and approval of actuarially sound capitation rates – appropriate for populations covered and services furnished under the contract
§438.4(b)(5)	Actuarial soundness; CMS review and approval of actuarially sound capitation rates – payments from any rate cell must not cross-subsidize or be cross-subsidized by payments from any other rate cell
§438.4(b)(6)	Actuarial soundness; CMS review and approval of actuarially sound capitation rates – certified by actuary as meeting requirements of this part
§438.5(a)	Rate development standards - definitions
§438.5(g)	Rate development standards – risk adjustment
§438.6(a)	Special contract provisions related to payment - definitions
§438.6(b)(1)	Special contract provisions related to payment - Basic requirements
§438.6(b)(2)	Special contract provisions related to payment - Incentive arrangements
§438.6(e)	Payments to MCOs and PIHPs for enrollees that are a patient in an institution for mental disease
§438.7(a)	CMS review and approval of the rate certification
§438.7(d)	Provision of additional information

§438.12	Provider discrimination prohibited
§438.50	State plan requirements
§438.52	Choice of MCOs, PIHPs, PAHPs, PCCMs and PCCM Entities
§438.54	Managed care enrollment
§438.56	Disenrollment: Requirements and limitations (except for §438.56(d)(2)(iv))
§438.58	Conflict of interest safeguards
§438.60	Prohibition of additional payments for services covered under MCO, PIHP, or PAHP contracts
§438.100	Enrollee rights
§438.102	Provider-enrollee communications
§438.104	Marketing activities
§438.106	Liability for payment
§438.108	Cost sharing
§438.114	Emergency and post-stabilization services
§438.116	Solvency standards
§438.214	Provider selection
§438.224	Confidentiality
§438.228	Grievance and appeal systems
§438.236	Practice guidelines
§438.310	Subpart E; Basis, scope and applicability
§438.320	Subpart E; Definitions
§438.352	External quality review protocols
§438.600	Subpart H; Statutory basis
§438.602(i)	State responsibilities – entities located outside of the U.S.
§438.610	Prohibited affiliations

§438.700	Basis for imposition of sanctions
§438.702	Types of intermediate sanctions
§438.704	Amounts of civil monetary penalties
§438.706	Special rules for temporary managements
§438.708	Termination of an MCO, PCCM or PCCM entity contract
§438.710	Notice of sanction and pre-termination hearing
§438.722	Disenrollment during termination hearing process
§438.724	Notice to CMS
§438.726	State plan requirement
§438.730	Sanction by CMS: Special rules for MCOs
§438.802	Subpart J; Basic requirements
§438.806	Prior approval
§438.808	Exclusion of entities
§438.810	Expenditures for enrollment broker services
§438.812	Costs under risk and non-risk contracts
§438.816	Expenditures for beneficiary support system for enrollees using LTSS
§440.262	Access and cultural considerations
No later than rating period for contracts starting on or after July 1, 2017	
§438.3(h)	Inspection and audit of records and access to facilities
§438.3(m)	Audited financial reports
§438.3(q)	Additional rules for contracts with PCCMs
§438.3(r)	Additional rules for contracts with PCCM entities
§438.3(s)	Requirements for MCOs, PIHPs, or PAHPs that provide covered outpatient drugs
§438.3(t)	Requirements for MCOs, PIHPs, or PAHPs responsible for coordinating benefits for dually eligible individuals

§438.3(u)	Recordkeeping requirements
§438.4(b)(7)	Actuarial soundness; CMS review and approval of actuarially sound capitation rates – meet applicable special contract provisions in §438.6
§438.4(b)(8)	Actuarial soundness; CMS review and approval of actuarially sound capitation rates – provided in format and timeframe that meets §438.7
§438.5(b)	Rate development standards – process and requirements for setting actuarially sound capitation rates
§438.5(c)	Rate development standards – base data
§438.5(d)	Rate development standards - trend
§438.5(e)	Rate development standards – non-benefit component of the rate
§438.5(f)	Rate development standards - adjustments
§438.6(b)(3)	Withhold arrangements
§438.6(c)	Delivery system and provider payment initiatives under MCO, PIHP, or PAHP contracts
§438.6(d)	Pass-through payments under MCO, PIHP, and PAHP contracts
§438.7(b), (c)(1), (c)(2)	Rate certification submission
§438.8	Medical loss ratio standards
§438.9	Provisions that apply to NEMT PAHPs
§438.10	Information requirements
§438.14	§438.14 – Requirements that apply to managed care contracts involving Indians, IHCPs and IMCEs
§438.56(d)(2)(iv)	Disenrollment: MLTSS cause for disenrollment
§438.66(a)-(d)	State monitoring requirements; Readiness Reviews
§438.70	Stakeholder engagement when LTSS is delivery through a managed care program
§438.74	State oversight of the minimum MLR requirement
§438.110	Member advisory committee

§438.208	Coordination and continuity of care
§438.210	Coverage and authorization of services
§438.230	Subcontractual relationships and delegation
§438.242	Health information systems
§438.330	Quality assessment and performance improvement program
§438.332	State review of the accreditation status of MCOs, PIHPs and PAHPs
§438.400	Subpart F; Statutory basis and definitions
§438.402	Subpart F; General requirements
§438.404	Timely and adequate notice of adverse benefit determination
§438.406	Handling of grievances and appeals
§438.408	Resolution and notification: Grievances and appeals
§438.410	Expedited resolution of appeals
§438.414	Information about the grievance system to providers and subcontractors
§438.416	Recordkeeping requirements
§438.420	Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending
§438.424	Effectuation of reversed appeal resolutions
§438.602(a)	State responsibilities – monitoring contractor compliance
§438.602(c)	State responsibilities – ownership and control information
§438.602(d)	State responsibilities – federal database checks
§438.602(e)	State responsibilities – periodic audits
§438.602(f)	State responsibilities - whistleblowers
§438.602(g)	State responsibilities - transparency
§438.602(h)	State responsibilities – contracting integrity
§438.604	Data, information, and documentation that must be submitted

§438.606	Source, content, and timing of certification
§438.608(a)	Program integrity requirements under the contract – administrative and management arrangements or procedures to detect and prevent fraud, waste and abuse
§438.608(c)	Program integrity requirements under the contract - disclosures
§438.608(d)	Program integrity requirements under the contract – treatment of recoveries made by the MCO, PIHP or PAHP of overpayments to providers
No later than rating period for contracts starting on or after July 1, 2018	
§438.4(b)(3)	Actuarially sound capitation rates; Capitation rates adequate to meet §§438.206, 438.207, 438.208
§438.4(b)(4)	Actuarial certification to capitation rate per rate cell
§438.7(c)(3)	Ability to increase or decrease certified capitation rate (per rate cell) by 1.5 percent without revised rate certification
§438.62	Continued services to enrollees
§438.68	Network adequacy standards
§438.71	Beneficiary support system
§438.206	Availability of services
§438.207	Assurances of adequate capacity and services
§438.602(b)	Screening and enrollment and revalidation of providers
§438.608(b)	Provider screening and enrollment requirements
§438.818	Enrollee encounter data
No later than July 1, 2018	
§438.340	Managed care state quality strategy
§438.350	External quality review
§438.354	Qualifications of external quality review organizations
§438.356	State contract options for external quality review

§438.358	Activities related to external quality review
§438.360	Nonduplication of mandatory activities
§438.362	Exemption from external quality review
§438.364	External quality review results
No later than rating period for contracts starting on or after July 1, 2019	
§438.4(b)(9)	Actuarial soundness; CMS review and approval of actuarially sound capitation rates – develop rates so that plan can reasonably achieve an MLR of at least 85 percent
Rating period for contracts that start after the release of CMS guidance	
§438.66(e)	Annual program report
No later than 3 years from the date of a final notice published in the Federal Register	
§438.334	Medicaid managed care quality rating system
No later than one year from the issuance of the associated EQR protocol	
§438.358(b)(1)(iv)	States must begin conducting the mandatory EQR activity of validation of network adequacy
No earlier than the issuance of the associated EQR protocol	
§438.358(c)(6)	States may begin conducting the optional EQR-related activity of plan rating

CHIP Managed Care		
Date	**Citation**	**Description**
Effective Date	§457.204	Withholding of FFP for failure to comply with federal requirements
No later than state fiscal year beginning on or after July 1, 2018	See description	All changes to part 457, including new subpart L, except as otherwise noted.
No later than one year from the issuance of the associated EQR protocol.	§438.358(b)(1)(iv), as applied to CHIP per §457.1250	Mandatory EQR activity of validation of network adequacy), as applied to CHIP
No later than 3 years from the date of a final notice published in the **Federal Register**	§457.1240(d)	CHIP managed care quality rating system

Until that applicability date listed above, States are required to continue to comply with the following sections codified in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015		
Citation	**Remains Effective Until Date**	**Description**
§438.6(g)	Contracts July 1, 2017	Inspection and audit of financial records
§438.6(k)	Contracts July 1, 2017	Additional rules for contracts with PCCMs
§438.10	Contracts July 1, 2017	Information requirements
§438.62	Contracts July 1, 2018	Continued services to enrollees
§438.66	Contracts July 1, 2017	Monitoring procedures
§438.202	July 1, 2018	State responsibilities for a quality strategy
§438.204	July 1, 2018	Elements of State quality strategies
§438.206	Contracts July 1, 2018	Availability of services
§438.207	Contracts July 1, 2018	Assurances of adequate capacity and services
§438.208	Contracts July 1, 2017	Coordination and continuity of care
§438.210	Contracts July 1, 2017	Coverage and authorization of services
§438.230	Contracts July 1, 2017	Subcontractual relationships and delegation
§438.236	Contracts July 1, 2017	Practice Guidelines
§438.240	Contracts July 1, 2017	Quality assessment and performance improvement program
§438.242	Contracts July 1, 2017	Health information systems
§ 438.350	July 1, 2018	External quality review, state responsibilities
§438.354	July 1, 2018	Qualifications of external quality review organizations
§438.356	July 1, 2018	State contract options for external quality review
§438.358	July 1, 2018	Activities related to external quality review
§438.360	July 1, 2018	Nonduplication of mandatory activities
§438.362	July 1, 2018	Exemption from external quality review
§438.364	July 1, 2018	External quality review results
Subpart F	Contracts July 1, 2017	Grievance and appeal system
Subpart H	Contracts July 1, 2017	Additional program integrity safeguards

States are required to continue to comply with the following sections codified in the 42 CFR parts 457, edition revised as of October 1, 2015 until the date indicated.		
Citation	**Remains Effective Until Date**	**Description**
§457.10	The first day of the state fiscal year beginning after June 30, 2018	Definitions
§457.902	The first day of the state fiscal year beginning after June 30, 2018	Definitions
§457.940	The first day of the state fiscal year beginning after June 30, 2018	Procurement Standards
§457.950	The first day of the state fiscal year beginning after June 30, 2018	Contract and payment requirements including certification of payment related information.
§457.955	The first day of the state fiscal year beginning after June 30, 2018	Conditions necessary to contract as a managed care entity (MCE).

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